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MAINTAINING A NURSING ETHIC:

**A GROUNDED THEORY OF THE MORAL PRACTICE
OF EXPERIENCED NURSES**

by

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ABSTRACT

This thesis presents a study of the every-day moral decision making of experienced nurses. Eight experienced registered nurses participated in the completed research that is based on data gathered through interviews, document audit and literature review. A grounded theory approach was used to analyse the extensive data gathered for the study. This methodology generated a theoretical description involving the antecedents, processes and consequences of nursing moral decision making.

Nursing practice has a moral content, if not an entirely moral purpose, and moral decision making is the central component of this practice. Every day, in numerous institutions and community settings, registered nurses make moral decisions in their practice, yet the ethical aspects of nursing practice remain a comparatively recent field of study. It is therefore essential to nurses *and* their patients that this process is adequately studied and theorised. To date, very few studies have been undertaken in this area in New Zealand. This study aims to at least partially redress this situation by offering insights through conceptualisation and theoretical description of nursing moral decision making.

The findings of the study reveal that antecedents such as personal moral development, upbringing and social experiences, contribute to a 'nursing ethic' that guided the moral decision making of the experienced nurses who participated in the study. Furthermore, the study shows that the context and individual and shared perceptions of moral events influence the degree of nursing involvement in ethical situations. Finally, the study maintains that an intrinsic and enduring nursing ethic may serve to guide ethical decision making in nursing. This ethic is an undeniable phenomenon of considerable significance to nursing practice and education.

PREFACE

This study has been a long time in the making. Indeed, it may be said that the ideas behind such an undertaking started as soon as I entered the nursing profession at the age of eighteen years, and quite possibly long before that. To shed light on this notion, and possibly several other ideas in the study, I thought it perhaps useful to introduce myself to you, the reader, in this brief preface.

In pursuit of the idea of what it might mean to practise 'good' nursing, and to live a good life for that matter, I have been involved in my adult years with two great and very worthwhile pursuits, namely nursing and philosophy. Hence, from a simple interest in the general philosophical issues that have fascinated others over time, and throughout the years in nursing practice and education, I have been most contented when studying nursing and philosophy in more or less equal amounts.

Hence, as a student nurse, practising nurse, and later as a nurse lecturer, the notion of nursing as a moral enterprise has remained a constant fascination for me. I have little doubt that this interest is a common phenomenon amongst nurses world-wide, because most of the nurses that I have met in this and other countries seem to have pondered on the nature of 'the good' within nursing at some time or another. Indeed, after many hours of interesting conversations with nursing students at both undergraduate and post-graduate levels, I have concluded that nurses frequently consider their work in a variety of philosophical ways. Most of these nurses, and myself, have never described nursing as just 'an ordinary job', whatever that might mean, but as a focused expression of human caring.

Thus, mindful of my own philosophical ideas on moral practice in nursing which have clearly influenced my choice of study, I offer the reflections of other experienced nurses for your consideration in this thesis. They, like myself, would no doubt be more than pleased if you were enlightened by the contents within.

ACKNOWLEDGEMENTS

It would be an understatement if I said that this research study has been a tremendous learning experience for me. From its very conception to the final product, I have frequently been overwhelmed by the sheer enormity of the undertaking. I am now amazed that it is actually a finished product and that I can *at last* fully reflect on the process of writing a thesis for publication.

None of this study would have been possible without the aid of countless others. Many are those who have tolerated and even nurtured my sometimes idiosyncratic ideas and mental aberrations throughout this research, and perhaps, most of my adult life. In many ways, I count myself fortunate for having been lucky enough to have known and learned from some exceptionally gifted people. Naturally it is impossible to list them all—I only wish I could—but they are all remembered with much affection.

To the research participants, I extend heartfelt thanks and admiration. The products of their thoughtful insights are to be found within this study. The kind and considerate attention that they extended to my research gave me tremendous encouragement during the interviews and as the study took shape. Never let it be said that nurses are uninterested in the moral issues within their practice!

To my nursing and academic colleagues past and present, I offer my warmest regards and respect. Several have not only shown considerable interest in my research, but have offered reassurance and kindness when it was needed most. In this regard, I could not have wished for more suitable research supervisors than Dr. Jo Ann Walton, Dr. Andrew Brien and Prof. Julie Boddy. The patient assistance of Lesley Batten when listening to my ideas, offering useful suggestions and proof-reading the finished document must also be noted. I must also thank the Graduate Research Fund committee of Massey University for their financial contribution to the cost of preparing this study.

Finally, I thank my long suffering but fortunately forgiving wife, Helen, and my children, Philip, Adam, Jenifer, Michael and Julia, who have waited a very long time for their father to return to normal. With any luck, this may happen any day now...

CHAPTER ONE

INTRODUCTION AND OVERVIEW

Every art and every inquiry, and similarly every action and pursuit, is thought to aim at some good: hence it has been well said that the Good is that at which all things aim.

Aristotle, *Nicomachean Ethics*.

This research project seeks to discover how experienced nurses make moral decisions in their practice, and the antecedents to and possible consequences of those decisions. To practise in ways that are ethically acceptable to both themselves, their patients *and* others, nurses have to adjust to the demands of several factors in a health care delivery system that is becoming increasingly complex both within institutions and the wider community. Modern technological advances, the information explosion, the drive towards greater efficiencies in health care spending, the casualisation of the nursing workforce and the emergence of new laws relating to health care practice, privacy and confidentiality, have all contributed to the pressures upon nurses to deliver professional and morally justified care to often vulnerable and needy people in rapidly changing circumstances. To achieve professional and morally acceptable care, nurses need to make those moral decisions that will enhance and support their ethical practice. The promotion and maintenance of such practice comes within the domain of nursing ethics.

NURSING ETHICS IN NEW ZEALAND

Nursing ethics, and in particular that branch of nursing ethics concerned with moral justifications of actions, remains relatively under-researched in New Zealand. As both a specific educational requirement in the preparation of nurses and a general necessity of good nursing practice, the ethical practice of nurses has only recently emerged as a central focus of research based attention (Fry, 1994). Nursing ethics received legitimate recognition as a distinct and researchable phenomenon in its own right in the early 1980s, when it was described by Veatch as “a legitimate, if very limited term, referring to a field that is a sub-category of medical ethics” (1981, p. 17). The notion of nursing ethics as a sub-category of a larger field such as medical or bioethics has been the focus of considerable debate ever since.

In the last decade, as caring practice and the nursing role in the health care system became the focus of considerable theoretical development (Benner, 1984; Benner & Wrubel, 1989; Swanson, 1991; Watson, 1985), so too did the emphasis on the ethical component of nursing practice. The simultaneous development of highly influential but 'non-traditional' theories of moral decision making that are based upon alternative explanations of ethical reasoning (as in, for instance, the works of Gilligan, 1982, and Noddings, 1984), has led to a major re-appraisal of the ways in which nurses may reach ethical decisions in their work. In recent years, some nurse theorists have concluded that nursing is *fundamentally* a moral endeavour above all else (Watson, 1990).

The need for in-depth research in the area of nursing moral decision making within the New Zealand health care arena has been conclusively and decisively highlighted within the last decade due to the following major events:

Firstly, recent incidents involving the 'whistle-blowing' actions of nurses in what are perceived as major health care ethics issues are clearly on the increase in New Zealand. The most well known of these incidents in recent years was that involving Charge Nurse Neil Pugmire (Hubbard, 1994; Liddell, 1994; Peach, 1994). Pugmire, a dedicated nurse of some years experience, held the position of Charge Nurse in a large psychiatric institution in the North Island of New Zealand. It came to his attention that a dangerously disturbed patient with self-admitted tendencies towards paedophilia was soon to be released from the hospital under the Mental Health Act of 1992. Following several discussions with other members of staff, including his unit manager, Pugmire drafted a letter to the Minister of Health outlining his "professional and moral" concerns over the imminent release of this patient.

The events that followed during the next few weeks and months attained considerable notoriety amongst nurses and the general public in New Zealand. The letter was largely ignored at governmental levels, and Pugmire duly received two non-committal letters from ministerial sources. The patient was released and within a short space of time had attacked a toddler. Pugmire, now incensed by the lack of action following his letter and most certainly by the attack on the child, sent a copy of his original letter to the opposition spokesperson for Health, who was already asking questions about this and related cases in Parliament. This time the results were startling because part of the

confidential information he had provided quickly became public knowledge through the politician's disclosures to radio and press. The issue at stake was described as that of patient confidentiality versus the public good. Following a long and protracted series of disciplinary hearings, suspensions and court appearances, Pugmire's actions were eventually vindicated, but the cost to him, and his family, was very high. Three years after the event, the Privacy Commissioner found that Neil Pugmire had acted in breach of the Privacy Act 1993.

This watershed incident had not fully faded from the public gaze before yet further nurse-related ethical incidents made media headlines. In 1995 a related incident involved another senior nurse 'going public' with concerns over the returning to the community of certain residents of a large institution who have serious behavioural problems (Martin, 1995). New ethical concerns are presently emerging in New Zealand that involve nurses over safety issues and the apparent lack of adequate staffing in a large general hospital (Martin, 1997). 'Whistle-blowers' legislation has recently been proposed in New Zealand, and nurse leaders have been major protagonists for such legislation (NZPA, 1995). Thus, in the areas of nursing influence, significant ethical incidents of public concern are becoming more commonplace.

Second, the repercussions of the unethical research and practice that occurred at the National Women's Hospital over a period of several years until 1987 are still apparent within New Zealand society, and among its health care professions. Briefly, in this incident, nurses, as well as other health care professionals, were involved in certain unethical procedures. These included the taking of vaginal swabs from new-born infants, witnessing medical students 'practising' vaginal examinations on anaesthetised women, and assisting in limited aspects of medical research, in circumstances where the informed consent of the participants was absent (Johnstone, 1994). Without question, even though nursing as a profession was seen to be relatively blameless for these acts (some nurses questioned and even challenged these procedures), the implication remained that, because of their powerlessness, nurses were unable to act in an ethically autonomous fashion. This observation has, understandably, caused considerable distress to members of the nursing profession (Bickley, 1988).

Third, nurses are not only becoming more interested (and clearly more vocal) in the broader New Zealand ethical issues of health care, but also in their own, more immediate work-place ethical problems. As Hayne, Moore and Osborne (1990) infer, rapidly changing technologies, the information explosion, consumer movements, escalating health care costs, and other health care delivery changes, all place the nursing profession in an increasingly complex health care context. According to Batten (1995):

...constantly publicised are also concerns about how changes within the organisation of the nursing workforce, and specifically those brought about by health reforms, impact on issues of patient safety... and quality of nursing care... (p. 105).

From this observation, and from the findings of research into nursing ethics in New Zealand (Woods, 1992, 1994), it would appear that few nurses would assert that they do not face increasingly disturbing ethical issues in their workplaces on a regular basis. Indeed, the data collected for this small study tended to support this phenomenon. According to Woods (1994, p. 30), the ethical issues that concern nurses in their practice include;

- a) Client/patient issues, such as 'Not for Resuscitation' orders, confidentiality, informed consent and palliative care.
- b) Inter-collegial issues, such as the unsafe practice of peer and other health professionals, and the 'doctor - nurse' relationship.
- c) Professional issues, such as the effects on nurses and their patients of health service re-organisation and current working conditions.

Thus, for several reasons, research in nursing ethics in New Zealand is a timely and essential activity. However, whilst the more dramatic and headline promoting ethical issues confronting nurses are of concern, the need for research into the every-day moral experiences of nurses is even more pressing. Nursing occurs in thousands of instances daily, and is performed in common-place institutions and communities throughout the land. It follows that there must be numerous occasions every day where the ethical

practice of nurses is put to the test. Yet, research into the every-day aspects of ethical nursing practice in New Zealand is uncommon.

Subsequently, the focus of ethical research should be within the common-place practice of nursing itself, and those factors that affect this practice. This focus is an indistinct and unsure one because, as Penticuff (1991) argues, nursing ethics research is impaired by inadequate conceptualisations of both ethical practice and the factors that bear on this practice. In particular, there are major conceptual problems in adequately revealing the connections between the preparation, process and consequences of nursing moral decision making in practice.

THE AIM OF THIS STUDY

It is essential that nurses find suitable ways in which to explain their moral decisions and actions in those instances that represent the important ethical phenomena of their every-day practice. These instances may or may not be part of *all* nurses 'everyday' practices, but if the rapid changes in the delivery of health care continue to accelerate, then many nurses will eventually face such phenomena. In regard to the overall aim of this study, it is more likely that those nurses with some years of nursing experience will be able to relate more appropriately to the past and present phenomena that surround their moral decision making in everyday practice. Therefore, this study will attempt to achieve an explanation of the circumstances that precede, maintain and follow the moral decision making of experienced nurses in their everyday practice within the health care context.

SUMMARY

This brief chapter serves as an introduction and overview of this study which seeks to explore the moral decision making of experienced nurses in everyday practice. The nature and development of nursing ethics has been outlined with consideration for the nature of ethical nursing practice and issues within New Zealand. The background, importance and justification for this study have been outlined. The overall aim of this research has also been proposed. An overview of the structure of this thesis will now be presented.

ORGANISATION OF THE THESIS

To achieve the main aim of this study, the thesis is organised into eight chapters.

The first three chapters pertain to the introduction and overview of the thesis topic and objectives, the place of nursing ethics in the wider fields of bioethics and moral philosophy, and the selection and application of the research methodology.

Chapter two: Philosophy, bioethics and nursing ethics: A literature review

This chapter presents a discussion concerning the origins of nursing ethics within the wider fields of ethics and bioethics, the nature of ethical behaviour based on moral values, and the contemporary ethical concerns of nursing practice. A central component of this chapter is a discussion concerning the usefulness of ethical theory within nursing ethics.

Chapter three: Research methodology

This chapter explains the reasons why the research methodology of grounded theory was chosen for this study. The philosophical background of grounded theory is discussed in depth, as is its usefulness to the aims of this study.

The next three chapters, chapters four to six, are devoted to the presentation of those concepts that represent the 'antecedents', both distant and close to hand, that necessarily *precede* the act of nursing moral decision making. The discussion in these chapters is a description, by means of coding, of the extensive data gathered for this study in conjunction with the selected literature that is available on moral decision making in nursing and other caring professions. Each of these chapters follows a particular theme or main category as follows:

Chapter four: The personal and professional values of nurses within the health care context

This chapter deals with the development of personal and professional values and their importance to nursing moral decision making in the health care context. This chapter also includes an examination of the many contextual influences that may affect the development and maintenance of professional nursing values and subsequently, the moral decision making abilities of nurses in practice.

Chapter five: Nursing perceptions of moral practice

This chapter examines various nursing perceptions of moral practice within the health care context and the particular ethical situations and moral problems that nurses encounter in their practice. A comparison is offered that explores the differences between the moral perceptions of inexperienced and experienced nurses. Following an exploration of the possible barriers or obstacles that nurses identify as problematic to their moral decision making and subsequent actions, an analysis of the nurse-patient relationship and its relevance to the gradual process of moral refinement through nursing maturity and experience is presented.

Chapter six: Nursing levels of commitment in the health care context

This chapter is concerned with the various degrees of commitment made by nurses when they become involved, or otherwise, in moral situations. An entire spectrum is offered of the possibilities or degrees of nursing moral commitment. This commitment ranges from non-involvement to intensely radical, or even personally risky nursing involvement in ethical situations. It is also maintained that experienced nurses are far more likely to use the methods of involvement that are described in the middle section of the 'moral commitment spectrum' rather than those methods that are described in the other sections.

Chapter seven: Nursing moral decision making: Maintaining a nursing ethic

In this chapter, the means are examined by which all of the preceding elements in chapters four to six may influence and subsequently maintain the moral decision making approach that *morally committed* and experienced nurses invariably employ. It will be shown that more useful methods of ethical involvement and decision making that such nurses adopt are directly related to a central or 'intrinsic' ethic that is henceforth called 'a nursing ethic.' In this chapter in particular, the method of grounded theory becomes most transparent by revealing its usefulness as a process that produces extensive categorised data and analysis. The generation of theory is consequently most apparent in this chapter.

Chapter eight: Discussion and recommendations

This chapter presents the final discussion, implications and recommendations of the research findings. The nature of a nursing ethic and its value in nursing practice and education is discussed at length. The limitations of the study and possible implications for future research are considered, as is the development of a substantive theory of nursing decision making. The study concludes with a final statement on the nature of the moral decision making abilities of experienced nurses within the health care context.

LANGUAGE

An attempt has been made in the preparation of this study to avoid potentially sexist language, or gender typecasting. However, to avoid the unnecessary repetition of the ungainly 'she/he', the common convention of 'she' is frequently used for a nurse, and likewise 'he' for a patient. Otherwise, in those instances where the text includes a direct quotation concerning a female or male, the correct pronoun is used. It is also accepted that the use of the word 'patient' now carries certain connotations of vulnerability or inequality, but because it was the term that was most frequently used by the participants to refer to those to whom they gave care, it is utilised throughout the study.

CHAPTER TWO

PHILOSOPHY, BIOETHICS AND NURSING ETHICS: A LITERATURE REVIEW

Consider your origins: you were not made to live as brutes, but to follow virtue and knowledge.

Dante Aligheri, *Divina Comedia 'Inferno'*.

INTRODUCTION

This chapter traces the course of nursing ethics from its origins in nursing philosophy, theory and practice, and ethics - the branch of philosophy that deals with the moral dimension. Following discussion on values as the foundation of ethical behaviour, a brief description of the differences between bioethics, medical ethics and nursing ethics, and the development and contemporary concerns of nursing ethics are considered. Next, the theories of ethical decision making are examined. The relevance of the ethical theories used in nursing ethics is also debated. Concurrently throughout this latter section the usefulness of ethical theories will be discussed in relationship to nursing practice.

NURSING PHILOSOPHY, THEORY AND PRACTICE

The essence of nursing is generally represented by a system of beliefs, values, or tenets that are reflective of the views of nurses and of those who receive nursing. The nature of any inquiry concerning nursing that seeks to elucidate this system is therefore fundamentally philosophical in nature. As such, any nursing research that is undertaken in this area should at least concentrate upon the components of philosophical inquiry; that is, it should concern itself to a "rational investigation of being, knowledge, and right conduct" (Collins Dictionary and Thesaurus, 1992, p.742).

Nursing has evolved as a professional discipline since the turn of the century, but if a comparison is made with the other major health care profession of medicine, then nursing is a 'young' profession. As the profession evolved there was more emphasis on the scientific aspects of nursing than the philosophical aspects. Consequently, the contemplative or subjective nature of nursing, especially its moral nature, has been neglected in favour of its more perfunctory or objective nature. Yet, as even a newly

graduating nurse would maintain, there is within nursing an element of sublime involvement with the lot of others that is both highly inter-personal and often deeply meaningful. In recent times, as the nursing profession has evolved through research, theory development and practice refinements, so too has the depth of understanding of a philosophy of nursing. Hence, it is now proposed that the central tenets of nursing are closely associated with what were once exclusively philosophical notions only. These tenets are;

1. (What it means) to be a nurse (ontological)
2. personal knowledge (self knowing)
3. the acquisition of nursing knowledge (epistemological)
4. nursing practice, including the moral conduct of nurses (ethical)
5. socio-political contexts (contextual)

(Adapted from White, 1995).

Thus, nursing is now considered to be concerned with *being*, as a participant in human affairs and as 'a nurse'; *knowing*, as in knowing oneself and nursing knowledge; and *practice* in context, that is nursing within diverse socio-political contexts. The close connection between knowledge and practice is profound because: "Every discipline exists in part to provide knowledge which is to be utilised and thus has an associated practice realm" (Donaldson & Crowley, 1978, p.116-117). Furthermore, that practice must, if nursing is a human endeavour, be moral in nature, because nurses care for people who are often in vulnerable circumstances. Hence, knowledge, practice and ethics are essential to the philosophical concerns of nursing. Yet each component, as a part of the structure that is the discipline of nursing, would be philosophically confusing without the necessary connections between them, as it is only by understanding these necessary connections do we better understand the whole.

The search for the necessary connections in the pursuit of structural explications appears to be the search for what Donaldson and Crowley call the "relationships and commonalties" (1978, p.113). In their extensive review of nursing literature relating to

the 'recurrent themes' in nursing, they claim that these concerns are with:

- principles and laws that govern life processes, well-being, and optimum functioning of human beings - sick or well
- the patterning of human behaviour in interaction with the environment in critical life situations
- the processes by which positive changes in health status are affected.

Arguably these themes are the *epistemological connections* that unite the ontological and moral forms that are nursing. However, the philosophical essence of nursing is not merely a description of the acquired knowledge of nursing, but also an interpretation of nursing *as practised*. Indeed, it is nursing practice itself that gives us knowledge and theory, and not, as has been presumed, the other way around. As Bishop and Scudder maintain, "a theory of practice would discern the order which gives meaning to the practice" (1990, p.67). Nursing practice occurs within several contexts, but *ethical* nursing practice, or that part of nursing where ethical decisions and actions are made, occurs within what is now seen as the realm of bioethics.

BIOETHICS AND MEDICAL ETHICS

Bioethics may be described as a sub-class of ethics or moral philosophy. It is itself a relatively new term, emerging in literature in the 1970s to signify ordinary ethics applied to the bio-realm (Clouser, 1978) and in the health professions. It has become a major discipline within a relatively short space of time, being now considered as an umbrella term to cover all sub-groups concerning ethics, human life and health issues. Subsequently, health care workers, philosophers, lay practitioners, patients and their relatives, and members of the general public may be said to have an interest in bioethical issues. However, those who may benefit from a deeper understanding of bioethics are clearly those more closely involved in the delivery and research aspects of health care. For a variety of reasons, such as the rapid development of medical technology and research, the field of bioethics has been strongly associated with 'biomedical' concerns. Consequently, it may be claimed that in contemporary usage bioethics is so frequently

associated with biomedical or medical ethics that the ethical concerns of other health care professions, such as nursing, may be overlooked (Jameton, 1984).

Medical ethics is defined as “the study of ethical problems in medicine using the theories and techniques of moral philosophy” (Honderich, 1995, p.544), but in general terms it may also be used to signify those ethical beliefs, concerns and practices of doctors *and* nurses. Arguably, this more general usage of the term could be considered to be misrepresentative of those distinct ethical issues that concern the nursing profession. That is, the ethical concerns of the nursing profession are not necessarily the same as those of the medical profession, or even the wider bioethical concerns of the general populace.

NURSING ETHICS

As a study of the ethical beliefs, concerns and practices of nurses, nursing ethics has a long history. As Jameton (1984) notes: “No decade has passed since 1900 without publication of at least one basic text in nursing ethics” (p.36). However, it may be described as a more recent phenomenon in terms of academic development, research and inter-professional recognition. The growing realisation amongst nurses in the 1970s and beyond that their practice was not only quite distinct in many ways from medicine, but that it was also undergoing rapid changes may have been a driving force in this regard. According to Hayne, Moore, and Osborne (1990), changes in health care delivery systems and societal expectations; the advent and use of new technology; the rise of the women’s movement; and escalating health care costs and scarce resources, have all contributed to increased pressures on the nursing profession to find adequate responses in the last two decades. It is therefore likely that the impetus to accept the discipline of nursing ethics as a viable and distinct entity that is independent of, but related to, medical ethics mirrors the considerable recent efforts of nurses to become more autonomous and accountable for their own professional and ethical practices. Hence, a gradual recognition amongst nurses for the need of greater autonomy in nursing practice and ethical responsiveness has been a significant catalyst for change (Yarling & McElmurry, 1986).

For some, the development of nursing ethics as a distinctive and separate branch of bioethics is an unnecessary one. "Nursing's contribution...would not be to create nursing ethics but to inject health care ethics with a more patient/client-led perspective" (Melia, 1994, p.7). Melia's argument is basically that it may not be necessary to develop nursing ethics *per se*, but to promote greater nursing involvement in wider health care ethics issues. However, there are others who envisage the moral perspectives and practices of nurses as *no more than* a sub-category of health care ethics or bioethics, but as a viable practice for ethical analysis nonetheless (Veatch, 1981). Yet, as nursing theorists have increasingly made apparent in the 1980s and 90s, nursing merits its own theories based upon its own identifiable practice parameters (Benner, 1984; Benner & Wrubel, 1989; Swanson, 1991; Watson, 1985). If nursing is a predominantly human needs based enterprise, but more than a practical activity or a mere 'job of work', then arguably it is both a moral activity *and* worthy of ethical analysis.

In New Zealand, as the professional dimensions of nursing continued to expand both academically, as a discipline supported by research and theoretical application, and publicly, as a voice for the public good, nurses increasingly turned their gaze towards their own moral practice. Perhaps in response to these and other phenomena (previously noted), New Zealand's *first* code of ethics for nurses, arguably an *essential* requirement for any helping profession, was published in the late 1980s (New Zealand Nurses Association, 1988). However, from this period onwards, significant changes have occurred in New Zealand's health care climate that have brought the issues surrounding nursing ethics into a new and even sharper focus. The most significant development in health care delivery in New Zealand, as in many other developed nations in the last decade, has been the radical restructuring of the health services from a service based model to a business based model (Thompson, Melia & Boyd, 1994).

It is currently maintained that the profession of nursing may have its own, yet to be fully realised, theoretical and practice-based ethics. In any event, the notion of nursing ethics as a specific field of research and study remains a relatively new and possible contentious one. Whether it is a separate entity or a sub-category of bioethics, it remains evident that the debate over the place of nursing ethics will continue for a considerable time. Within nursing, the present debate is largely concerned with the problem of which general ethics

approach is the most suitable for nursing theory, practice and education (Allmark, 1995a, 1995b, 1996).

In reply to the debate over a satisfactory account of a comprehensive nursing ethic, Duckett, Rowan-Boyer, Ryden, Crisham, Savik and Rest (1992) have described some of the attempts to present nursing ethics as different from more traditional accounts of applied bioethics as vague or misperceived. These attempts are often centred upon the claim that nursing is a care-based activity that possesses a care-based ethic (Bradshaw, 1996; Fry, 1989b). Others seem to believe that the difficulty in expressing a coherent explanation of a nursing ethic (as opposed to a medical ethic) is understandable because nurses mainly act on 'intuition' or 'feelings' and do not necessarily 'justify', or even *have to justify*, their ethical behaviour at all (Parker, 1990). Alternatively there are those, often bioethicists who support various moral philosophical approaches like utilitarianism or deontology, who argue that nurses should use traditional methods such as universal ethical principles or rules in this pursuit (Kuhse, 1993, 1995). There is another group, comprising of nursing and medical ethicists in particular, who now espouse the view that all health care workers should re-appraise those virtues that have long been associated with cure and/or care based professions (Le Veille Gaul, 1995; Pellingrino & Thomasma, 1993; Thomasma, 1994). Then, there are those who advocate a type of values promoting ethical compromise in the pursuit of good nursing practice (Fry, 1989a). Finally, there are those, the sceptics perhaps, who believe that nurses are unable to act in a fully moral fashion due to the 'constraints of the system' (Yarling & McElmurry, 1986). In all the above possibilities, one factor is unavoidably clear. Nurses *are* involved in ethical actions, and therefore they *are* involved in one form of moral decision making or another. The extent of that involvement, the preparation beforehand and the eventual consequences of such decision making are thus of interest to the profession at large.

Benner (1984) concluded in her research that nursing knowledge derives from its own practice. Therefore, if the ethical practice of nurses is to be investigated or studied, the helping professions (such as nursing) should focus on those actions that are aimed at promoting human good in society, as Gadamer (1960) implies. An important role of research in nursing ethics is therefore to discover the moral nature of nursing through an explanation of nursing knowledge and practices that are of benefit to those who are

nursed in the present and in the future. However, any individual, nurse or otherwise, has to develop a sense of 'good' or beneficial acts before they can explain these acts in moral language or demonstrate goodness in moral behaviour. This requirement is considered to be an essential part of moral development, and is usually referred to as the acquisition of moral values.

VALUES, MORAL VALUES AND THE PROCESS OF CHOOSING

A value has been described as:

The basis from which we assess the importance or worth of something, estimate the relative salience of various things or actions, for the achievement of our life goals, or *the well-being of others/society* (Thompson, Melia & Boyd, 1994, p.9, italics added).

If, as Dewey (1964) maintains, the complex relationship between human thoughts and actions are to be understood, then the pluralistic acquisition of human knowledge and diversity of human experiences must be taken into account. As such, a nurse must acquire the necessary means whereby she may perceive (sensitivity), consider (cognition, reasoning) and act (response) upon each moral situation that confronts her, from some *previously learned* experiences that have formulated her *moral values*. Moral values are those values that we ascribe to human actions, behaviours, institutions, or character traits (Frankena, 1973).

Any theory concerning personal or socio-cultural value is likely to be a complicated one. From the earliest times to the present, the notion of value has been troublesome for philosophers. The complication is largely due to the nature of values themselves. In comparative studies of different societies, they may be considered to be a socio-cultural phenomenon, and therefore changeable according to time and place (a 'relativity' argument); or they may be seen as eternal or universal phenomena, applicable in any society at any time (an 'absolutist' position). To others, societal values may be just popular ideologies of the period, such as 'economic rationalism' or 'national socialism'. However, these major problems aside, it remains reasonable to assert that whatever the presumed values within society may be, all human values are consciously (and perhaps subconsciously) chosen by each individual, whoever they are and wherever they may be.

If this is so, then values must be 'discovered' by the human mind. It has been suggested that this process occurs in a similar way to the discovery of 'facts'. A fact, or, "a truth veritable from experience or observation" (Collins Dictionary & Thesaurus, 1992, p.356), must be accepted or not by each individual according to the process of cognitive choosing. Hence, in the case of values:

Values do not exist as eternal entities someplace to be discovered by the theoretical mind. Every person experiences the problem of choosing between two or more possibilities. The question about values arises in these experiences when choices have to be made (Stumpf, 1983, p. 396).

Choosing then, or appraising the relative importance of various things or actions, is the key to values. Each individual must choose depending upon their own motivations or desires, which themselves may be individually and/or socially based. This process of estimating or assessing is thought to become our 'value system' for present and future choosing of desirable acts within society. But this choosing cannot be a haphazard affair because all acts, however minor, are acts of the will. Decision making, be it moral or otherwise, relies firstly on cognition. Clearly, the knowledge gained from past experiences will serve as an important guide whereby a planned act may be appraised. Nevertheless, some values will be more important than others for each individual and are prioritised higher within each individual's value system.

MORAL PROBLEMS, DILEMMAS AND QUANDARIES: THEIR RELATIONSHIP TO VALUES

The difference between moral problems, dilemmas or quandaries may be, to some, a slight or unimportant difference only. In general usage, and in data for this study, the terms can sometimes be used synonymously. However, in the interests of clarity, the following definitions are suggested:

A *problem* is defined as "a doubtful or difficult matter requiring solution, something hard to understand or deal with, an exercise, test or challenge set for us, or 'thrown up' by life or experience."

A *dilemma* is “a situation in which a choice has to be made between alternatives that are both undesirable, or, in ethics, an apparent or actually irresolvable clash of competing principles or duties.”

A *quandary* is “a perplexed state, a state of practical uncertainty or puzzlement over alternative choices, a practical dilemma.”

(Thompson, Melia & Boyd, 1994, p.5).

Hence, a moral dilemma may contain elements of all of the above. This is because a moral dilemma presents us with a problem that is seemingly irresolvable, perplexing or puzzling. Yet while all moral dilemmas may indeed constitute moral problems, it is not the case that all moral problems are perceived as moral dilemmas. As Johnstone (1994) maintains, moral problems may occur when an individual is unable or unwilling to adequately recognise and respond to a moral situation. That is, ‘moral blindness’, moral indifference or complacency may represent a moral problem, but not necessarily a moral dilemma. There is little argument that moral dilemmas arise out of our *experiences*, and usually present as a *choice* between conflicting moral *values*. There is a moral problem though in this choosing, because the choices in moral dilemmas are often between one moral concept, principle or rule, and another.

Traditionally, a moral dilemma is thought to occur when the ‘right decision’ that precedes action in a given situation (context) is unclear. That is, there is a perceived conflict in justification (both personal and perhaps collectively) between:

- (a) the rights of another individual versus the duties of the moral agent
- or (b) two moral principles
- or (c) two moral rules.

A *moral principle* is a general but more fundamental statement than a moral rule. For example, it's wrong to lie to others (rule) because it depreciates their autonomy (principle). A *moral rule* is a general guideline governing actions of a certain kind. The rule asserts what ought to be done in a range of certain cases. A *moral judgement* expresses a decision or conclusion about a particular action. *Moral justification*

represents an answer or position concerning the reasons as to why a particular ethical action should be, or is, taken.

Some actions may not require elaborate moral justification (i.e. those acts that involve the application of moral theory). Instead, suggests Frankena (1973), more factual knowledge and/or greater conceptual clarity may be all that is required. However, whatever the 'true' nature of the moral conflict may be, it could be accepted that the degree of and need for moral justification may vary according to individual perception. The ability of each individual to assess and adequately respond to moral problems is directly related to the cognitive processes of choosing and 'prizing' (which is described as being pleased with or proud of one's choice), and then acting accordingly (Raths, Harmin & Simon, 1966). This is thought to involve the use of deductive reasoning by means of values clarification and the application of general ethical principles or rules in order to make a decision on the necessary action to be taken. These general principles include beneficence, non-malificence, autonomy and justice (Beauchamp & Childress, 1994). Moral principles are not intuited however, they are *learned*. Hence, a moral judgement is made by the individual of the situation at hand that is based on his or her hierarchy of learned moral values. Accordingly, there are theories of moral development that relate directly to the learning of moral values and moral decision making.

MORAL DEVELOPMENT

According to Piaget (1932/1968), the core of morality is the value of justice through the ability to reason by means of logic. Piaget identified four stages of mental growth in children. These stages are:

1. The early experiences with the world of physical objects
2. The development of intuitive reason (around the age of seven years)
3. The use of abstract concepts (including relationships)
4. The use of logical and systematic reasoning

Correspondingly, Kohlberg's (1981) theory of moral development occurs in stages that relate in the most part to those of human development from childhood to adulthood.

In Kohlberg's study of moral development, there are three levels and six stages. Kohlberg's first level of moral development is termed 'pre-conventional morality'; the second 'conventional morality' and the third, 'principled morality'. It is thought that only in the second and third levels of moral development do individuals develop a social system of morality, incorporating the notions of a social system and a social contract. The social contract in particular is seen in terms of respecting or valuing the rights of others in the form of highly regarded principles or rules that should be followed by all. Each level therefore represents moral progress from early childhood to adulthood and self-governance or *rational* decision making. Thus reasoning, by means of abstract principles based on justice, is considered the highest or 'adult' stage of moral development.

Kohlberg's (1981) view draws upon a synthesis of developmental theories. In his view, developmental changes of cognition (Piaget, 1932/1968), social role-taking (Selman, 1976), moral reasoning (Kohlberg, 1981) and ego development (Loevinger, 1976) occur in a sequential and necessary relationship to each other. That is, cognitive development is a necessary condition for a social perspective which is itself a necessary (but not sufficient) condition for the development of moral reasoning. Finally, the development of moral reasoning precedes the refinement of ego development, which is a (presumed) state of individual integrity. Kohlberg's (1971, 1981) work draws upon centuries of rational or reason-based philosophical thought, and his work owes much to the ideas and deontological methods of Kant (trans. 1972). Unlike Kant, who attempted to accommodate the empiricist view, Kohlberg stood in direct contradiction to this view, preferring a Platonic approach instead (Kuhmerker, Gielden, & Hayes, 1991). Nevertheless, Kohlberg was able to adapt Platonic assumptions into a rigorous methodology for research purposes.

It remains to note that Kohlberg's hypotheses about these structural relationships depends upon presupposed intellectual abilities, which in itself is related to Dewey's (1929) argument on cognition and learning. However, it should be understood that intellectual abilities do not guarantee advanced levels of moral reasoning. This observation therefore represents one possible challenge to the cognitive-psycho-social reasoning position of Kohlberg and others on moral development. There are other

challenges (the most notable being that Kohlberg used male subjects only for his research), but nevertheless Kohlberg's theory has been promoted as being of considerable value to ethicists and the 'helping professions' in recent years (Kuhmerker, Gielden & Hayes, 1991).

One of the most powerful arguments to challenge Kohlberg's (1981) theory of moral development has arisen from one of his associates, Carol Gilligan. Her research in 1982 with female subjects, which is also based on a study of psychologically orientated moral development (as in Kohlberg), led her to offer three arguments:

- 1) That the distinctly feminine voice of care, connection and responsibility in human relationships has been suppressed in Kohlberg's male orientated model of justice reasoning.
- 2) That Kohlberg's methods and theories misrepresent women's moral development which leads to artificially depressed scores for females responding to his justice-reasoning scale.
- 3) That the early development of girls favours the fusion of social attachment and empathy with identity development, while the early development of boys favours the fusion of separation, individualisation, and yearnings for autonomy.

Gilligan (1982) maintains that there are three levels of moral development, each with two transitional stages, but that these levels reflect a type of moral development that is not so much *rational* in nature but *character* orientated. This theory of moral development therefore draws inspiration from the works of Aristotle (trans. 1962), and Hume (trans. 1978) to some degree, rather than the rationalist works of Kant and others. In both Aristotelian ethics and in Hume's account of ethics, the notion of reason as a precursor to moral acts is not as important as moral sentiment or obligation to contextual relationships with others. Hence, upon completing her research on the moral development of females, Gilligan (1982) claimed that care and responsibility within personal relationships is ethically more important, or as important, as abstract reasoning. In Kohlberg's (1981) theory, care and responsibility is representative of only the third stage of moral development. Gilligan placed it much higher in her model, and concluded

that Kohlberg's higher emphasis on justice had led to the possible conclusion that females were slower in moral reasoning development than males, and that even when fully adult, many were incapable of fully abstract reasoning in this regard. This hypothesis was considered to be both insulting and detrimental towards women. Thus women, as expert caregivers and morally committed professionals, and as the bulk of the nursing workforce, were at least theoretically presumed to be unable to deal effectively with moral dilemmas.

In essence, Gilligan's work contrasts the notion of the feminine 'voice of care' with the masculine 'voice of justice', maintaining that there is "...one that speaks of connection, not hurting, care and response; and one that speaks of equality, reciprocity, justice and rights" (Gilligan, 1986, p.241-242). The significance of these apparent differences in the field of moral development and ethical decision making is of great interest in applied ethics because "these two moral voices are distinct orientations, distinguishable by differences in the reasoning strategies employed and the moral themes emphasised in the interpretation and resolution of moral problems" (Carse, 1991, p.6). Instead of an orientation towards the main concept of 'justice' and the necessary process of abstraction from the particular that this may involve, Gilligan's themes and strategies are orientated around (a) relationships, (b) the needs of others, and (c) the particular context of the care situation. According to Gilligan, this orientation, more favoured by women than men, is not a random phenomenon. However she, like Kohlberg, considers this type of moral decision making to be the product of a learned psycho-social process, or 'moral thinking', which begins in early childhood. Hence, to understand the process of moral decision making amongst nurses, an examination of the developmental and socially contextual *antecedents* of such decision making is necessary.

MORAL DECISION MAKING IN NURSING

Moral decision making or moral reasoning is traditionally considered to be dependent on at least two psycho-social processes, namely ethical sensitivity or perception, and an ability to morally reason. Thus, the process of moral decision making begins with a general awareness that a situation has moral qualities or dimensions that require a moral response, and ends after reasoning skills have been employed to decide upon an appropriate response, such as an opinion or action (Fry, 1994). However, moral decision

making does not occur within a vacuum, but within a social context. Hence, any explanation of how nurses, or any other individuals, make moral decisions or choices should relate not only to mental perception and reasoning capabilities, but also to context. Since the contexts that any moral individual may find himself or herself in may differ considerably, and the development of sensibility and reasoning may vary enormously, any theory of moral reasoning is fraught with complications. These complications are to be found in research into nursing ethics, particularly nursing moral decision making.

It is worthy of note that Kohlberg's (1971,1981) work was very influential on the methods used by nursing researchers in the 1980s to investigate the moral reasoning of nurses. For instance, these methods included the application of Rest's (1974) 'Defining Issues Test.' This test is based upon Kohlberg's theory of moral development (1971), and consisted of a multiple-choice test that measures the level of principled moral thinking over conventional and preconceived reasoning. It has been used extensively by nurse researchers with some apparent success (Ketefian & Ormond, 1988), but it was designed for general, rather than specific (i.e. nursing) use. Other methods, such as the 'Nursing Dilemma Test'(Chrisham, 1981) have also been popular in nursing ethics research. This test measured moral reasoning in nursing situations, and asked subjects to indicate their degree of familiarity with related dilemmas. As such, this test was considered an improvement on more generalised tests of moral reasoning, but all the tests used were considered to contain "methodological imperfections" (Ketefian & Ormond, 1988, p. 13).

Alternatively, Gilligan's (1982) position suggested that the 'care perspective' (as may be expected in nursing) is characteristically a female phenomenon. This claim has been challenged because there appear to be few gender differences in moral reasoning (Thoma, 1986). In Thoma's extensive study (over 6000 participants) the females actually scored slightly higher than the males on the 'principled thinking' level. Also, there is now considerable evidence to suggest that Gilligan's claims are unsubstantiated and even misguided due to the lack of a systematic review of relevant literature in her research (Walker, 1984). Yet, in a study using Gilligan's framework to analyse nurses' stories about making moral choices, Millette (1994) found that the caring orientation was clearly

present in conjunction with the lesser orientation towards the principle of justice. Yet for many perhaps, the basis of Gilligan's challenge to Kohlberg's work is seen as a feminist argument based on gender differences. Gilligan herself disclaims the view that she is merely advancing the idea of a 'male' and 'female' moral voice as such, but argues that it is a viable perspective to the male orientation that she sees in Kohlberg's work. If nothing else, Gilligan's contention that there was "a mode of thinking that is contextual and narrative rather than formal and abstract" (1982, p.19) has promoted the view that the moral domain includes a greater emphasis on caring, responsibility and responsiveness to the needs of others.

Subsequently, Gilligan, and others (such as Noddings, 1984), have at least provided an important stimulus for those nurse theorists advancing the philosophy, theory and ethic of care from their own research within nursing practice (Benner & Wrubel, 1989; Bishop & Scudder, 1991; Leininger, 1988; Watson, 1988). Thus, the ideas that began with Gilligan's work on moral development have become an issue of considerable interest in contemporary nursing ethics. Nurses may indeed be seen to function in particular relationship modes, and attend to the needs of others in specific ways, as in personal care or 'caring about' modes, and within specific caring contexts. Nurse ethicists and other writers have subsequently supported the concept of an ethic of care in nursing (Carse, 1991; Fry, 1989b; Gadow, 1985; Tschudin, 1992), or heavily criticised it (Allmark, 1995a; Kuhse, 1993, 1995). In this debate opinion, and certainly useful conclusions, remain mixed, but there is evidence in data obtained for this study (see later discussion) that nurses, male or female, do offer views that support a care based ethic as much as, or even more than, other views.

In any event, it remains pertinent to any discussion regarding moral actions that the necessary precursor to those actions involves *some* process or other associated with moral perception, reasoning, decision making or choosing. This is undoubtedly a complex process involving several variables. It should also be remembered that for an action to be regarded as a moral action, the act itself may not necessarily be described as moral *per se*, but the reasoning behind the act is, or should be. However, as noted earlier, the process of making an ethical decision is fraught with problems. In many instances, the 'moral agent' (i.e. the person faced with the moral decision) finds that she is in a moral

situation that presents in a confusing or complicated way. In short, there is no easy decision, only conflicting possibilities. This situation is the stuff of moral philosophy or ethics.

ETHICS, NURSING AND NURSING ETHICS

Ethics is that branch of philosophy that is concerned with the ways in which humans ought to live their lives. This is a complex topic, because it introduces numerous moral phenomena such as the value of moral character, interpretations of moral acts, theories of ethical behaviour and many more. Ethics terminology and meaning may vary depending on source and philosophical positions, but Seedhouse's (1988) use of the term 'every-day' ethics is of interest in this study. Seedhouse maintains that 'every-day ethics' signifies the more intuitive and spontaneous moral responses to life's dramas and dilemmas; that is, the ways in which ordinary people may behave and justify their moral behaviour. Others argue that ethics is a more systematically organised examination of those principles or rules by which we should conduct our lives (Hare, 1952). For the purposes of this thesis, Seedhouse's notion of ethics is preferred over, but does not exclude, more formal notions of ethics.

An *ethical theory* is traditionally viewed as a collection of morally based rules and principles that relate in a systematic way. There may be times when general rules or principles are not sufficient, and then it is believed that ethical theory may assist. Ethical theory is thought to introduce clarity, substance, and a systematic approach to ethically responding to moral questions. It is claimed by some ethicists that ethical theory may enable an individual to choose not only a certain response, but also to show why that individual chose that response, and to justify his actions, if necessary (Beauchamp & Childress, 1994).

The use of ethical theory may also guide the decision making process. In brief, the process of moral decision making in response to a moral issue or dilemma would follow a response similar to the diagram in *figure 1*. Nurse educators have used various ethical theories to assist student nurses to examine, analyse and understand their moral practice. The practical effects of using these theories in this manner are perhaps of mixed value because of the danger of oversimplification of the moral decision making process. This is

problematic in the sense that it may lead to a similar oversimplification of the moral problem or situation. Nevertheless, such approaches, and others, are common in nursing ethics literature.



(adapted from Beauchamp & Childress, 1994).

Figure 1. Moral decision making using a traditional ethics approach.

COMMON ETHICAL APPROACHES IN NURSING ETHICS

Nursing ethics literature, with a few exceptions perhaps, has until recent years reflected the use of what may be described as 'traditional' or 'formal' methods of ethical analysis and decision making. Formal approaches to ethics usually comprise of the application of grand theories or views of ethics, by means of a philosophically based explanation of moral principles, rules, rights and duties, from which the individual may decide and act. There is considerable diversity in such views because centuries of theological, historical, sociological and psychological opinion have provided a great number of ethical views from which to choose.

FORMAL APPROACHES

Moral egoist theory

The moral egoist position requires that the moral agent should do what will promote his own greatest good. So, the right thing to do, morally speaking, is that that is desired by the agent. (To be desired it must produce 'good' for the agent). The right act is therefore the one that promotes the agent's own good, pleasure and comfort. There are alternatives to this general notion:

- a) If the alternative promotes even more comfort for the agent.
- b) If the agent is not a complete hedonist, and is acting in a way that recognises the need to consider the general good for all, including herself, of course.

In ethics, and also in nursing ethics, this theory is considered dubious due to several factors;

- It avoids the moral concerns facing the agent.
- It may be useless when conflicts of principles or values are present.
- It is difficult to defend as a universal rule or principle, because the idea that everyone should act this way tends to suggest that everyone agrees on what is good or comfortable, which is patently not the case.

Teleological theories

In teleological theory, what is morally right or obligatory is based upon the notion that the comparative amount of good produced in any situation must outweigh the evil. An act is right, therefore, when it, or the rule that may be applied to it, will probably produce a greater balance of good. An act is wrong when it is the reverse. In short, teleological theories are concerned with the *consequences* or *results* of actions rather than the means. Teleological theory is sometimes seen to be an extension, if not a desirable improvement, of hedonist or egoist moral theories in that the good that is desired is the good of pleasure and comfort over pain.

The most commonly known form of teleological theory is *utilitarianism* (Bentham, trans.1948; Mill, trans.1972), which is based on the theory or principle of utility. This theory states that ‘the good’ equals *happiness* or *pleasure*, and so the right actions maximise the greatest good (and least amount of harm) for the greatest number of people. This theory therefore presumes that one can measure benefit or harm in some way and arrive at a balanced equation. Of course each individual has a value of *one* in utilitarianism. Both Bentham and Mill tried to find ways of quantifying or calculating pleasure or ‘the good.’ Utilitarianism was presented as the standard by which right and wrong actions could be compared, and in many respects was an answer to moral egoism and deontology, because it was, arguably not self-serving, and not heedless of the consequences of actions. There are two main types of utilitarianism:

Act utilitarianism

Whenever possible, the principle of utility is used by trying to see which actions will produce the greatest good for the greatest number. One has to ask “what effect over good and evil will my doing this act in this situation have?” The act-utilitarian sees each case as a new challenge because of the different possibilities in each new case. In brief, the act-utilitarian seeks those *acts* that have the greatest utility.

Rule utilitarianism

A rule utilitarian sees rules as central to moral justification. Following rules may be quicker than carefully assessing each case that presents itself to consider the right action to take, as in act-utilitarianism. To determine appropriate moral rules, however, we should ask which rules will promote the greatest general good for everybody. In brief, the rule-utilitarian seeks those *rules* that have the greatest utility (Stumpf, 1983).

There are a number of problems that persist in any examination of utilitarianism theory. These problems include:

- a) Difficulties in establishing the ‘greatest good’ and differentiating it from the least amount of harm.
- b) Problems associated with the idea of happiness. For instance, do we seek total happiness for some, or average happiness for many?

- c) Confusion over the meaning of the 'good' because it varies considerably between individuals.
- d) An inability to know what the consequences will be even if they are thought to be good.
- e) The notion that act utilitarianism could take a lot of time to consider each new situation, or there may not be general agreement on 'the rules' in rule utilitarianism.
- f) The possibility that utilitarianism could lead to a minority having to suffer so that the majority can benefit.

(Adapted from Halverson, 1981).

Deontological theory

The deontological approach to ethics, which is sometimes called the 'formalist' approach, is attributed to Kant (trans. 1972) who suggests that the *moral significance* of actions depends on the nature or form of these actions. That is, there is more than just the 'good' consequences to consider in moral situations because the greatest balance of good over evil, or pleasure over pain, for oneself or others or society, is not necessarily the 'morally good.' Certain features of the act itself, and not its consequences, are worthy of consideration. It could be argued that an act is a moral one *even if* it does not produce the greatest amount of good over evil. Deontological theory supports the notion that the rightness or wrongness of an act depends upon the moral weight of the act itself, and not necessarily the end product.

There are two main types of deontological theory:

Act deontology

The *moral values* of the agent are of paramount importance because one's moral values are the reason for acting in a certain way. The general idea is to consider the moral value of an act in a given circumstance. That is, to ask oneself what would be needed to act morally in a particular situation. Telling the truth is intrinsically a moral act, to be of moral value, and therefore an act that involves being truthful has moral value to humans.

This type of reasoning, that all humans could, by 'intuition', decide the best course of action supposes that any honest person would choose truth and virtue above others. Because in modern usage the word 'intuition' may be misunderstood, it may be more adequately understood as signifying a process of 'reflection'. As in the case of act-utilitarianism, there may be some problems in deciding just which moral values should apply to each particular situation.

Rule deontology

Rule deontology uses rules to define the standards of right and wrong, and therefore to guide our actions. For instance, 'we should always tell the truth', is a rule that if universally applied would (theoretically) prevent harm to others. The maxim: 'Do unto others as you would have them do unto you...' is often associated with the notion of following a general rule or rules. These rules, deontologists argue, are valid whether they promote good or not. It would be logically inconsistent to promote a rule that may be described as a 'universal rule' and then argue that this rule should not apply to everyone. These rules are therefore basic and thus are not derived from any particular situation (as in act deontology). In short, we have moral duties and obligations towards others because the rational human state is to be consistent in our actions towards others (Curtin & Flaherty, 1982).

As is the case with utilitarian theory, there are numerous problems within deontological theory, for instance;

- a) Appeals to intuition may not be enough to justify actions.
- b) There may not always be enough time to judge each situation and consider the right act.
- c) Ethical rules may conflict, and one has to try to prioritise the rules, which is difficult.
- d) There is disagreement about what 'the ethical rules' actually are. In different cultures such rules may vary considerably (the 'cultural relativism' argument).
- e) There are exceptions to rules.

(Adapted from Halverson, 1981).

Kant, the 'founder of deontology', offered the *categorical imperative* in answer to some of these questions or problems: "Act only on that maxim which you can at the same time will to be a universal law" (Kant, trans.1972, p.29). That is, we should act only according to the idea of pursuing the duties of ordinary morality. Following this process of reasoning, the individual would see the inherent reasoning or lack of reasoning in her chosen position. A categorical imperative is therefore an unconditional command, morally necessary and obligatory under any circumstances. However, it is not always possible or desirable to separate duty from consequences. Furthermore, rigidly following the categorical imperative could lead to moral inflexibility (Larmore, 1996). The truth, for instance, can hurt people enormously, but a 'pure' Kantian would argue that it must be told.

THE USE OF FORMAL MORAL APPROACHES IN NURSING ETHICS

In recent years, the danger has been raised of nurses becoming over-dependent on the possibly careless application of rules or principles-based ethics such as may be found in utilitarian or deontological ethics (Cooper, 1991; Gaul, 1986/1987). The argument is that the 'mechanical' or unskilled use of universal principles to resolve moral dilemmas in practice could be detrimental rather than helpful to the overall outcome. That is, it is not sufficient to prepare nurses for ethical decision making by exposing them to a few hours of 'traditional' ethical theory, which is usually based on the use of moral principles or rules, with the expectation that they will apply this theory to practice. There is even a case to be made that the very cornerstones of traditional bioethics, i.e. moral principles such as autonomy, justice, and others, may themselves be insufficient as justification for moral actions because they are not grounded in any particular theory as such (Green, 1990). However, the promotion of traditional ethical theory for use in nursing ethics, both in literature and education, continues to be a common phenomenon. According to Fry, "traditional ethics has had a powerful influence on our understanding of the relevance of ethics to nursing practice" (1994, p. 33). Hence, it may be accepted that traditional ethics approaches may contribute to an understanding of ethical nursing practice, but whether or not nurses actually *use* either principle or rule based approaches to assist their ethical decision making in practice remains unclear.

Nurses are most concerned with those moral quandaries that reflect *their* perception, position and actions in these quandaries. That is, nurses may not necessarily be predisposed to employ abstract and measured ethical methods to immediate moral problems in their workplace. Perhaps, as Seedhouse (1988) maintained, nurses morally respond to life's dramas and dilemmas with an 'every-day ethic' that is more intuitive and spontaneous. Nevertheless, nurses *are* moral agents, and do seek ways to respond to moral dilemmas that relate to their particular involvement. Thus in light of the above, and mindful that significantly different theories (or perhaps even 'anti-theories') have been proposed for nursing ethics, there now follows a section on the use of alternative possibilities to ethical perception, choosing and conduct.

'ALTERNATIVE' APPROACHES

Virtue theory

Virtue ethics is concerned with the notion of the personal or collective possession of good character traits and is most closely associated with Aristotelian moral philosophy (Aristotle, trans. 1962). In nurses, these traits would necessarily include for instance, empathy and compassion. The 'virtuous' nurse may not respond to ethical dilemmas by an appeal to principles or rules, but by the very nature of her self chosen 'vocation'. That is, if she is a nurse who possesses the appropriate character traits of a 'good' nurse, then she will naturally respond to a given dilemma in a moral way.

This idea relates to the notion of nursing as an ethic of care (see below) because such an ethic requires attention to meeting the needs of others with a caring attitude incorporating empathy and compassion. In an article that examines nursing compassion, Le Veille Gaul (1995) implies that an analysis of nursing's ethic of care is possible using 'casuistry', a (non-principle) method originating in Aristotelian moral philosophy. This descriptive method seeks to explicate "the issues or their [ethical dilemmas] nature as they pertain to the unique role of the nurse" (Le Veille Gaul, 1995, p. 48). As such, she claims that the combination of the casuistry method (as both method and validation) with an ethic of care (as a theoretical framework), provides a means of providing data from practice that is conceptually consistent with an ethic of care. Pellingrino and Thomasma (1993) suggest that doctors also should consider a virtue ethics approach. Their advocacy of virtue ethics may also be applied to nursing in that they advocate concepts

(like the pursuance of excellence in moral life, purity of intention and sensitivity to moral complicity) that nurses and doctors could imitate.

Caring ethics/Relationship ethics

Some nursing scholars (Benner & Wrubel, 1989; Johnstone, 1994; Swanson, 1991; Watson, 1988) maintain that caring is the central component of nursing practice. They maintain that it is both the philosophical and theoretical foundation of nursing. The emergence of feminist moral philosophy, as in the works of Gilligan (1982) and Noddings (1984), has done much to encourage the view of caring as the major phenomenon in moral decision making. Accordingly, it does not seem too unreasonable to propose that an ethic of care is a major ethical approach for use in nursing practice (as claimed by Watson, 1990). Other nurses are now arguing that nursing embraces an ethic of care more than any other ethical approach because this ethic most closely reflects or epitomises the moral practice of nurses (Hodge, 1993; Parker, 1990).

The concept of caring ethics or '*an ethic of care*', is predominantly an ethical term based upon the theory of care. It is sometimes considered to be both descriptive *and* ontological because it has profound implications as *a moral way of being*. The use of the term '*a nursing ethic of care*' implies that there is an ethic within nursing practice that is based predominantly on caring as a complete moral response to the health related needs of others. This ethic recognises the importance of the inter-personal relationship that must necessarily exist between each nurse and each patient. This relationship may be well established, as may occur in 'one to one' nursing over a period of time, or it may be of a looser nature, as in 'day care' nursing, or the like. However, an effective nurse, or even a less effective one, will form *some sort* of relationship with her patient(s). These relationships always occur within specific contexts, which may be described as socio-cultural, political, and personal. A nursing ethic of care presumes that the nurse will respond to the individual needs of each of her patients in ways that are cognisant with their given or perceived contextual circumstances. Subsequently, a marked degree of nursing compassion and commitment towards the needs and circumstances of each patient in their care is indicated. As noted by Le Veille Gaul (1995, p.50):

An ethic of care considers empathy and concern essential to moral reasoning and emphasises responsiveness and responsibility in relationships...[It]...does not stand alone in moral reasoning but considers the contextual nature of a moral problem as absolutely necessary for consideration and resolution.

The nurse-patient context, often regarded as ethically problematic due to the various 'restraints of the system', requires careful consideration. Gadow (1988) claims that only within the context of care may nurses reconcile the 'chasm' of (power based) vulnerability between nurse and patient. These aspects of an ethic of care have led to the comparison of such an ethic between 'situation' ethics (Merleau-Ponty, 1945) and 'relational ethics' (Bishop & Scudder, 1990) or "relationship ethics" (Thomasma, 1994, p.94). In both situation ethics and relationship ethics, the moral act is dependent on the actual situation and the relationship between those directly involved.

The 'integrity-preserving moral compromise' view

In what may be seen as a pragmatic attempt to reconcile the conflicting ethical views of all concerned parties involved in an ethical situation, and in the spirit of compromise rather than confrontation, it has been suggested that moral compromise may offer "one way to reach well-grounded ethical decisions that respect the conflicting values of all parties" (Fry, 1989a, p.152). It is, after all, quite unlikely that every patient, nurse and doctor will agree on the most suitable response to a given moral dilemma; but it is possible that these differences of moral opinion may be reconciled if a way could be found that both recognises these differences and at the same time enables all concerned to contribute as equally as possible to finding a course of action that maintains each participant's integrity.

The method requires that all parties in an ethical dispute discuss the given problem (values, principles and interests to the fore and not hidden), in a spirit of co-operation rather than dispute. Ultimately, a 'best decision', and not 'the solution', is reached that the various parties can accept. To achieve the situation of mutual moral integrity, four conditions have been proposed, namely "the sharing of a moral language, mutual respect on the part of those who differ, acknowledgement of factual and moral complexities, and recognition of limits of compromise" (Winslow & Winslow, 1991, p. 307).

These proposed requirements for integrity in ethical discourse are no doubt necessary, but are they possible? Nurses cite the commonly experienced alternative that is often seen as the norm in nurse-physician relationships (or increasingly, in nurse-bureaucracy situations), namely that in ethical disputes it is the nurse, and not the physician, who must often compromise her ethical position (Grunstein-Amado, 1992, p.132). If either party supports the notion that there *has* to be a 'solution', then this tends to lead to the conclusion that there *has* to be a 'right' answer. Thus, the moral compromise approach may not suit everyone, as compromise may not be acceptable to *all* parties, especially those who are perceived to have 'power' in the health care system. Arguably, if medical hegemony is the norm, then it is more than likely that the doctor's opinion will prevail in an ethical decision making situation, and the nurse's opinion will not. However, if this phenomenon does occur it could be argued that the role of the nurse is to support the patient's opinion by acting as an advocate if necessary. Integrity-preserving moral compromise does not mean moral abdication in this regard.

Narrative ethics

It could be argued that in nursing, and perhaps in the study of nursing ethics in particular, there is a rich and deep seam of reflective interpretation and even practical wisdom 'embedded' within the experiences of every nurse. If, as is now suggested by a growing number of nursing writers (Diekelmann, 1993; Rogers & Niven, 1996; Uden, Norberg & Norberg, 1995), these experiences could be used as the basis for inquiry into the life experiences of others, then a more complete understanding of the personal significance of various life events could be more fully elucidated. Furthermore, if these experiences, in the form of stories or *narratives*, could not only be recorded and described but used as the basis for inquiry into the ethical experiences of nurses, then the values, beliefs *and emotions* that underpin the moral decisions and actions of nurses could be interpreted.

According to Nussbaum (1986), ethical behaviour is as much a result of an emotional response as a rational one. As such, the 'rationalistic approach' to ethical situations may be open to criticisms of ignoring human uncertainties, arguably the norm in human affairs, in favour of theoretical certainties. Nussbaum claims that moral problems cannot be 'solved' (as if they were mathematical problems); moral problems can only be approached through personal involvement and intuition. The way to sustain and

understand the impact of intuition is through stories or narratives. We learn to be moral, essentially, from the stories of others and by a process of reflection on these stories.

In any event, nurses have shown considerable interest in narrative ethics in the last few years because, it could be argued, nurses frequently approach the moral problems that they encounter in their practice by telling each other their 'stories'. This process enables other nurses to learn from the experiences of others, especially if the stories contain a covert or even an overt moral message. Such a phenomenon may thereby enhance moral discourse and ethical cohesion amongst nurses because, as Gadamer (1960) maintains: "Understanding in dialogue is not holding to one's own point of view, but being transformed into a common position, in which one no longer is the same as one was before" (p. 360). As disillusionment with the more traditional methods of ethical analysis and decision making has slowly set in amongst many nurse theorists and ethicists, narrative ethics, either alone or more commonly combined with an ethic of care, is rapidly making ground.

The 'constraints of the system suppressing nursing' (ethics) view

This view is not a position on nurses' moral decision making per se, but an explanation as to why nurses are unable to morally decide and justify their actions in the first place. In their now famous study of cases involving nurses in 'moral situations', Yarling and McElmurry (1986) argue that "the moral predicament facing nurses is their not being free to be moral because they are deprived of the free exercise of moral agency" (p. 63). In support of their claim they offer examples from case studies that give sustenance to their contention that "professional nurses are conceived in moral contradiction and born in compromise" (p. 67).

There is anecdotal and research based evidence that nurses in New Zealand also feel significantly compromised in acting upon their chosen ethical decisions (Woods, 1992). Whilst this, and Yarling and McElmurry's (1986) work, suggest that nurses do, for powerful and persuasive reasons, morally acquiesce in the requirements of physicians and bureaucracy, there are instances when some nurses do not. The consequences for these nurses are usually severe, their actions seen as 'heroic' but futile in the face of great odds.

Yarling and McElmurry's conclusion that "unless nursing ... acquires a balance of controlling power in [the] institution or creates new structures for the organisation of practice, it cannot effectively implement standards of care for its own practice" (1986, p. 73) is a powerful plea. Some may conclude that under the present conditions in New Zealand's health care system the plea for greater nursing autonomy is a bleak prospect indeed, but others maintain that there is no guarantee that increasing nursing autonomy in this fashion will necessarily lead to beneficial moral actions in any event (Packard & Ferrara, 1988). For instance, it is arguable that in the wider field of health care that professional autonomy alone is not a sufficient cause of ethical behaviour. Indeed, such autonomy may actually lead to negative consequences (as in the Report of the Cervical Cancer Inquiry, 1988).

These outlines of the various theoretical and non-theoretical approaches to nursing ethics, and hence the ethical practice of nurses, represent most of the positions or views of nursing authors in the literature of the last twenty years. That there is no particular view that is fully accepted as the correct ethical position for nursing is a reflection not only of the current differences of opinion within nursing ethics, but also of great diversity of opinion within ethics and bioethics. Irrespective of this apparent difficulty, nursing continues to offer care and commitment within society. If, as Carper (1978) and later White (1995) maintain, nursing is faced by a complexity of ethical issues in modern health care settings, then the need to respond to this complexity with clear and effective moral strategies is paramount. Such a requirement has recently led to a major debate amongst bioethicists and nurse ethicists concerning the most suitable ethical approaches for nursing practice.

THE CURRENT DEBATE CONCERNING ETHICAL APPROACHES IN NURSING

In recent years, the notion that ethical dilemmas or issues could be analysed and solved 'from the armchair' or in abstract, disconnected ways, has been considerably challenged. This notion is often seen to belong to what may be called 'traditional' or 'rational-based' ethics, such as may be found in the deontological ethics of Kant (trans. 1972) or the utilitarianism of Bentham (trans. 1948) or Mill (trans. 1972). However, the development in recent decades of more contemporary and certainly less 'traditional' philosophical approaches to moral problems, such as existential ethics (Sartre, 1965), situation ethics

(Fletcher, 1967), relationship/caring ethics (Gilligan, 1982) and narrative ethics (Nussbaum, 1986), has recently led to several objections to traditional methods of ethical analysis. These objections nearly always take the form of various challenges to the abstract and uninvolved nature of the traditional methods (that often incorporate the use of a hierarchy of ethical principles or rules) in favour of a more personal or 'contextually involved' approach. That is, it is argued that no-one is immune from, or may abstract themselves out of (by means of appeal to universal principles or rules), the context or situation that each moral agent operates within.

In the contemporary discussion concerning the future direction and inherent ethical approaches within nursing ethics, the contextually involved argument has found considerable support (Carse, 1991; Condon, 1991; Cooper, 1991; Fry, 1989a, 1989b; Hanford, 1994; Hodge, 1993; Johnstone, 1994; Parker, 1990; Roach, 1987; Whitbeck, 1992). However, current arguments remain focused around the differences between an 'intrinsic' or applied (nursing) ethic, such as an ethic of care, and 'extrinsic' or formal ethics, such as may be found within traditional ethics (Olsen, 1992).

An 'intrinsic' nursing ethic such as an ethic of care stands in stark contrast to other more traditional explanations of ethical approaches in nursing in that it poses a challenge to the traditional or reasoned-based ethics that has largely been the status quo in bioethics, and, by association, in nursing ethics. The notion of nursing as caring, let alone as being guided by an ethic of care, is not necessarily accepted by all nurses, and certainly not by some nurse-ethicists (Allmark, 1996). From wider philosophical sources, and frequently by means of 'traditionalist' arguments (as in Kuhse, 1993; 1995) opposition towards the notion of a nursing ethic of care is formidable and persuasive. Those who support formal methods of ethical analysis in nursing practice frequently object to the highly subjective, hence 'distracting,' notions of empathy and compassionate engagement in matters of ethical reasoning. As Kuhse (1993) states:

A caring attitude or disposition may well be necessary to attune us to what a patient wants, or to determine what is in her/his best interests. When it comes to justifying a particular course of action, however, we need to give rational arguments for our views (p. 40).

Hence, ethical 'traditionalists' maintain that something akin to algorithmic methodology is needed to provide a reliable approach to ethical reasoning in nursing. Consequently, the traditional or formal ethics approach promotes the use of abstract or universal principles or rules to guide actions or practice. It is argued that by considering ethical dilemmas in such an abstract or emotionally neutral fashion, sensible and rational decisions may be made. The medical profession is perceived to have largely embraced such an approach for use in clinical practice by means of the application of normative principles to concrete cases (Beauchamp & Childress, 1994). However, nurses, as professional members of the health care team, are also exhorted to respond to those ethical problems that are pertinent to *their* practice by using similar methods.

SUMMARY

This chapter has discussed several key aspects of nursing ethics from its recent origins to the present. The philosophical, theoretical and practical dimensions of nursing ethics have been explored, and a survey of the uses of common ethics terminology, theories and approaches to moral problems has been offered. The relationship of various ethical theories to nursing has been considered in light of past and more recent developments. This study aims to clarify the possible confusion that may currently exist in nursing ethics concerning the most appropriate position or approach to moral decision making that may assist practising nurses. It has been maintained that nursing ethics, and thus nursing moral decision making, is presumed to be a very similar discipline to medical ethics or bioethics. It has also been presumed that nurses, like doctors, either use *or should use* traditional ethical approaches to resolve moral dilemmas in practice. Yet, as contemporary moral philosophers and nursing theorists maintain, the contextual circumstances that involve the moral agent are as important as the abstract reasoning that the moral agent may employ when confronted by an ethical problem. Hence, to encourage nurses to make appropriate moral decisions in practice based contexts, the actual practice of moral decision making in nursing requires further study. From such an examination, those methods that are effective in nursing moral decision making can be extracted from those that are not effective. This study therefore begins with an examination of practice which then yields theory. In chapter three, the discussion concerns the research methodology chosen to undertake this task.

CHAPTER THREE

RESEARCH METHODOLOGY

Growth itself is the only moral end

John Dewey (1920/1957).

INTRODUCTION

This study was devised to explore the phenomenon of moral decision making within the every-day practice of experienced nurses. It was presumed at the start of the research that such nurses would make ethical decisions in their practice, and that this process was a frequent, rather than rare, occurrence within daily practice. Thus, the study was undertaken to ascertain if there was a common and shared approach to ethical decision making amongst experienced nurses. Once discovered, it was hoped that this approach would then possibly allow the construction of a general ethical theory of nursing moral decision making, thereby yielding both a descriptive and a prescriptive ethical theory for nursing that was based on effective moral practice rather than abstract theoretical supposition or speculation. However, because the research was clearly socially orientated research (because nursing is without doubt, a societal occupation) and also research in the area of moral philosophy, a suitably flexible research methodology was required. Such a methodology was found in the grounded theory approach.

This chapter will trace the background rationale and the application of the thinking that led to the selection and use of grounded theory in this study. The central theme of the discussion within the chapter revolves around the reasons why grounded theory was the chosen methodology and its significance to the study. Considering the philosophical nature of moral decision making *and* the grounded nature of the research (which focuses on the context of ethical nursing decision making *in practice*), this chapter also contains discussion on how the chosen research methodology philosophically complements the aims of the research.

PHILOSOPHICAL PARADIGMS AND METHODS OF INQUIRY

For perhaps the last three hundred years or so, humankind has lived through an age that was ruled by the notions of scientific cosmology and rational thought. That is, an age where "faith in the homogeneity of the universe and its systemic, rational order" held sway (Doll, 1993, p.6). This epoch was mainly underpinned by the modernist paradigm. Within this paradigm the pursuit of knowledge about the world and the 'things' in the world (including human beings) was largely a synthesis between Cartesian, rationalist, or deductive methods of inquiry, and Newtonian, empirical, or inductive methods. The pursuit of knowledge, either by rationalist or by empiricist means, or by a combination of both, was eventually to become a major influence on late-modernist philosophy. This philosophy reached its zenith as the philosophy of *logical positivism* by the early twentieth century. In this form it is frequently referred to as the 'Received View version of science' (Stumpf, 1983).

The empiricist paradigm was the result of highly influential assumptions about the nature of 'the physical world', and perhaps unintentionally, on the presumed nature of the world of human beings. These assumptions applied to many 'worlds' which included the world of medicine and early social studies, psychology and sociology in particular. Subsequently, this development led to presumptions regarding the nature of human thought and actions that were indubitably 'mechanical' or, as in the social sciences, 'behaviourist.' As Chalmers (1982) notes: "The whole of the physical world ... [was] ...explained as a mechanical system operating under the influence of various forces according to the dictates of Newton's laws of motion" (p.91).

This view strongly relates to the Cartesian notion of 'bodies' or extensions in space and time in which they are, as if like clockwork, caused to move by various forces. Yet Newton's empirical interpretations of events in time and space were based upon *a posteriori* or observable 'truths', and not the *a priori* or purely rational 'truths' of Descartes and other rationalists. Thus, for the empiricists, and for scientists researching *any* given phenomenon, observation, measuring, and testing hypotheses was the only way to true knowledge about the world. This philosophy of science essentially produced

what is now described as 'normal science' (Kuhn, 1970). It was from this viewpoint that research into the subject materials of the social sciences emerged.

When the philosophy and methods of 'normal science' were applied to sociological studies, the results were often less than clear. This was because "[although] modern science enlightened the world and enhanced everyday life, its approach failed to deliver the anticipated empirical base for ultimate meaning and truth about human beings and their world" (Reed, 1995, p.71). In other words, science has indeed given us theories to describe and answer the 'what' questions, but not the 'why'. Philosophers of both the early and late modernist ages pondered the 'why', struggled with the 'what' (Hawking, 1988), and, especially in existentialist and phenomenological philosophy, questioned the 'how' (Heidegger, 1962). Thus, the much respected vision of the world as observable phenomena, both natural and human, has changed over time. In the post-modernist age, this view is being replaced by new, and as yet frequently uncertain, *visions* of the world.

Thus, in a few decades, the philosophies that underpinned the modernist epoch are giving way (but not necessarily gracefully) to philosophies that re-appraise or 'unpin' the previously revered philosophies. This unpinning is described as different types of re-constructive or de-constructive activities (Doll, 1993). In many ways, a number of influential twentieth century philosophers (such as Heidegger, 1962; Merleau-Ponty, 1945; Sartre, 1956) were each responding in their own way to "the rigid dichotomies modernity has created between objective reality and subjective experience, fact and imagination, secular and sacred, public and private" (Doll, 1993, p.5). Kuhn (1970) saw the eventual demise of the old 'scientific' paradigm and the emergence of a 'new' paradigm as a form of re-construction rather than destruction. In his view, the 'new normal science' was constructed from the 'old normal science', but in ways that reflected the "new fundamentals" and changes in "some of the fields most elementary theoretical generalisations..."(pp. 84-85). Kuhn's overall view was that the development of post-modernism reflects 'process thinking', rather than the structuralist or empirical thinking of the modernist paradigm. This type of thinking owes much to the philosophical works of Whitehead (1929/1960) and Dewey (1929), both of whom wrestled with the problem of studying *human* or social structures and processes rather than those of the 'physical' or 'natural' world.

Dewey (1929) was predominantly absorbed by the apparent problems inherent in the widely differing empiricist and rationalist positions on social thought and moral behaviour. In a typically pragmatist fashion, Dewey maintained that if an understanding of the process of human cognition and subsequent actions is to be gained, then the experiences of human beings must be considered in situational or experiential contexts. This view maintains that human experiences leading to self knowledge, wisdom, and a guide for future actions, rely on the essential process of social interaction. Thus, this position maintains that human understanding and meaning occur through interactions with others. Therefore, human learning is seen as *a social construct*.

Dewey (1920/1957) was interested in the philosophy of pragmatism in which an attempt was made to mediate between the seemingly polar views of empiricist and rationalist positions regarding human knowledge and actions. The empiricist position held that human thought was a mechanistic or biological process that merely 'reflected' or observed natural physical processes. The rationalist position, on the other hand, held that human thought processes were the central component of human reality. The pragmatist response to the apparent differences of opinion inherent in these two contrasting perspectives on the relationship between human thoughts and actions was based upon the notion of the acceptance of a pluralistic approach to the acquisition of human knowledge, and the valuing of diverse human experiences. Whilst Dewey's work led to significant developments in the established fields of education, ethics and religious studies, his eventual contribution to sociology and social psychology was less direct. This only occurred when Dewey's philosophical ideas on social interaction (1920/1957, 1929) were applied to the Symbolic Interactionist Tradition.

THE SYMBOLIC INTERACTIONIST TRADITION

Modern sociological inquiries (such as grounded theory) have their origins in the symbolic interactionist tradition that underpinned the development of American sociological studies in the 1930s and 40s. This tradition was first described by George Herbert Mead (1934) and later refined by Herbert Blumer (1969), who both worked as social psychologists at the University of Chicago. Mead was influenced by Dewey's (1929) ideas on human cognition as a socially interactive event for use in the relatively new discipline of sociology. Both sociology and social psychology were in crucial stages

of development as distinct areas of academic inquiry in the early to middle parts of the twentieth century. During this time Mead, and later Blumer (1969), became increasingly aware that the absence of a reliable sociological research methodology was becoming the focus for major scientific criticism. However, as Kaplan (1964) infers, if all theories regarding the world, both human and physical, are theories of reality, then they are symbolic or abstract theories of reality. If theories are symbolic, then it also follows that theories regarding human thought and actions also relate to some kind of interaction between 'the self' and others. Thus, it is claimed, each of us must learn about the world through a process of 'symbolic interaction'. Because human beings are quite unlike other 'things' in the world, in that they are both multifarious and unpredictable, this process is a pluralistic and wildly diverse one.

Thus, as social scientists increasingly maintained throughout the century, human behaviour does not easily lend itself to theories based upon mechanical models, reductionism, or even 'general principles'. Such theories may even be at odds with observable data if the theory in question is speculative rather than empirical, especially in the case of the construction of general theories. Hence, in the search for a reliable perspective in the social sciences that would both answer the criticisms of the natural scientists, and meet the requirements of social scientists who wished to study human phenomena, Mead developed the perspective of symbolic interactionism. This perspective was based within the socially constructed world in that it explored human interactional processes, and was also philosophically adequate. Mead developed a view of social psychology that was based upon the notion of the individual becoming aware of 'self' in the world. His view may be encapsulated as follows:

Human beings act towards things based on the meanings that the things have for them; the meanings of such things are derived from the social interaction that the individual has with his fellows; and meanings are handled in, and modified through an interpretive process and by the person dealing with the things they encounter (Blumer, 1969, p.2).

This perspective was to become the foundation for a significant method of social inquiry now known as grounded theory.

GROUNDING THEORY

The method known as grounded theory was developed by Barney Glaser and Anselm Strauss at the University of California in the 1960s. Following exposure to the perspective of symbolic interactionism at Chicago University, Strauss joined Glaser in the production of two influential books based on their studies of dying people (1965, 1968). These studies provided the impetus for the two researchers to turn their attentions to a book on the sociological research methodology that emerged from their research. This text, *The Discovery of Grounded Theory* (1967), forms the basis for this study, although additional sources are used where appropriate.

Glaser and Strauss viewed human actions as individually perceived phenomena rather than social systems phenomena. They argued that analysis of human behaviour should be induced from an individual's perspective of his or her involvement in social groups, institutions, and similar, rather than from an attempted analysis of the wider societal perspective. Furthermore, whatever meaning may be derived by individuals from the 'things' or 'objects' in the world, it may only be understood from each individual's (subjective) interpretation of that thing, and not by the presumed (objective) meanings of things or objects. Hence, individual interpretations of things in the world may vary considerably, but nevertheless, the consequences of these things are 'real' for each individual.

Grounded theory is therefore a research method that is 'grounded' in each individual's interpretations of his or her perceptions and given meanings to things in the world. It is subsequently as concerned with 'particulars' rather than with general abstractions. The particulars of each participant are analysed and examined in conjunction with the particulars of others. This analysis may, but not always, yield certain commonalties that form shared patterns of behaviour. This behaviour can be interpreted in various ways, not least by the individual concerned. As such, grounded theory represents a significant development in the study of social phenomena. This is because, unlike the things in the world (that are scientifically scrutinised by an examination of 'the parts' or general characteristics), human 'things' or phenomenological events are dependent upon human interpretation. Hence, grounded theory explains human interpretations of meaning that

are entirely human orientated rather than machine or systems orientated. The implications for nursing research are thus profound.

Grounded theories may be substantive or formal. That is, they may contribute to the development of other theories, or they may be a complete theory if enough substantive theory is produced. Grounded theory may not only contribute to an understanding of an individual's interpretation of a given phenomenon, but by implication, the interpretations of like minded individuals or groups with shared or common interpretations. The main approach to the grounded theory method, based on Glaser and Strauss (1967) and Glaser (1992), is as follows:

1. The researcher identifies and begins to gather data from an area chosen for investigation, mindful of the overall aim of building a theoretical analysis from these data, which are often extensive. Because the grounded theory method refrains from the standard or traditional method of beginning with a preconceived framework or hypotheses, these data provide the necessary abstract concepts and propositions upon which the researcher builds 'theory' or a conceptual theoretical framework.
2. Data continue to be collected and simultaneously examined 'line by line' and coded according to the similarity of the material to other gathered material. This process is called 'coding' because each piece of information provides a code or conceptual unit that may be useful in the eventual construction of a conceptual framework. Dissimilarities to other codes are also noted with the aim of explicating the theoretical properties of each. Analytical memos are produced by the researcher at the same time to summarise the emerging theoretical explanations.
3. Data collection stops when the researcher decides that no new material, or new codes, are being generated. At the same time, each code is gradually merged into bigger codes or conceptual units until main codes, or categories, emerge. Every incident within each new category is compared with the 'dimensions' or properties of that category to allow integration into a unified whole. That is,

when the relationships between the dimensions are presented as an integrated whole, or a complete 'picture', the data are complete.

4. The categories and their properties are examined for 'underlying uniformities' that may eliminate extraneous material and subsequently reduce the number of categories to a sufficiently representational level. This process is part of the process of 'theoretical saturation'; that is, even if further data were gathered, it would be unlikely that new incidents would provide further categorisation material.
5. From the detailed examination of codes by means of constant comparative analysis, and their conversion into bigger codes, a 'core integrating category', or a 'core variable' eventually emerges. This final category is the overarching theme for the grounded theory that unifies codes and categories and underpins theory. The emerging theory is then shared with the participants.

In recent years Glaser and Strauss have developed widely differing viewpoints on how data gathered for grounded theory research should be examined (Glaser, 1992; Strauss & Corbin, 1990). However, for the purposes of this study, Glaser's (1992) description of the three major questions that must be asked of the data when using the grounded theory method has been accepted as a reasonable and reliable guide. The questions are;

- a) What is the chief concern or problem for this group of people?
- b) What accounts for the most variation in processing this problem?
- c) To what category, or to what property of what category, does this incident indicate?

Thus, the research undertaken for this project remains as close as possible to the overriding and fundamental notion of grounded analytical methodology. In this research, codes and categories emerged from the data whilst at the same time the theory within was given eminence by virtue of inductive analysis. The established techniques of theoretical sampling, constant comparative analysis and theoretical memo-ing were used throughout the data analysis phase. The grounded theory method that was employed

within the research is, as far as possible, akin to Glaser's (1992) basic assertion that it is the systematic discovery of theory from data. This occurs as the concepts emerge and integrate by means of the 'constant comparative method' as an inductive device. As Kaplan (1964) maintains, the theory that emerges is a symbolic construction of reality. Such a construction relies heavily not upon the methodology associated with experiment or quantitative research, but upon the methodology of qualitative research.

THE USE OF GROUNDED THEORY IN QUALITATIVE NURSING RESEARCH

Several research methods, both quantitative and qualitative, have been successfully applied to studies of nursing practice. These methods have been discussed in the literature of Polit & Hungler (1993) and other nursing literature at great length. However, one particular aspect of successful nursing research has emerged in recent years that has enabled a greater understanding of meaning in contemporary nursing practice (the 'why' in nursing rather than the 'what'). That aspect is a qualitative one. As Chenitz and Swanson (1986, p.7) maintain: "The researcher needs to understand behaviour as the participants understand it, learn about their world, learn their interpretation of self in the interaction, and share their definitions."

The emphasis on self-interpretation of the world and upon interaction with others is, as expected, of considerable interest to nurses. It is unsurprising therefore, that in the search for a suitable research method, the ideas and possibilities of grounded theory have not gone unnoticed. As Wilson (1985, p.398) notes:

Qualitative research...concerns itself with the natural everyday world of human group life... It also views the research process itself as a form of symbolic interaction, wherein the investigator is the "tool" or "technique" in both data collection and analysis.

Hence, as both an excellent tool for researching the everyday world of human group life, and a technique *par excellence* of symbolic interaction, grounded theory is a well recognised, widely used and popular method for researching nursing issues (Chenitz & Swanson, 1986; Polit & Hungler, 1993; Stern, 1980, 1985).

THE USE OF LITERATURE IN THIS GROUNDED THEORY STUDY

Grounded theory methodology represents a significant departure from established or more traditional research procedures in several ways. Perhaps one of the most important departures is to be found in the use of literature relating to the given topic. In many research methodologies the researcher does not begin the research project until an exhaustive study has been made of the available literature on that topic. However, in grounded theory studies, the emphasis on the sufficiency of data, and upon the theory 'emerging' from these data, overrides such a requirement. Indeed, the very idea of an extensive literature review in this case is not merely unnecessary, but probably *undesirable*. As Glaser (1992, p. 31) notes:

It is hard enough to generate one's own concepts, without the added burden of contending with the "rich" derailments provided by the relative literature in the form of conscious or unrecognised assumptions of what ought to be found in data.

Hence, in an attempt to avoid 'derailment', and to maintain an open and uncluttered position on the moral preparation, decision making and actions of nurses, the following method of literature review was adopted before, during, and (crucially) after data collection.

Firstly, an overview of the topic was written that included any material from the already personally known literature on nursing ethics and moral decision making. This overview served two purposes, the first purpose being an outline of the frequently cited literature on the topic; the second purpose being to alert the reader to the possibility of already pre-conceived 'rich derailments' that may have influenced sections of the research.

Second, as the research progressed, appropriate literature on the topic was eagerly sought out and used, especially the literature that most closely related to the emerging concepts and beginning theory in data. The expectations of the researcher were considered and acknowledged wherever possible, because researcher bias is an inevitable phenomenon that must be recognised. Thus, as far as possible, data provided the emerging codes and categories.

Third, as the data for the research continued to be analysed, any appropriate literature was added to the deliberations over the final emergence of the theory within these data. It was at this stage that the general layout of the thesis was decided. Mindful of the need for an orderly explanation of nursing moral decision making, but aware also that such a process does not 'appear' without substance, the researcher chose to seek out a suitable model that would match these data as closely as possible. The models suggested by various authors (Beauchamp & Childress, 1994; Kohlberg, 1981; Thompson, Melia & Boyd, 1994) were rejected because they did not include the same 'categories' that emerged from data. Glaser's (1992) warning about potential theoretical 'derailment' by unwanted assumptions was also taken very seriously.

THE STUDY OF NURSES' MORAL DECISION MAKING

METHOD AND PROCEDURE

A description of the application of the methods of grounded theory to the study now follows. The preparation, performance and data gathering methods are considered, as are other related issues of the research project.

Procedures for recruiting participants and obtaining informed consent

Participants for this research were recruited by asking for volunteers from the large pool of nursing students undertaking studies within the Department of Nursing and Midwifery at Massey University. To achieve this, a general information sheet entitled 'Research into moral decision making in nursing practice: Request for potential volunteers' (appendix 1), was given to lecturers for distribution to nursing students in their various courses.

The following is an outline of the information that was offered on the preliminary request for volunteers:

- a) That nursing volunteers were sought to take part in thesis research on nurses' moral decision making.
- b) That volunteers were sought with adequate nursing experience, that is at least four years post-registration experience in clinical settings.

- c) That the volunteer would be fully aware that the research will entail a series of interviews (at their convenience), that may, collectively, amount to approximately between 3-4 hours.
- d) That data would be gathered at a venue that is suitable for them, in their own time and only after a full explanatory meeting has been held with each of the chosen volunteers.
- e) That the volunteer was to be fully aware that the research is in no way connected to either her/his role as a student or the researcher's role as a lecturer in the Department.
- f) That not every volunteer would be selected due to the restraints of the research in matters of numbers, ranges of clinical experience and availability for interviews.

Volunteers were asked to contact the researcher by phone in the first instance. Following an analysis of the suitability of each volunteer (according to the given criteria) each proposed participant was contacted by phone and later given an information form (appendix 2). After further explanations of the research in person, they were then invited to give formal consent (appendix 3) to participate if they so wished.

Procedure in which the research participants were involved

Each participant was asked to participate in data gathering by means of two semi-structured interviews lasting approximately 1-2 hours each. The interviews were performed over a period of time from April until August 1996. Each interview contained a number of open ended questions and replies which were audio-taped, and 'field notes' were taken by the researcher. The interviews were arranged at times and venues suitable to each participant, and every effort was made to minimise any inconvenience.

Procedures used in handling the information and material produced during the research

All information and material produced in the form of raw data was kept in the strictest confidence. All cassette tapes, notes and any other such material were stored in a locked and safe cabinet for the duration of the project. The researcher, supervisor(s) and

'transcriber'(who also signed a confidentiality agreement before any material was seen) were the only ones with access to this material. The correct storage of tapes and full confidentiality was a proviso of the agreement with the transcriber (appendix four). Once the research had been completed, the cassette tapes were returned to the participants if they so wished. Transcribed material, notes and any other material relating to the participants, were stored in a safe place until the finished thesis was made available for public scrutiny and there had been sufficient time for validation of the research findings.

The Participants

Eight participants were involved throughout the study, comprising of six females and two males. A ninth participant took part in an informal preliminary interview, but was not included in the final research project. The post-registration experiences of the nurse participants ranged from four full time years to over twenty years. However, the collective years of nursing experience of the group was approximately 120 years. About two thirds of the participants had undergone nursing 'training' under the 'hospital-based' system, whilst the remainder had been educated under the more recent 'polytechnic' system. The age ranges of the participants were between the late twenties to the early fifties.

A common feature of all the participants was that they had worked in a number of different areas of nursing, both within New Zealand and abroad. The overseas nursing experiences of those who had worked abroad included such places as the United States of America, Great Britain and other European countries, and certain African countries. The areas ranged from various medical-surgical wards, special units such as intensive care, coronary care, and burns units, public health nursing, nursing education and many more. At least half of the participants either currently held, or had held, nursing positions at Charge Nurse level and above. At various intervals, most had worked a number of years full time and had also undertaken part time work from time to time.

The other most obvious link between the participants was that all of them had either recently completed further studies at Degree level in nursing, or were presently working towards a nursing degree.

Data Analysis

After each transcribed cassette tape was received in the form of a computer disk, it was initially examined for any identifying features that were removed if discovered. Any unclear passages were carefully corrected following the playing back of the original recordings. Page and line numbers were applied to each transcription on disk, and every page labelled with the code number of each participant. They were then printed for further analysis.

The transcripts were then analysed by process of line by line analysis based on the question "what is going on here?" Each 'code' or description, emerging theme, or point of interest was marked. This was initially done by hand on the actual transcripts that resulted in several 'codes'.

The resultant material was then added to the computer transcript by means of colour coding and symbols. As this process continued, and especially in the case of the second sets of transcribed interviews, less work was achieved by hand and more by the computer programme's 'tools'. This process involved much trial and error. It represented a combination of the traditional method of 'cut and paste' data analysis that is normally used in the grounded theory method and what may be described as an 'electronic' method, namely coding on the computer. However, the researcher made *all* coding decisions and used the computer merely as a tool to assist the coding process. The eventual result was very satisfying, and enabled the simultaneous process of data analysis, coding, analysis, memo noting and literature reviewing to occur unimpeded by the sheer physical volume of data which was more than 250 pages of interviews.

As required by the grounded theory method, the large number of codes became groups of codes or 'families' of codes following extensive analysis. This analysis comprised of searching for similarities and differences in the material. However, a process of total absorption in data was also noticed which lasted for several months. This process, and the more formal one of 'line by line' analysis, eventually produced the desired merging of codes into larger 'categories'. These categories, or more precisely, these theoretical categories (for that is what they were becoming) formed the basis or structural framework within which all data and literature were compared and contrasted. By the

time of the final analysis of data of the eighth interview, which was a long and complex one, it became obvious that the theoretical categories were sufficient for the purpose of the study.

Indeed, it was around this time that what would be described as a core variable emerged, or was yielded, from the process of data analysis. This variable, the integrating socio-psychological process of the entire data, emerged as a 'propositional link', but was to the researcher more of an occasion akin to what can only be described as a profound vision. The entire nature of given data, the structure, the linkages, the process and the model 'appeared' at once. Such was the intensity of this event that a rough model of the whole process could be drawn immediately. However, this model was later to be refined on several occasions.

Throughout the study, each participant remained in contact at their convenience either through personal enquiries or by way of the arranged appointments. Indeed, the participants were frequently curious about the progress of data analysis, and contributed further to the study by informal discussion and support. The model was seen and commented on by the research supervisor and some of the participants.

ETHICAL CONCERNS

Informed Consent

This was obtained according to the 'Code of Ethical Conduct for Researching and Teaching involving Human Subjects', Massey University (1994).

All participants were fully informed verbally and in writing (see 'Consent Form', appendix 2) about the nature of the research and their likely involvement in time and energy. It was made clear at the start that they may withdraw from the research at any time and that no reason would be sought unless offered.

Anonymity and Confidentiality

The participants were assured that full confidentiality would be maintained at all times. Each participant had a pseudonym or a number that was known to the researcher and the participant. As the transcriber also had access to the raw data, each participant was assured that this person signed a confidentiality agreement in case their name or any

other distinguishable material was mentioned during the recordings. Because direct quotations from each of the participants were used in the thesis, every effort was made to suppress the identity of the participants. Furthermore, any identifiable references to places, institutes, other health care personnel or any persons alive or dead were omitted from the thesis.

Potential Harm to Participants

No participants appeared to suffer any noticeable harm during data gathering for the research. Whilst it was unlikely that any participant would suffer any major harm during this project, it was conceivable that, on occasion, they may have experienced a degree of mental disquiet or even temporary distress. This is because the research required that each nurse relate past incidents that they were involved in that they consider to have an ethical component. It is therefore quite possible that some of these recalled incidents may have brought back a variety of emotions. However, the most noticeable effect of the interviews on each participant was that of a deeper appreciation of past events and their connections. Indeed, a common statement was that for the first time they could now clearly see what the situation in question really meant for them or others. No situation occurred where I, the researcher, considered that the interview was causing undue stress to the participant. I was prepared, if necessary, to suggest that the interview be stopped, either temporarily or until another date if participant distress was evident. This was not necessary in any of the interviews. Subsequently, it was not necessary to suggest, as was planned, to any participant that he or she seek assistance if necessary, such as counselling or professional help.

The Participant's right to decline to take part

Every participant's right to decline to take part at any time during the research was meticulously followed. Participants were reminded of this right both verbally and in writing. It is of interest that some of the participants frequently expressed great interest in the research, largely because they found the process to be of 'a therapeutic nature'.

Uses of the Information

The information obtained from this research will be disseminated in three ways:

- a) The research will be presented to the appropriate authority at Massey University as a thesis for consideration towards a Master of Arts.
- b) Parts of the research will be re-worked for use at conferences, articles for journals and/or teaching sessions.
- c) Most importantly, every effort will be made to share the research findings with the participants by means of a follow up meeting with each one separately.

Ethical committees

The proposed research required among 8 to 10 experienced nurses to privately volunteer for this project. These volunteers all related incidents that were representative of their observations over several years of practice. None of these volunteers were students taking any of the papers offered by the researcher (a lecturer) at the time of the research. Because nurses frequently change jobs from area to area, country to country, it was considered very difficult, and virtually impossible, to seek permission from various other ethics committees that may have, under other circumstances, expressed an interest in this research. Thus, approaches to other ethical bodies other than the Human Ethics Committee at Massey University were not considered feasible or necessary.

LEGAL ISSUES

It was conceivable that during data gathering phases of this research, some participants would disclose information concerning their own acts, or the acts of others, that was legally dubious or even clearly illegal. Subsequently, a suitable clause was inserted into the Informed Consent document that alerted the participant to this possibility, and to the possibility of disclosure of such information to the appropriate authorities. However, no difficult legal circumstance emerged during the data gathering phase, although some of the descriptions of the acts of others were potentially dubious in the legal sense. These issues have also been addressed in the research.

THE USEFULNESS OF THIS STUDY

This study has been written primarily for nurses in practice, nurse educators and nurse ethicists. Its usefulness will therefore depend on how these nurses perceive it and choose to use it in their work. If it is of use to others, such as doctors or health care ethicists, in the understanding of a nursing perspective on ethical responses to practice based issues, then all the better. However, no piece of research can ever be the 'final word' on anything. Instead, it gains credibility and usefulness by being used as yet another 'piece in the jigsaw' to those who use it. If, as is hoped, it fills a piece of the puzzle that leads to a greater part of 'the picture' being realised, then it has been worthwhile. If, on the other hand, such a possibility is not possible, then at least it is hoped to have filled another small gap which will lead to greater things.

The study is obviously a qualitative one, and thus subject to critique by qualitative means. As Leininger (1994) asserts:

...qualitative researchers should not rely on the use of quantitative criteria such validity and reliability to explain or justify their findings. Such a dependence reflects a lack of knowledge of the different purposes, goals, and philosophical assumptions of the two paradigms (p. 105).

Instead, Leininger (1994) offers a qualitative alternative to these methods in the form of qualitative criteria that is largely in keeping with the grounded theory methodology. Her recommendations are used below in the following critique of the study:

a) Credibility

This refers to the value or 'believability' aspects of the study. It is, in short, the degree by which the experienced 'truth' offered by the participants comes through in the study. In this way, the credibility of the study is assessed by the extent to which the 'real-world' experiences of the participants are explained, analysed and recognised by the participants and others. As far as possible, the credibility aspect seems to be intact in this study. The participants certainly recognised their own contributions to the study, and generally agreed with the suggested interpretations of these contributions. If other nurses recognise and concur with these interpretations, then the study has been a credible one.

b) Confirmability

'Confirmability' refers to the process of checking data and findings with each participant to ensure that their contributions remain confirmed throughout the study. In all aspects of this study, data gathering, the analytical stage, and the development of a grounded theory, the participants input and confirmation of interpretations was sought. On several occasions, the participants concurred with the study's main findings and some even declared that the process had 'given them new insights into their practice.'

c) Meaning-in-context

This concept refers to data that have become more understandable because they are within the lived contexts of those involved in the research. There seems to be little doubt that this study has achieved this criterion because context, and meaning-in-context represent a very large proportion of the study. As noted previously, the derived meaning of the contextual aspects of this study impressed the participants considerably. Several commented that 'this is [or was] it!', or similar, when they discussed the emerging ideas and concepts from data.

d) Recurring patterns

The notion of recurring patterns refers to the repeated instances and experiences that tended to repeat themselves in various ways in different or similar contexts. Such patterns, of course, were discovered in this study, because without them the codes, categories and core variable would not have emerged. Thus, the study has more than an ample degree of recurring patterns.

e) Saturation

This is noted when the full 'taking in of occurrences' seems to have occurred. That is, when no new data seemed to be emerging from the interviews. In this, it must be admitted that eight participants may seem, to some, as the minimum number at which to stop data gathering. However, a ninth participant, who was not finally included in the study, kindly provided informal commentary on the research findings. As no new codes

or categories came out of this discussion, it was decided that the research had probably become saturated.

f) Transferability

Transferability refers to whether or not the findings from a particular qualitative study can be transferred to another context or study and still preserve particularised meanings or interpretations. In this study, great effort has gone into the design and layout of the study to assist other nurse researchers, and especially those researchers and educators in nursing ethics, to transfer the findings of this study into different nursing situations and circumstances to attempt to discover the possibility of the 'unifying elements' of a nursing ethic. If, however, the research is transferable to other areas of the study of professional health care workers, then all the better.

SUMMARY

This chapter has presented material that has shown the possible connections between nursing, philosophy, nursing ethics and grounded theory methodology. It has been argued that these connections are more than cursory. Rather, the discussion in this chapter has illustrated the advantages and complimentary nature of the grounded theory method to this type of nursing ethics research. Finally, an outline of the usefulness of this study was presented.

The next four chapters will present these data and associated substantive codes that led to the eventual discovery of the core variable or conceptual model. As the study progresses, the values, moral development, contextual influences, perceptions, degree of involvement and moral decision making methods of experienced nurses will be seen to emerge from the data. That is, it will be shown that the data gathered for the study provided sufficient insights into the antecedents (both cognitive and circumstantial), actions and consequences of moral decision making in nursing practice.

INTRODUCTION TO THE DATA

KEY TO THE INTERVIEW ABBREVIATIONS

The following conventions have been adopted within the data chapters and are presented here to assist reader interpretation.

001-008	'code number' for each participant
/1 or /2	first or second interview (N.B. participant 008 had one long interview only which was noted as '/1-2')
...	material edited
[]	insertion of additional material by researcher, usually explanatory
<i>italics</i>	researcher's question or comment
<i>(field note)</i>	Field note and date of reference
<i>(memo item)</i>	Memo item and date of reference

CHAPTER FOUR

THE PERSONAL AND PROFESSIONAL VALUES OF NURSES WITHIN THE HEALTH CARE CONTEXT

*I spent a lot of time doing terminal care of people in their own homes
... it had quite a profound sort of effect on me at times (008/1-2/p.3).*

INTRODUCTION

This chapter is the first of four chapters which present a synthesis and analysis of data gathered from a series of interviews with the research participants. The abstract constructs and categories that emerge from this process are supplemented by field notes, analytical memos and associated literature in all four chapters. The key categories and supporting codes from data are included throughout the chapters in support of the core variable, which in turn underpins the eventual grounded theory of moral decision making in nursing. Hence the core variable, that serves to unite the process of nursing moral decision making, gradually emerges during these chapters and is made specific in chapter eight.

In this chapter, and to a lesser extent in chapter five, the *antecedents* of moral decision making in nursing will be introduced, explored and analysed. It will be shown that the participants of the study clearly entered the profession with a number of strong moral values already established in their everyday lives. It will also be maintained that the participants may have modified their hierarchy of personal moral values when they made moral decisions as qualified nurses, but that they did not abandon them.

This chapter will also examine the essential element of *context* in the nature of nursing ethical decision making. The circumstances within which nurses practice are many and varied, being an all embracing milieu that includes both physical and socio-psychological phenomena. The effect of contextual influences on nursing moral decision making may be perceived to be slight and superficial or serious and profound. In all cases, the nurse works within a continuously changing health care context. The health care context is the overarching context for nurses that unites all others such as the nurse-patient, nurse-colleague, nurse-profession and nurse-societal contexts.

THE DEVELOPMENT OF PERSONAL MORAL VALUES

Two major categories emerged from data when the participants were asked to explain the origins and developmental sources of the moral values that they considered underpinned their moral decision making in practice. These categories were 'early childhood experiences' and 'learned socio-cultural norms.' They encapsulate a number of codes yielded by data. These codes include parental, genealogical, peer and gender influences, and the importance of socio-cultural norms and values.

EARLY CHILDHOOD EXPERIENCES

There can be no denying the influences of parents or close relatives in the development of moral values in the crucial years of early childhood. Nearly all of the participants in this study, when asked to trace their earliest memories of moral understanding, noted such an influence:

[I learned about morality] ... on my mother's knee, really ... (003/1/p.2).

My father was a really strong influence and my mother ... I went to my grandmother's when I was born, my grandmother and my elder sister looked after me ... (006/1/p.2).

It is likely that there would be general agreement over the influence of parents or guardians on the developing infant's view of 'good' and 'bad', and later on moral understanding. Just as the infant learns about the nature of the world of things that surround her, she also learns about the nature of the inter-relationships between things and the value of things for her and for others. Cultural values, and thus cultural moral values, appear to be passed on in the early years of child development:

My grandmother was [a very moral person], she was quite highly ranked in her birth and had quite a position of power within the tribe that I grew up in and I spent a lot of time with her as a young girl. And she taught me right from wrong and what was acceptable and what was not (005/1/p.7).

However, as the child grows, the circle of influences expands accordingly and other socio-cultural values, both practical and moral, emerge.

SOCIO-CULTURAL NORMS AND EXPERIENCES

The developing child is cognitively influenced by a dazzling array of new experiences, many of which are learning opportunities about the world as understood by others. These experiences are socio-culturally orientated. In this regard, some participants identified themselves with the notion of meeting the needs of others at an early age:

I think I like the idea of looking after people, I also tended to identify with the underdog. As a five year old I made a very close friend with a child who had a congenital heart problem which couldn't be fixed, at that time it couldn't be fixed. And so she really was like a semi-invalid, there was very little she could do and I spent quite a lot of time with her ... (001/1/p.1).

Other participants claimed that they were 'conditioned' in ways that reflected the development of a type of moral attitude through caring and meeting the needs of others:

The caring, touching, feeling side has gone down all of us kids (004/1/p.7).

One participant loosely reflected an early stage of Piaget's (1932/1968) interpretation of child development by concluding:

I suppose you learn by osmosis by what's happening with the people that are surrounding you and what's good and what's bad and what's, you know, ten commandments type stuff. But apart from being reprimanded for doing things bad and sort of seeing what happened to my friends when they did things that were bad, it was more like an ambulance at the bottom of the cliff, you got told when you were bad, you didn't often get told when you were good. I suppose you formed your own opinions from there (003/1/p.2).

The previously learned moral values that each individual brings to her chosen career, such as nursing, may also be tentatively traced back to educational and religious influences:

So going to Sunday school was as close as I could get [to a formal moral education] ... and yeah we had some moral teachings there, the word of God and do unto others as you would have done unto you and those types of things (003/1/p.2).

According to Piaget, a child is ready to rationalise these experiences and formulate a value system around the age of seven (Piaget, 1932/1968). This is around the time that many children experienced more formalised religious education:

But I mean we did go [to Sunday School and then Bible Class] and I knew all the stories, all the parables and yeah, so I'm sure it had an influence on knowing what was right and what was wrong (007/1/p.4).

On the other hand, for some, inculcation into a set of religious beliefs was a negative experience more than a helpful one:

Just thinking of religious thrashings to look after your fellow man—and by God that was rammed down your throats, whether you liked it or not, continuously right up to the age where I gave it all up ... I was probably 13 or 14 or 15, quite old really (004/1/p.11).

As maintained in chapter two, all cultures share the facility of valuing. However, it is also apparent that individuals from different cultures exhibit behaviours that reflect the common values of their cultural heritage in ways that are clearly relative to the general societal values of another culture. In the case of the moral values of nurses, these differences may present in different forms. In traditional Maori culture, for instance, the value of communal sharing is pronounced and affects the moral perceptions and development of the child who later becomes the nurse:

I think also the Maori upbringing is quite spiritual in that you're clearly connected to the past and you have responsibilities wherever you sit in your immediate family and your extended family. My father felt that incredibly. You always made sure there was enough food for us, and everybody else... So there was all those sorts of things, responsibilities...(005/1/p.7).

The importance of communal caring is thus high in the value system of this participant. However, cultural values may also be learned when a group of people are placed together under new and challenging circumstances, as in the circumstances that surround nurse training.

ENTERING THE HEALTH CARE CONTEXT: EARLY IMPRESSIONS

Context is described as “the circumstances that are relevant to an event, fact, etc.” (Collins Dictionary & Thesaurus, 1992, p.211). For most people, female or male, young adult or older, entering the nursing profession is an experience within a vastly new set of circumstances that leaves indelible impressions for many years, and quite possibly for life. Hence, in data collected for this study, several participants supplied reflective material concerning their ‘induction’ into nursing that was indicative of these general expectations:

It [nursing] was what I expected, but what I didn't expect was the harshness of the system.

This harshness—how did it show itself?

Well it was what you expected but there was some harshness, was the word. There was a very rigid, very clear hierarchy ... The hierarchy showed itself all the time in our work. If we were in the ward office and even someone three months senior to us came in, we were expected to stand and put our hands behind our backs (006/1/p.4).

The theme of 'harshness' was a common one in discussions concerning nursing training, but also at times, a morally illuminating one. Within the frequently regimented and authoritarian system that was, and *still is* to some, the health care system, young seventeen and eighteen year olds started training and working on wards. They found the system harsh and uncompromising, and the work brought new challenges that were often well beyond their own personal experiences:

...we were put into senior positions when we were very junior. Like we would be there a year and we'd be in charge of a ward, we'd be certifying that somebody had died...and we could see the paradoxes... (006/2/p.16).

In all branches of nurse training, data revealed a similar story. In the case of what was psychopaedic nursing (a separate qualification for registration in New Zealand until the mid 1980s), the training was regimented but not always challenging:

... we used to go for walks and they [the residents] were always made to walk in pairs and they weren't allowed to get out of line and you had to go at a certain pace. It was all very military. And we would walk down the railway line and sit in long grass and the staff would smoke and the residents would do what they liked and then we'd come back again! And that was my training (007/1/p.2).

However, even in these circumstances, there were new personal challenges for the mainly young adults who undertook such work:

...and they also had ones who were much more badly affected by their disability, who were bedridden and they were in bed all of the time, and our time was just spent changing and turning and feeding them (007/1/p.1-2).

Even then, moral problems arose that were taxing to the young adults left to care for sometimes difficult and unpredictable residents:

Yes, [problems arose] because of the constant haranguing that you got from some of the residents, I mean they just tested your patience immensely. When they would just go up to windows and go boom and break them and there'd be glass everywhere and the whole place would be in an uproar. And you would want to, if

they were smearing faeces over the walls, you would want to stop them, you would want to use strong arm tactics, but you weren't supposed to. I don't think that we really ever did (007/2/p.2).

When I was training it was, that was all you needed to be, I mean there wasn't any great rush for getting off to university, or there wasn't any great rush for looking at research based practice, you were judged on whether you were clinically competent, that's all you were (005/2/p.1).

Yet some did get help to adjust to the new and often alarming context that was nursing in the health care system if they needed it. This help was often given covertly, presumably because of the authoritarian overtones within the system:

And I figured that out very fast [that the system was powerful] and I had a tutor who actually helped me with that, you know I went to her in tears one day and said I think they're going to kick me out and by this time I discovered that I actually had a passion for it and I wanted to stay and so she gave me some good subversive type rules. Like you know, do what you have to do to get through and do what you do, but don't rock the boat. And if you're going to rock the boat, do it in such a way that they don't know that you're rocking the boat. So I learnt that very fast, and once I'd sort of gotten that I was OK (005/1/p.1).

This phenomenon is perhaps a good example of a situation that is familiar to nurses. According to Hutchinson (1990), nurses engage in responsible subversion when they are confronted by a clash of values. This clash occurs most often when their own (nursing) values and the values of the health care institute do not concur, either in minor or major ways. The covert or subversive method, which is basically a method of quietly 'bending' rules, reappears in chapter seven as one of the many methods of the moral decision making of nurses. Attention is drawn to it here because it is arguable that 'covert' subversion is a coping strategy that is learned in the training context, and used much later in ethical decision making within professional practice.

THE DEVELOPMENT OF PROFESSIONAL MORAL VALUES

If, as was the case in the moral development of the child, moral values are learned by means of a gradually widening collection of intimate and common contextual relationships, firstly with family members and then later with others in society, then it is possible that a similar process occurs when the individual enters the nursing profession. The participants of the study offered several insights into the preliminary observations and experiences that eventually assisted them to later focus on the ethical issues that

concerned nursing responses. These insights supplied two key strategies or substantive codes in the study. These strategies represent the ways in which the participants learned about professional ethical practice. Hence, these codes operate within the larger category of 'developing professional moral values.' These codes are discussed below.

Through preliminary experiences in the health care context

Nurses commence their training with certain moral values already learned and incorporated into their moral decision making abilities and ethical behaviour. These moral values are different in each individual, but perhaps those entering nursing have some in common. For instance, nursing has traditionally been presented as a virtuous occupation for 'young ladies' in that it not only enabled them to further develop the values of beneficence and consideration of the needs of others, but to also to become respected members of society (Baly, 1986). Subsequently, the educational aim of nursing in Nightingale's time was to provide a skilled nurse who was also 'a good woman' (Johnstone, 1994). However, this virtuous tradition that even now may underpin the general moral aims of modern nursing, also encouraged the virtue of obedience to authority figures. As Rodgers (1994) claims:

Adopting a hierarchical structure for her nurse organisation suited Nightingale's intention that superior women should control nursing services in a structure which paralleled the organisational structure of the army, public institutions and religious orders (p. 26).

This hierarchical and rigid system was not necessarily a 'male dominated' way of exerting control over women. If anything, the desire to control nurses, and especially the students of nursing, owes much to Nightingale and her followers. Yet, if nursing has developed into a more autonomous and professional discipline this century, then the value of obedience to others in authority should no longer hold such power. The contemporary emphasis on greater nursing autonomy, especially in those matters relating to moral decision making within nursing, should now be more evident. According to the participants of this study, the ethical and care-based decisions of the medical profession continued to over-ride those of nurses well into the 1980s:

...when I look back on my training I kept thinking how inadequate it was when it came to people. We were just interested in the signs and symptoms and pathophysiology and the doctor's orders of providing client care and we were discouraged from being involved with moral issues (001/2/p.1).

Consequently, student nurses in training have received mixed messages about their chosen profession because the traditional nursing virtues of respect, beneficence and obedience to those in authority are paradoxically maintained within an educational atmosphere of self responsibility and professionalism. On the one hand they are expected to develop a high degree of autonomy through knowledge and skilful practice, but on the other they are expected to blindly follow the orders of doctors or other authority figures. In this latter aspect, the moral requirements of their practice appear to be also subsumed by the decisions of others.

According to the following participant, as a student nurse she was educated in an increasingly liberal educational system (*field note*, 5/9/96) but gained clinical experience and worked as dutiful 'hand-maiden' within a rigidly authoritarian system:

I think we were educated in a very rigid, narrow, hierarchical, patriarchal and medical model system (001/2/p.3).

For some, the notion of taking on such a difficult and complex profession at a very young age was daunting. The consequences of so much responsibility at a young age and stage of maturity were obvious:

...why did we allow people to nurse at such a young age? That was my thing, that when I was thinking about things [like] ...going in to see Mr. Bloggs I had to look after on the night shift. I said, "I'll look after this man"; and you walk into a ward and say "where is he?" And you're twenty or something, the nurse is nineteen and a half, and I walk in there and say, "where is Mr. Bloggs..." "Um, oh, he's around here somewhere", and she walks down the ward and looks, "Oh! there he is! Oh! He's dead." And he's just lying dead in his bed, completely on his own, no relatives, no nothing, no flowers, nothing (004/1/p.4).

The nursing context was therefore a difficult one for young but willing students of nursing. As noted by the next participant, the training offered to student nurses did not necessarily imbue them with an adequate grasp of the important moral values such as maintaining safe standards or quality of care within nursing :

... the only thing that my nursing training had prepared me for was management skills, the running of a ward as students. From about three o'clock [PM] till seven

o'clock [AM] the next day the whole place was run by students, with the odd staff nurse floating around (001/1/p.3).

As may be expected of new entrants to nursing, every opportunity to learn about the practice and even about the philosophy of nursing was eagerly sought. Unfortunately, not every learning opportunity was the great moment of discovery that the student nurse expected:

I found that [working on wards as a student] quite hard, there were the very 'old school' nurses in those days who ... I remember at the end of a shift when it was coming up to ten o'clock and she [the Charge nurse] said, " X, come with me ... I'm going to teach you the fundamentals of nursing"...I was aghast, she taught me how to do a ward tidy! Now, and I mean you may laugh now but she said to me, "you can do whatever you like, ... but you cannot work in a disorganised ward, you cannot work in a disorganised fashion." She was true, I mean she was right. But she felt that this was the fundamentals of nursing, I thought well that's OK, I'll just take what I can (005/1/p. 2-3).

For others, often regardless of their difficulties, the work was to their liking. However, the student nurse's view of nursing and the management's view of nursing was not always the same one:

I was quite good at the work, I found that I could talk to patients easily and they seemed to respond to me. But in discovering that, I discovered that the hierarchy and I weren't getting on. So my training was quite difficult, it was fraught with visits to the matron's office, threatening of not passing or, you know, not letting me continue (005/1/p.1-2).

This early clash of idealism versus authority and tradition is a familiar scenario in the participants' stories. In essence, it would appear that the genuine desire to help alleviate the misfortunes of others was turned into a sometimes bitter resentment of authority figures. It seems that control rather than co-operation was a key nursing value within the health care system in which many of the participants were trained. The clash of personal versus institutional values must have been problematic for many of them.

Fry (1994) maintains that the values 'hierarchy' of an individual is likely to have remained fairly stable over time, but some values are also replaced by other, higher values based on experiences and an individual's reassessment of his or her values. The new environment of nursing within a new context (the health care system) clearly brought some modification to the moral values of nurses in training, but these newer

values were not always an improvement on existing ones. Indeed, it seems apparent that the values of obedience and conformity were an anathema for some participants in the study. The consequences of a hierarchical and authoritarian environment in nursing training may lead to behaviours that are not compliant but rebellious. Hence, the learning environment that was provided during training may be a strong background influence, or moral antecedent, of the experienced nurse's capacity in moral decision making.

Through preliminary moral focusing within the health care context

Three main methods, or categories, emerged from the data in regard to the ways in which the participants, as student nurses, developed a greater understanding of professional nursing values to aid them in the process of moral focusing and moral decision making. In this regard the methods were largely either 'fending for themselves' or using a moral mentor or ethical role model. Education, the third method, also gave some participants a greater moral understanding of nursing decision making, but was considerably less representative of early professional ethics preparation within data than the other two. The first method has been given its title from a phrase suggested by a participant.

Fending for themselves/self taught

In the absence of any formal or even informal ethics education or preparation, many participants claimed that they were left to their own resources, often reverting to, or modifying, already established values to help them analyse and attempt to deal with a given ethical situation:

I think we fended for ourselves largely [learning how to make moral decisions], although... in class going through the training we might have talked about it a bit (007/2/p.3).

For the following participant, this process took her right back to early childhood experiences and values

So I guess in that [moral acts], you had the other thing that came from my Maori upbringing...you had tremendous respect for the dying person or the dead, and that was something I did really well, right from the beginning. I enjoyed that work, you know working with the dead or the dying and their families, and I did a lot of that in my training, you know I sort of opted for that sort of work (005/1/p.3).

In the latter case, the participant shows that she *sought out* and developed expertise in those experiences that had cultural meaning for her. The culture of student nurses, meanwhile, led to behaviours that were supportive or even comforting to those involved:

So that 'outside' [the health care system, the institution, etc.] as a student body we were very supportive of each other and we also found ways to fight the system and have a social life (006/1/p.4).

There were other student nurses in training who obviously reverted to their own sets of moral values when dealing with ethical situations. The religious influence on the moral values of others was noted:

... there were Christian girls that I trained with who were always a bit sort of woolly, you know, and who were doing it for the good of people and for the good of God and all that sort ... (005/2/p.14).

However, most participants concluded that moral decision making was a process that gradually emerged from experience and maturity:

Back in those days I think that moral decision making was something that was very dependent on the maturity of the person, and something that you learned in the ranks rather than learned in class... I have thought back long and hard and I don't actually remember it ever being a big issue about morals and about ethics (003/1/p.1).

Thus, each participant, in their own way, expressed thoughts about the haphazard ways that they learned about moral values and ethical decision making as student nurses. These ways were largely unplanned, uncoordinated and informal. As one participant put it:

You suddenly realised that you've been treated like a mushroom and kept in the dark (001/1/p.1).

If the context was difficult and the experiences often confusing, some participants obviously developed at least a beginning viewpoint or position concerning professional moral values in their training:

I think there was an instinct or a sense of common sense or even just justice [during the nurse training years]. Yeah, justice is the word, that things are not right and there was a better way of doing things, ... and stuff like that (001/2/p.3).

This phenomenon occurred frequently in the stories that were related by the participants. It would appear that learning from others who were ill-equipped to teach, or whose behaviour was reprehensible (or offended the student nurse's moral values or principles) was a common experience:

I think this thing about the negative practice was more the huge influencing factor for me in that I decided how not, you know how I didn't want to practice (005/1/p.10).

The 'fending for themselves' method seems to belie the aims of nursing ethics literature. Instead of an orderly, carefully planned and expertly guided set of ethical experiences in practice, these data show that student nurses were frequently left to 'fend for themselves' in ethical matters. They did not learn about professional ethics or moral decision making in anything like an organised or formal fashion in clinical settings.

By using a preceptor, mentor or role model

The most crucial element in assisting the student and beginning nurse to practice ethically is good role modelling from other more experienced nurses. The value of such role models cannot be underestimated because, as several participants concluded, in the absence of any particular formal ethics education, they either fended for themselves, as noted previously, or modelled their ethical actions around the practice of an admired and experienced nurse. Those nurses that were chosen for this difficult task by the trainee or beginning nurse practitioner were often influential for many years to come:

The preceptor nurse that I had as a new graduate staff nurse grew to be one of my closest and dearest friends. But it really illustrated the point to me about how important it is to have a really strong, knowledgeable, efficient and effective role model. And it taught me how to be a role model myself in these years (003/1/p.5).

For this participant, the connection between the moral decision making and the professional behaviour of her mentor is an important one. She went on to state:

I remember X handling it [a difficult moral situation concerning an alcoholic mother who came to the ward in a drunken state wishing to take her baby home] in quite a professional manner by talking about how at the moment she wasn't safe and diffusing her anger, because from X's standpoint she would rather that this child never went back to this mother. But she accepted that, obviously as we must, that this child belongs to this woman and in spite of the fact that it might break our hearts to see this poor little thing routinely because it was being under-loved and under cared for, and going back into a hostile environment. I do remember her sort

of making the opportunity for this mother to be with the child, while being supervised and sort of discouraging her from going and taking the child (003/2/p.8).

If good ethical role models were sometimes unavailable to student nurses in practice settings in the form of experienced nurses, there were other possibilities in the form of nursing tutors or lecturers who visited the student nurse in clinical settings:

And I think informally it was part of the professional role modelling, we had quite a lot of tutor input in terms of tutors working along side us in the clinical area, so there was modelling there. And we were asked to reflect upon ourselves and what was happening, continuously really (002/2/p.4).

Some participants noted preceptors who *they* found morally impressive, but might not have been perceived this way by others. In this, it may be seen that the value system of one individual may appeal to another, *but not to everyone*:

No, I think she [*a named preceptor*] was a moral person. I mean she knew how much she could cope with in her ward and if patients were coming through the door too fast, she would get on the phone and ring A and E and say I'm not taking anymore, it's not safe for me to have anymore. I can remember her arguing over a bed trolley in the doorway to ward x ... a man, quite a sick man, she said "I'm not taking him in my ward, I haven't got the nurses to look after him, send him somewhere else", she was telling the orderly [laugh]. Things I'd never seen before. I mean everyone else thought she was mad, she was quite, but I thought she was very good really (007/1/p.5).

However, as the participants clearly indicated, when they were nurses in training or in the early years of their profession, they also 'learned' from bad preceptors; that is, those whose behaviours clearly challenged the value system of the participant, and probably many others. In short, they learned from the behaviours of such people because they despised these behaviours:

...but I guess the most modelling that I got was how **not** to nurse. The people who used to frustrate the hell out of me, who would make me cry, who were mean, who were nasty, who were authoritarian. You know I used to think to myself as a student, I am going to be a charge nurse and I am going to change that, I'm never going to be like that and in many ways that was the greatest modelling for me, you know the moral development. And that was *my*—that was how I became—I believe. So a good nurse is this passion to be not like them. And it was a passion, they used to make me so angry (005/1/p.4).

Not all of the participants maintained purely nursing influences in their early professional moral development as nurses. Some values are universal in appeal, whoever the preceptor. In the following example, the values of tolerance, patience and kindness are noted:

I think Doctor X was a big influence there as well because of his tolerance of these people, he was incredibly tolerant and had great patience and listened, he was a great listener and kind to them (007/1/p.6).

Early professional and ethical preceptors may influence nurses in their formative years far more than may be realised. Indeed, this influence may continue for many years or even a lifetime:

[They were] influential in the way they sort of shaped my thinking towards further training and influential in the way that ... their moral practices I suppose, impacted upon me. From preceptorship onwards then, X has and still does exert a certain amount of, guidance, moral sort of consideration for what you do (003/2/p.1).

Some participants clearly perceived ethical practice to be synonymous with professional or expert practice:

She had this kind of professional correctness about her all the time, she's still like that now [several years later] ... (007/1/p.3).

The theme of ethical practice being associated with professional practice is an important one in nursing, especially in nursing education, and will therefore be further explored in chapter eight. However, in the absence of a guiding mentor, other nurses continue to draw on much older and more traditional sources:

They both died [grandparents] when I was quite young but they seemed to have quite a [moral] influence on me...

Which of those you could say maybe was the most influential?

My grandfather...he was a very religious man and he had very high moral standards I guess and he sort of imparted to us that you could have high moral standards as well as having fun.

Do you think you bring that with you...?

I think so, yeah. (008/1-2/p.1).

In this way it can be seen that in those circumstances where the learning experiences and in-practice teaching processes in nursing ethics were deficient, or there was a shortage of good role models, nursing students who later became experienced nurses, such as those in this study, reverted to personal values, or fending for themselves when dealing with

ethical decision making situations in practice. All of the participants could remember such situations from their student nursing training. Many indicated that they did not receive adequate support or guidance in ethical matters. What then of nursing education in ethics?

By exposure to professional moral values through formal education

The participants in this study appeared to learn about professional moral values *informally* when they were student nurses. They did this by teaching themselves, or by finding a good nursing mentor or role model to observe and copy. Yet, when asked about *formal* preparation through nursing education through an examination of moral values or methods of ethical analysis and decision making in the health care context, most participants related very similar and remarkably negative stories. When asked about their educational preparation for ethical practice, the participants' replies were almost invariably the same. Here are some typical examples:

None, *categorically* none. None in the training schools... but when it came down to the nitty-gritty we were the few who were expected to deal with it and that was extremely problematical (001/1/p.4).

No, nothing, nothing. We learned a systems approach and it was all to do with ward work, there was nothing ... (005/1/p.3).

I don't remember any. I'm sure we must have had some ... Yeah, there was some about you don't talk to other people about what happens. You don't talk about patients, you don't talk outside of the hospital or outside of the people that are within the ward working with those patients (006/1/p.5).

Very little, if any... (008/1-2/p.2).

These responses concur strongly with Woods' (1994) findings regarding the pre-graduate level of nursing education that: "51% of the participants could not recall any ethics education at this level at all. Of the remainder, most seemed to remember no more than ten hours of ethics education at this stage" (p. 8).

Participants who were educated within the more recent polytechnic system (as opposed to the older, hospital based system of nurse training) could remember slightly more effort in ethics education. However, they could only recall formal ethics education that was of mixed or little value:

We had formal ethics training, we had a package in either year one or year two I think which was focused on ethics, ethical theories and their application. I'm not sure how long it was, I've got an idea it was perhaps about four to six hours, it was a fairly standard package (002/2/p.4).

The "fairly standard package" for this participant was no more than a collection of idiosyncratic lectures interspersed between larger topic areas. For instance, in the psychiatric module, the participant remembers only limited discussion concerning the issues of suicide and patient autonomy (memo item 4/6/96).

Another participant related a similar story concerning the hotchpotch ways of learning about nursing ethics and ethical values in an educational setting:

I think that we talked very superficially about things like abortion, about things like blood transfusion and religious beliefs and things like that but as I said it was superficial ... (003/1/p.1).

This participant did at least remember one other potentially important phenomenon concerning ethics education and professional moral values that was offered to her *at the end* of her nursing education:

...it was at the end of our comprehensive training and we did 'the oath', [the Nightingale pledge] and that again was historical. But I was surprised...that a lot of other training schools and centres didn't actually do that (003/1/p.2).

This mention of the Nightingale pledge is a reference to an early example of a code of practice for nurses. It was written by Lystra E. Gretter, an American nurse, at the end of the nineteenth century (Kelly, 1985). This pledge is probably the earliest example of a nursing code that is ethically orientated, and contains several appeals to what may be described as nursing virtues such as benevolence and respect for patients. Whilst the promotion of such a code may be commendable, it would appear that, in the absence or shallowness of a more comprehensive education in moral decision making in nursing, many participants basically *taught themselves* how to make such decisions. Yet, according to Fry (1994): "Nurses learn about professional values, both from formal instruction and from informal observation of practising nurses, and gradually incorporate professional values into their personal value system" (p.12). However, the nurses who provided data for this study suggested that carefully planned formal instruction or education in professional values that relate to *their* ethical practice was clearly lacking.

Professional values, in ways not too dissimilar from societal values, represent those attributes of a profession that are desirable to the members of that profession, and, as is likely, the society that that profession serves. It follows that these values generally underpin the ethical practice of such professionals. However, if, as is certainly the case for the participants in this study, the development of professional values, and the ethical behaviour that should proceed from such values, is a process that depends as much on trial and error as any other method, then the new nursing practitioner may be influenced by other sources instead.

THE INFLUENCE OF CONTEXT ON THE DEVELOPMENT OF PROFESSIONAL NURSING VALUES

The data gathered for this study revealed that the health care context had (and still has) a very significant impact upon the ethical development and continuing moral practice of nurses. For most participants, the entry into the health care context as a student nurse was a largely new and cognitively demanding phenomenon that demanded a re-examination of their personal moral values and behaviours. The health care context is influenced by, and influences, other major contexts such as socio-political, relational and inter-personal contexts.

The data revealed that, almost without exception, the moral experiences of nurses in everyday practice were heavily contextual, specific and influential. The main contextual influences on the ethical development and moral practice of nurses fell into five main categories. These categories were the socio-political, the employer/bureaucracy, the nurse-doctor, the nurse-nurse, and the nurse-patient contexts. They are presented below in order of relative importance to the participants.

THE NURSE-PATIENT CONTEXT

When nurse training was near an end, or had even been completed, the new practitioner is supposed to be professionally prepared for almost any contextual eventuality. This does not seem to be the case, because many participants in this study related similar stories of lack of preparation for professional practice. An example:

Well I think I remember the most scary time was looking after the infectious ward and we had a child with meningitis and the child's mother was a nurse and I felt terribly inadequate, because she came up to me for support and I didn't know how

to give it, because of my own experience I suppose. And I didn't get on with the paediatric specialists terribly well, they were a funny bunch as well I thought at the time [laugh]. And I used to hate febrile convulsions being admitted, they were scary things as well. But it was all to do with inexperience (007/1/p.7).

This theme, of feeling unprepared for the demands of nursing even after training, did not necessarily fade on becoming qualified for some participants:

When I was registered I felt really poorly prepared to take on the responsibility of staff nurse. And I don't know if that was just me not having a lot of self confidence or if it was to do with that very rigid, quite critical regime (006/1/p.7).

As circumstances changed, so did the need for greater preparation. However, in the stories offered by the participants, there was a clear indication that even as practising (qualified) nurses there was no guarantee that this need would be met:

Well I became a relieving charge nurse, which was you relieved people's holidays in various wards round the hospital, it was very scary stuff because I didn't think I had a lot of experience at that stage. I mean I quickly worked out that to be a really good charge nurse, you should have been the most senior person around, not the most junior charge nurse because you went from ward to ward. They justify it by saying well you're not actually making any changes, you're just care-taking, but in fact you had to deal with a lot of different situations over a short period of time (007/1/p.7).

However, for others, their experiences in the context of delivering qualified nursing care were pleasurable. In the following example, the nurse was working within a very understaffed ward, but had time to follow her own nursing value system:

... so there'd be a nun, a registered nurse and a ward aide. I just loved it, I felt I could be the sort of nurse I wanted to be. There was time to put the patient's feet in the bowl when I washed them and things like that. And I just loved it (006/1/p.9).

Other participants noted that satisfaction could be gained by working as a team, with others of like mind or culture (i.e. the New Zealand nursing culture in the USA):

We worked far more collectively [than the American nurses], and I can say ...we were far more interested in what was actually happening with the people and how they were going about things, how they were managing, rather than the equipment, rather than the documentation (003/2/p.4).

Registered nurses often have to adjust to working in quite different contexts to their training, although most maintain that the changed context does not mean a change in overall ethical purpose:

Yes it is, and it's a bit of a strange thing to say, and I worked there [in a prison] for nearly a year I think and perhaps for the first six months or so, they were just, you just saw them as people requiring care, shall I say. And you did everything, they were drug addicts, child molesters, murderers, the whole gambit (004/2/p.7).

THE EMPLOYER/BUREAUCRACY-NURSE CONTEXT

Much has been said about the impact of the last decade of restructuring within the health care system in New Zealand, but nurses have been particularly vocal about the effect of these changes on the relationship between themselves and their employers. This phenomenon has been noted by several commentators. As Wilson (1992) maintains, stress is endemic in the health service, thus reducing still further the staff's morale and their trust in management.

The perceived damage that has been done to the nurse-manager relationship in recent years is potentially serious in the area of ethical nursing practice. This is because some nurses now claim that they cannot offer ethical practice because the conditions that they are forced to work under are counterproductive to such practice. Yet "...it is worth noting that employers have the same obligations to employees that clients have to professionals, namely, to keep to commitments, to be truthful, and not to ask them to act unethically" (Bayles, 1989, p.155).

One participant in this study argued that one of the main problems between nurses and management was the restrictions on the use of resources. These arguments nearly always have their origins in economics or efficient use of materials:

Like it's not uncommon for us to have huge debates about supplies of incontinence products and the managerial part of the establishment say, you're spending too much money on this. You know, people should be sat on newspaper and shouldn't have anything to drink after four o'clock in the afternoon and then they wouldn't wet their beds so much, you know type of thing, because it's costing us this much money to actually supply all these incontinence products, sheeting on the bed and things to prevent incontinence. There's a lot of that, because it's... not quite the same as... [an American hospital]... where every single thing you use is charged, but close (003/2/p.8).

Such debates are as common within nursing as they are in the wider health care arena, and are thought to reflect “a real tension... between the service ethic or the caring ethic of the traditional caring professions, and the business ethic of the new management and contract culture of the purchaser-provider internal market” (Thompson, Melia & Boyd, 1994, p.130).

It is not uncommon for some nurses to associate their more immediate peers, in management or advisory positions, with their employers. In this process, the uneasy relationship between nurses and bureaucracy is aggravated (because these managers are often nurses themselves) rather than alleviated:

And these clinical nurse specialists were condoning a lot of things that were happening that weren't good, and the staff were kind of having their concerns minimised and marginalised by these two quite powerful nurses. (002/2/p.2, italics added).

The notion of clinical nurse specialists condoning undesirable changes is an powerful one, indicating a clash of values that is becoming increasingly commonplace in health care institutions. According to Robertson, Thompson and Porter, (1992), nurses and other health care professionals do not generally appreciate the ‘new values’ of the administrators and, by association if nothing else, those who manage the changes that are based on these ‘new values.’ These individuals are perceived by several nurses to run hospitals and health care facilities in ways that they considered as an affront to their personal and professional values. However, it was until recently a government requirement, rather than a deliberate managerial manoeuvre, that hospitals be run as profit making enterprises or businesses. In New Zealand, this phenomenon has been met with statements from health care lobby groups that reflect this perception: “Health is not simply something that can be bought and sold like any other commodity” (Coalition for Public Health, 1992, p.2). Overall, nurses appear to resent changes to health care delivery by resenting those who are seen to be instigating them. As such, the nurse-bureaucracy context is a contentious one.

THE NURSE-DOCTOR CONTEXT

If the material supplied by the participants in this study concerning the contextual relationships between nurses and doctors are taken into account, then the effects on the ethical practice of nurses within this relationship, and thus on the care of their patients, can be significant. Several participants were quite clear and specific about the professional and moral tensions that sometimes affected their relationships with members of the medical profession. Even in the wider context of medical community care, when nursing input was low, the ethical decisions and actions of doctors impacted upon nursing practice indirectly. The following participant remembered a contextual problem that impacted on the community in which she practised:

I remember in X [a small town] that it was near impossible to get birth control because all the town's doctors were Catholic and would not prescribe. What an impact that had on a community! (003/2/p.10).

In more immediate or every-day working situations though, the nurse-doctor relationship can be perceived as an oppressive one:

It's 'nurses should still be controlled and told what to do', and at the end of the day you only do what the doctors tell you to do at the hospital (004/2/p.10).

Nurses perceive their relationships with doctors differently than doctors perceive their relationships with nurses, and appear to use different approaches when making ethical decisions (Grunstein-Amado, 1992). Within these differences, the contextual elements of control and authority continue to blight good communication and working relationships. Nurses clearly see their primary responsibilities as being towards their patients, often trying to effect care that is necessary from a nursing perspective. Thus, in regard to the ethical impact of the relationship:

The moral issues then, were not so much patient based ... but one of the continual battles I have is trying to battle the doctor/nurse relationship. How do I get the best for my patient, or what I consider to be the best for my patient, when medical staff don't listen. So that's I guess for me that's a battle that I've kept battling on with (005/1/p.8).

Much has been written over time by nurses and others on the subject of the nurse-doctor relationship. Stein (1967), for instance, saw this relationship as a type of 'game', concluding that "the game is basically a transactional neurosis, and both professions

would enhance themselves by taking steps to change the attitudes which breed the game” (p. 703). Nevertheless, ethical disagreements between doctors and nurses are frequent causes of nursing distress (Benjamin & Curtis, 1992). This distress is perhaps caused by a combination of factors, but a common element is a clash between nursing values and medical values. This phenomenon is explored in more detail in chapter five.

THE NURSE-NURSE CONTEXT

Curiously, the participants in this study did not dwell on the issue of the nurse-nurse relationship. There were instances where the actions of other nurses were praised or condemned, but overall each participant concentrated her or his reflections on their own actions as much as the actions of others. Questions concerning the safe practice of other nurses and upon the value of working with colleagues who were overtly moral in their behaviour did however, meet with either an unspoken coolness (*field note*, 20/6/96) or in responses that were less than complimentary. An example:

I can think of a couple of younger midwives who...I thought had a different approach. But I really can't think of anybody who stood out as being charismatic or special or different, they [other nurses] were [morally] inadequate as opposed to reasonable (002/1/p. 7).

The practices of other nurses seemed to morally disturb some participants more than anything else. In the following extract, the participant remembers a practice from several years ago, but still clearly found this practice disturbing:

I think ... what I found disturbing was that basically they [premature babies, still-born] were treated as garbage basically. They were treated as debris, you know you put them on the same bench as you put the bed pans... It appeared that the further the gestational age the more they were treated as a real baby. So that the smaller babies might be sort of wrapped and put in like a shoe box lid, the old, the full term babies that were still born were sometimes put in a crib (002/2/p.5).

The typical response to those situations where a colleague or a senior nurse is causing moral unease is not necessarily to confront or discuss the problem with them, but to avoid them:

Well this is the person she was buddied with! And they [student nurses] just see behaviour that they can't believe in. They actually say to me, "look, I don't want to be buddied with that person." And if I can I possibly change them, but it's not always possible (007/2/p.15).

Curtin and Flaherty (1982) argue that nurses have a moral commitment to care not only for their patients, but for each other. Yet, this commitment is not always easy to maintain. There are several reasons why this should be so, but perhaps a significant one is that as a societal group, nurses are prone to 'horizontal violence'. This phenomenon has been described as common in those groups that exhibit the characteristics of an oppressed group (Jolley & Allen, 1989). These characteristics include lack of self esteem, lack of pride in nursing, displaced aggression towards nursing colleagues and an inability to achieve consensus on important issues in the profession. Difficulties within the nurse-nurse relationship are ethically problematic because nurses who are thus distracted may not focus properly on ethical issues. Nevertheless, there is clearly a problem of moral importance that involves the relationships between nurses. Finding suitable remedies to relieve this problem may be as important, or even more important overall, as the nurse-doctor relationship. For instance, in his report on the ethical concerns of nurses, Woods (1994) noted that, "there is a considerable degree of concern over unsafe collegial practice ...and, to a lesser extent, nurse-physician relationships" (p. 10).

THE SOCIO-POLITICAL CONTEXT

Several concepts emerged from data supplied by the participants that related to the highly pervasive socio-political contextual influences on the ethical values and practice of nurses. Because these concepts were obviously important to the participants' understanding of the contextual difficulties of maintaining professional values, they are included below as sub-categories of the main category of the socio-political context. The sub-categories are as follows;

Low staffing ratios and resource allocation

The participants were almost unanimous in their criticism of the problems associated with maintaining high standards of care under low staffing and restrained resources. Nearly all maintained that these problems were quickly apparent when they were entering nursing, and remain problematic to the present time:

Resources [are] becoming a little bit more pinched and so inadequacies in staffing are becoming fairly constant... I think the other factor is to do with what is actually happening on the ground and that bed occupancy rates have been very, very high, staffing levels have been consistently low. It would appear that the team

leader and the clinical nurse leader have been reducing staff numbers and so that they're really noticing it (002/2/p.2).

In most cases, nursing staffing ratios and resource allocation have dropped over the last ten years in New Zealand. According to the New Zealand Nurses Organisation (NZNO, 1993), nurses are now frequently relating stories of replacement by casual nurses, insufficient nurse-patient contact, diminished quality of care, less job satisfaction and concerns about patient safety. These phenomena have produced numerous ethical problems for nurses, the most disturbing being that of anxiety over the care that patients may receive in the face of such cuts to staffing and resources.

These contextual issues are not divorced from ethical values issues. As one participant noted when asked about the consequences of falling staff levels and increasing workloads:

Moral issues, starting off with things like resource allocation. If you've got umpteen babies coming into the unit and you've only got so much equipment, how do you allocate, who gets what? Incubators, ventilators, anything, how do you redistribute the equipment so that the babies who are at risk still remain safe, but can you actually find the resources for the next baby coming in? (001/2/p.7-8).

Hence, for nurses, the contextual problem of low staffing levels is a professional, personal *and* ethical one:

Our reality is so hard these days, you know our workload is so different. You can have patients who are ... so sick that they need a one on one nurse, well the reality is that the nurses aren't there anyway. It's like saying well look I need an extra nurse for this shift, well they just don't exist. So it's how are we going to manage to give all the patients in that ward the care that they require with the resources that we have. And I think that's the hardest thing for nurses to see, it's that you can't magic more nurses out of thin air (005/2/p.11).

However, some changes, past and present, were not all negative ones, even if they were made out of necessity rather than desire:

The neonatal unit when I went to, it was absolutely short staffed so it was sort of ... task orientated care rather than personalised care, it was the environment and just the context at that time that drove that. Once the unit got more staffing and things did improve, nursing staff had more time to actually start looking at the issues involved in a clinical setting in the unit (001/2/p.7).

Interestingly, the results of such changes were noted with mixed feelings:

So that took away some of the stress of the workload in the unit and that was really good, I'm quite pleased that happened. But then again it got, the intensive care side got bigger so they switched the rooms around, so the intensive care side went into the two largest rooms...Well that was ludicrous, that was absolutely ludicrous, because while it sometimes got down to five or six babies, more like twelve, thirteen or fourteen were in there: and there was no space, and it was a very, very, very stressful environment...(001/1/p.3).

The basic argument in the above comments seems to be that inadequate resources and low staffing levels may lead to moral problems for nurses because they cannot meet the needs of others, give care and act professionally in conditions that are dangerous or unsuitable for others or themselves:

... resource allocation in the intensive care unit, that's a moral decision. Which baby gets which piece of equipment, one over the other. Space, bed spacing, that's another issue for me. Staffing issues, conflict between parents and nursing staff, conflict between nurses and doctors, conflict between parents and doctors too (001/1/p.7).

Inappropriate staff mix/ Low staff levels

The new health care environment has, by and large, seen the advent of a reduction of the numbers of nurses in the workplace with the simultaneous addition of semi-skilled or unskilled staff. The participants generally argued that this phenomenon was a measure that was aimed primarily at fiscal control rather than an attempt to enable nurses to practice more specifically and skilfully in those areas that required the input of professional rather than general care. Various mixtures of skilled and unskilled staffing are now commonly utilised within health care institutions. This practice has led to sometimes risky situations being forced upon the nurse desperate to work in either the private or public health care setting:

... as a student in a elderly care centre on night duty with 28 residents, being sole charge... And being sole charge for these people, and again in hindsight not really knowing a whole lot about them, and wondering what would happen if something happened to them, you know ... But I had nothing about their history, I had nothing about the medications they were on, or anything like that, there were no firm orders about resuscitation or anything. It was more important that I did the ironing and the rest, because I was employed as a caregiver (003/1/3).

Overall, the participants of this study were cynical about the development of staff mixing because they perceived such a development as the normalisation of previously covert methods of reducing costs at the expense of appropriate health care.

Increased workloads

As staffing levels fall and resources become limited, the effect on nurses can be detrimental. Nearly all participants noted that, throughout their years of nursing, the workloads placed upon them were usually too high for effective and personalised nursing care. The following example refers to the psychiatric setting:

They're saying [nurses] that if we had a staff member available to be one to one with a client, we could let them out of the ICU for periods of time. I don't believe that the use of seclusion has increased, but staff are doing considerable amounts of overtime in order to maintain enough nurses on the ground to prevent incidents ... But the only way they can do that is to do overtime, a considerable amount of overtime is done as a matter of course anyway without ever being charged for. They're feeling that they're kind of being stretched and stretched and there's only so much more they can give and that the situation as it is just isn't tenable (002/2/p.3-4).

This phenomenon has been confirmed by Boddy (1992) who concluded that many nurses now work in an organisational context that is not supportive of sustained therapeutic interactions between nurses and patients. Indeed, in the past decade, nurses in New Zealand, Australia and other Western nations such as the UK and the USA, have become acutely aware of the rapidly changing health care context that they practice within. Economic rationalism, which has appeared in various guises, is considered by several observers to be one of the major causes of ill-ease amongst health professions. In many instances, the changes brought about by such developments have been viewed negatively by nurses. In accepting economic rationalism there has been a dismissal, or at least a failure to take account of, both past Australian experiences and other international experiences (Cordery, 1995).

The recent experience of such fiscal restraint has been largely a negative one for health workers within New Zealand, whose health system is now considered as being under severe strain. In New Zealand, many nurse leaders have been quite vocal and frequently damning in their assessment of the economic-rationalist changes to the health care system that has been euphemistically called 'health care reform'. The consequences of such changes on the practice of nursing have been described as loss of services, bed shortages, inappropriate staff mixes, increased workloads and nursing frustration (Williams, 1996). These phenomena are clearly linked to the ethical practice of nursing because nursing

practice occurs within the socio-political milieu. Changes to health care delivery therefore mean changes to nursing care delivery, which, as alluded to in previous chapters, is inextricably linked to moral actions.

However, regardless of the problems associated with socio-political and other contextual influences (previously discussed) in the health care setting, the participants maintained that they continued to seek ways of maintaining professional moral values nevertheless. This striving for ethical nursing practice within an increasingly complex, demanding and sometimes confounding health care context may be seen as a type of refinement of moral values. It has been argued that nurses enter the profession with a hierarchy of moral values, and that these values may be shaped and re-shaped by experiences within the health care system. Hence, regardless of the apparent problems that face nurses working in the health care system, such as staffing and resource difficulties, relational and hegemonic differences, and the philosophical quandaries that massive change may produce, the participants continuously maintained that these experiences led to an ongoing refinement of their moral values.

PRELIMINARY MORAL FOCUSING IN THE HEALTH CARE CONTEXT

In ways similar to the previous methods of learning through experience (informally) rather than through education (formally), the participants in this study became experienced in promoting professional moral values and making ethical decisions largely by a process of immersion in a number of clinical settings, and also by 'trial and error.' The main or substantive codes of this 'focusing' process include coping strategies that reflect an important stage of professional moral development. These codes are as follows:

Dealing with the moral demands of the job

In general, the participants argued that they had a moral duty to nurse anybody, patient, family or others, regardless of the (sometimes negative) values or behaviours of others that confronted them:

He was very, he was obnoxious and rude and I remember thinking about it at the time and many times there, if I just had a video recorder with these folk and showed them the next day they'd be absolutely horrified at their own behaviour.

I'm sure they would be, because they wouldn't believe that they were capable of doing such things or saying such terrible things to us [laugh] (007/2/p.5).

Abusive or aggressive patients clearly present a moral challenge to nurses both in training and in professional practice. To continue to nurse someone under such conditions requires considerable dedication to the values of beneficence and respect for others when, under different circumstances, the societal behavioural norm may be to avoid or criticise such people wherever possible.

In the next example, the participant explains how she learned to accept that as a health professional she had a duty to care irrespective of the apparently unfriendly reception afforded to her:

The other things is that when you go to a home you don't really know what you're going to come across. One day I tested a child's eyes and her vision wasn't perfect, but it wasn't bad enough to need correction. But I also felt if a nurse, I mean as a parent, looked at my child I'd want to know about it. So I went to the child's home and I also wanted to tell the parents that they need to just keep an eye on her vision. And when I got there, it was in summer and the kitchen windows were open and this large woman's voice floated out the window and it said, "it's the fucking government!" [because] I had New Zealand government on my car. And [laugh] they met me at the door and they started going on about the park opposite...(006/2/p.11).

Other participants related similar stories, but maintained overall that they learned to cope with difficult patient behaviour by accepting the value of respect towards others irrespective of personal circumstances.

Coping with realities of life and death

There are some moral experiences in nursing that are perhaps not everyday ones. In the nurse-patient context there are some situations that no amount of preparation will ever fully suffice. The following extract, which is very long because the impact of the context would be lost otherwise, concerns a woman in her late thirties who was dying from breast cancer:

She wanted to come home to die and she had young children so she wanted to be with them as much as she could, although she couldn't because she was just too ill. And they were doing, what do they call them, needle aspirations sort of every day to get rid of the fluid so she could breathe easier. And it was just the most horrific death I have ever seen, and she wasn't ready to die, she'd not come to terms with it at all and she was absolutely terrified ...And in the end she basically drowned,

her lungs filled up with fluid very quickly one day and the doctor came in, did an aspiration and she was filling up, she was filling up as quickly as he was pulling the fluid out. And in the end we just had to stop and she died not long after that and it was a hideous death and her husband stayed with her and he was just totally shocked by the whole thing, hadn't expected that she would die like that and I hadn't expected she would die like that. And it was a very, very difficult situation... And just trying to do the best for her was just so hard and not knowing how to deal with the situation too was very difficult. It was sort of a little bit over my head really? ... Oh it was awful, it was really awful. And the day before one of her children had had a birthday and I'd got her washed and partially dressed and walked her over to the window to watch the children having a birthday party and she wanted to go down but she couldn't cause she was too sick. And it was all we could do to get her to the window to have a look at the kids playing in the backyard and it was horrible. And no matter what I did, I couldn't do anything, I didn't feel like I could do anything to help her because she was so sick, she was so physically sick she was unable to go through the mental processes of being terminally ill. She couldn't deal with it, so she wasn't able to deal with it and come to terms with it and that was really hard (008/1-2/p.15-16).

In this excerpt, the full force of 'being involved', in the wider moral sense, with another person and her family is brought to bear. Arguably, no amount of preparation, professional, philosophical or otherwise, could fully replicate or prepare a nurse for the perceived psychological difficulties of the actual situation noted above.

As in earlier experiences (when they were students), some participants continued to examine issues relating to life and death and find them not only psychologically disturbing, but also morally disturbing:

As a staff nurse I worked in a ward with babies, up to two years of age and I felt a terrible lack of preparation in telling parents that their baby had died. So from that point of view I was very aware that there had been some terrible lack in my preparation for that job. ...Well I didn't have anything to draw on... I'd had no experience of death in my personal life (006/1/p.5).

Because nurses do have to deal with very difficult and sometimes overwhelmingly profound human situations, it could be argued that their understanding of the needs of humankind in all of its many passions can only be increased. Such understanding may lead to a nursing moral viewpoint that is based on the values of compassion and empathy with the lot of others through experience. In any nurse-patient context, there is nearly always a much wider relational context to consider. In the case of ethical decision making, for instance, it is rare that the only participants in decision making are the patient and her nurse.

Responding to the decisions and behaviours of others

A common theme in the interviews with most participants was the observation that the acts of other health workers concerned them in a moral or moral values sense. Some of these experiences were to them, as in the previous case of nurse training, at least learning experiences about the importance of maintaining moral values:

I think [working with other nurses in] maternity was probably the area where I saw most ethical dilemmas to do with the way that women were treated (002/2/p.5).

The following participant noted that as a qualified nurse, as in the case of the previous undergraduate training, there is a requirement to work within collegial contexts that are not always of their choosing, or where personal values clash with those of group purpose:

It happens, and probably it still happens in CPR. Usually the person wouldn't be pronounced dead at that stage, but I've actually seen them practising putting down an ET tube after the person's been pronounced dead and everybody's stopped doing whatever they're doing.

Did you ever observe nurses' behaviour during these times?

Sometimes you sort of think ... they were quite blasé about the whole thing. And their behaviour from the point of view of a relative who may be there briefly and then be escorted away, someone else who wasn't used to it would think: "Oh, these people aren't taking this seriously" (007/2/p.7).

Responses varied amongst the participants as to how they morally perceived the decisions and behaviours of others (see chapter five), but a common phenomenon was the realisation of the strengths of experience as a learning tool.

By realising the power of experience as an ethics learning tool

Several participants brought to notice one very important phenomenon in the scheme of nursing ethics and decision making. This phenomenon, that of the value of experience, is a key category in the preliminary preparation of nurses for their role in ethical decision making:

... it's life experience as much as nursing experience. My opinions on things from when I was a comprehensive nursing student to when I was a Bachelor of Nursing student have vastly changed, but that was with the benefit of experience - of going overseas and seeing that such a change and coming home and realising what is here. ...But when I worked overseas in the States ... I witnessed [nursing care] that was technologically proficiency based: there was not a nurse in the place that I

worked that couldn't work every piece of machinery that came across her path, but you gave her a naked patient, or them a naked patient in the bed and they had absolutely no idea what to do with them. That was a real eye opener to me (003/1/p.9-10).

When asked how she knew whether or not her actions were the right ones, morally speaking, one participant said:

I questioned myself all the time ... Often in hindsight. I would say that I use intuition a lot, but I know that's a pretty hard thing to pin down, intuition. But I think intuition comes from *knowledge and experience* a lot of the time anyway. I think being, having good communication with your patients often helps you to make decisions too, because ... you can sort of from that respect make a decision I think (008/1-2/p.p. 23-24, italics added).

Through the realisation of the value of further education in ethics

Some, if not all, participants maintained that they really started to examine nursing values and moral decision making methods when they went back into education on post-basic nursing courses:

I mean I knew what was right and what was wrong, sometimes the areas were very merged and blurred, sometimes things weren't always as clear cut as one would like them to be, and I suppose that's when I used to get righteous. But suddenly with the benefit of some of the lectures that we had last year [post registration studies] discussing ethics and morals and things I'm sure that it developed my way of thinking a lot more ... And I'm sure that it's just having ... my eyes opened to what is there, and just looking back and thinking about how you thought about things then and how you think about things now (003/1/p.9).

Nurses make reasoned moral choices in their everyday practice. These choices occur as a result of a cognitive process that is primarily related, but not necessarily exclusively so, to previous developmental experiences within society. Nurses, like anyone else, emerge from the narrower influences of parents and family into wider and wider societal contexts. As they enter nursing, they are influenced by those values associated with nursing. The assimilation of these values, like any other, is part of a constant process of cognition following experience. Thus, the various health care and socio-political contexts that nurses work within are influential ones and may affect future ethical decisions and actions. That is, if early experiences in the family and societal context contribute to the development of moral values, then it follows that early experiences in nursing training and later education may lead to the development of professional values and behaviour.

SUMMARY

This chapter has presented several categories concerning the development of values from early childhood to professional adult career. It has been shown that the participants developed a sense of personal and societal values through experiences in life within several contextual settings. Particular reference has been made to the contextual relationships between these nurses and others in the health care system. These relationships begin in early training and extend to the present day. The socio-political context has been carefully considered because nurses have little choice but to practice within this system. These experiences may be positive or negative, cultural, personal or professional, but the consequence of such diverse life and work experiences is usually an appreciation of the values that underpin ethical behaviours. Their moral values and ethical decision making capabilities in practice are therefore affected and formed through the influence of a diverse variety of contextual factors.

CHAPTER FIVE

NURSING PERCEPTIONS OF MORAL PRACTICE

I find that I'm becoming more critical of what I do and I assess, I look at things perhaps with the same eyes that I always have obviously, but that I actually look at what I do in a slightly different way (003/2/p.14).

INTRODUCTION

Thus far, this study has considered the antecedents of moral decision making in nursing. These antecedents are the development of personal, societal and nursing or professional moral values and the effects of contextual influences. An examination of one final major phenomenon is now required to complete the discussion concerning the preparatory stages of moral decision making in nursing practice. That phenomenon is perception. Perception in this study is the term used to describe how nurses perceive and comprehend the moral situation, problem, dilemma or quandary, and the circumstances that relate to that situation. It will be argued that moral perception is both an antecedent and a beginning phenomenon of the preparatory process of moral decision making in nursing.

THE PROCESS OF MORAL PERCEPTION IN THE NURSING CONTEXT

In philosophy, perception usually refers to: "The discovery, by the senses, of knowledge about the world; the apprehension of everyday objects, for example trees, through sense impressions" (Stumpf, 1983, p.C-2). However, the concept of perception *in this study* emerged from the ways that the participants alluded to how they morally 'saw' or sensed a situation or problem in everyday nursing practice. In this regard, this study is concerned with implicit and contextual *moral* perception rather than explicit and empirical sense perception. The easiest explanation is to compare moral perception to the act of looking through a hypothetical 'lens.' Each individual looks through the 'lens' in ways that are unique to that individual. What she or he sees, what is 'perceived' may vary by degree, or according to already established 'patterns of seeing.' These 'patterns' are the equivalent of the personal, societal, professional and past and present contextual

experiences of the individual. It is as if their 'seeing lens' has been 'ground' by unique and personal experiences. Hence, moral perception refers to the cognitive process that occurs when a nurse 'senses' that a moral problem or situation exists that is of concern to her.

Each nurse will perceive each ethical situation according to his or her own interpretations. Indeed, in a similar way to sense perception, each nurse will perceive a given situation differently according to his or her values system. What may be perceived as an ethical situation for one nurse, may be seen as a practical problem to another. These interpretations vary enormously according to experience, but there is no mistaking the cumulative effects of these experiences on each nurse:

Some of my patients have had a profound influence on my life, they really have ... Sometimes I'd like to know if I've had some kind of influence on them but you never really know do you? (008/1-2/p.20).

Hence, deeper moral perception of events does not seem to occur immediately, but rather later when the nurse has undergone a process of reflection on her actions in response to that event. In the case of ethical interpretation, perception may be a very long process based on a period of reflection. On being asked about when a clearer moral perception of past events occurred, the following participant said:

Years later. So you're talking when I was twenty then [as a student], but [perception came] probably not till my thirties, which is terrible isn't it... And sometimes you don't honestly reflect on them [past incidents] until something in your mind changes because your poor old brain can only hold so much, so you might be reminded of something... (004/1/p.5).

Other participants supplied similar explanations of their perceptions of moral events. Therefore, if individuals learn about the world and act within it through a process of interaction with 'things' (both material and transcendental) within the world, then they do so because of the meaning that they give to these things. In this regard, meaning is a phenomenon that derives from social interaction, and is allocated by each individual according to their own interpretations. This explanation owes something to the symbolic interactionist tradition of Mead (1934) and Blumer (1969), and the philosophical ideas of Dewey (1929). Hence, when nurses are making ethical decisions in their practice, they are doing so from previous and present interpretations or perceptions of *meaning*.

HOW INEXPERIENCED NURSES MAY PERCEIVE ETHICAL SITUATIONS

To make a moral decision, and to act accordingly, requires that the individual nurse be 'trained to see' or morally perceive a given ethical situation in the first instance. Admittedly the beginning nurse will perceive according to her previous experiences, but these experiences are usually limited to personal development, and not to expert nursing.

Two main problems in the preliminary moral perceptions of inexperienced or beginning nurses (i.e. nursing students) arose from data. They were the problems of either not morally perceiving or morally misperceiving a given situation involving themselves and others in the health care context. These problems are to be expected in beginning nursing students because they have not had sufficient preparation in either applied or theoretical ethics to fully appreciate any given situations in context:

...when I was a student I was fairly black and white in my thinking and so many ethical issues that I see now, I didn't see then, because I didn't perceive them particularly as being ethical issues. I probably found it quite hard to distinguish between ethical issues and practice issues ...What did I feel was ethical? Things that caused me discomfort, or I guess a combination of those things (002/1/ p4).

Those participants who presently work with student nurses confirm this observation, and generally conclude that problems with ethical perception are usually most likely within the early stages of nurse training:

They [nursing students] on the whole, I would suggest, they don't perceive ethical problems. You see a student...observed a patient being more or less forced across to the bathroom for a walk, for a wash...She was a lady who was very, very sick and not expected to live many more days. And she [the student] said to me, "I just cannot understand why the staff nurse wanted to get her across to the bathroom when we could have given her a very easy wash in her bedroom." But she said, "I wasn't brave enough to say anything to the staff nurse, or even ask her why are you insisting that we go to the bathroom, when I could do the job here..." Then you say to the student, "well, what have you learnt in this situation? Would you have done this, or would you have been kinder to the patient and allowed her to remain?" You see the woman died two days later (007/2/p.14-15).

Experienced nurses understand these problems. The student in the story above perceived an incident that triggered a certain response (from a personal moral values position), which was certainly the appropriate feeling or 'gut response', but the incident did not lead to a moral decision to act according to this response. In the instance above the

student did not perceive *herself* as being able to intervene, even if she had wanted. This process is explained very aptly in the following excerpt:

I do believe the way that you perceive a situation, and I'm talking about perception in quite a cognitive schema kind of way, is the way that you can see how 'the situation' changes. She [referring to Benner, 1984 (*field note*, 5/9/97)] describes quite clearly the types of changes in thinking from a novice to an expert nurse. In terms of ethical reasoning I would see as a novice nurse you would be focusing more on your intellectual understanding of the issue and the sort of 'clunky' ethical theories that you use. Later on you may get more of a sense, more an instinctive sense of what the ethical theories are in relationship to this particular case... And I think you'd also be able to focus on the client or the family that you're working with, the situation. So rather than just thinking of you and your intellectual processes in the early phase, you're able to look at a slightly more complex situation as it involves nursing practice, ethical practice and the client situation (002/2/ p.7).

HOW EXPERIENCED NURSES MAY PERCEIVE ETHICAL SITUATIONS

From an analysis of data, three major concepts emerged that explained the ways in which experienced nurses perceived (in the wider sense) ethical situations in practice. These ways are as follows;

As a potential conflict of views

Experienced nurses understand very well why some situations are ethically difficult for others. This is because they have experienced the differences between various parties in moral perceptions of a situation, and also because of their close involvement with those concerned:

There was conflict of views between the family and I guess the health professionals. I guess there was a lack of understanding and a lack of awareness of where people were coming from, and that people actually had the right to make those sorts of decisions, whether you agreed with them or not... but the thing is that we didn't know what the mother was thinking. And I just... kept thinking why we didn't do that, was it a cultural thing or were we not approachable, couldn't she trust us, you know things like that ...And actually, she talked to me about it and I was really comfortable and I just checked around for stuff like that, just to make sure that what she was saying was what she really wanted and she wasn't being coerced by anybody (001/1/p.15).

In the example above, the participant not only recognised that there would be differences of moral perception regarding the situation in question, but also took actions that made

sure that the mother of the child (the one who was most directly involved) was included and supported in the eventual ethical decision making process.

As a contextually influenced phenomenon

Experienced nurses are also acutely aware of the changing contexts that affect their ability to offer good nursing care:

There are times when you need to have one on one nurse/patient relationship and there are times, I believe now, given the financial constraints that we practice in, where nurses can delegate some of their work to care assistants, nurse aides whatever you want to call them. There is some stuff that nurses can give away. But the trick is not to give away the important things that nurses do (005/2/p.11-12).

Hence, awareness or perception of contextual restraints is one thing, but finding appropriate ways to deal with these restraints is another. The experienced nurse does not easily allow the “important things that nurses do” to be eroded away, constraints or otherwise.

As particular ethical problems that require a nursing response

The participants gave answers to questions about those issues that were pertinent to their own areas of practice. The following selections from data are offered to illustrate the breadth and width of ethical nursing concerns. For convenience only, the examples from data have been arranged according to the suggested main categories used by Woods (1994, p.30) in previous nursing ethics research within the New Zealand health care context:

Client/patient issues, such as 'Not for Resuscitation' Orders, confidentiality, informed consent and palliative care.

... what to do with a baby who was not getting better but was slowly dying but not dying quickly—that slow, long dying trajectory. The care for those babies? You know, whether you go out all aggressively or go out for passive care, those sorts of issues. And when to terminate [aggressive treatments] (001/1/p.7).

Babies that, not in all cases, but babies that could have had a much different outcome had they had earlier intervention, or children that were being kept alive for the sake of being kept alive, but what was their quality of life? I certainly considered it then, but in hindsight I've considered it more I think (003/1/p.3).

You get the people [referring to nurses] who could quite easily let the kid [a patient with severe burns to most of his body] go, there's so many wires and tubes.

If they wanted to, it would be not difficult at all. But they'll fight to keep him alive, but they don't want to (004/2/p.15).

Inter-collegial issues, such as the unsafe practice of peer and other health professionals, and the 'doctor - nurse' relationship.

...resource allocation in the intensive care unit, that's a moral decision, which baby gets which piece of equipment, one over the other. Space, bed spacing, that's another issue for me. Staffing issues, conflict between parents and nursing staff, conflict between nurses and doctors, conflict between parents and doctors too (001/1/p.7).

Professional issues, such as the effects on nurses and their patients of health service re-organisation and current working conditions.

The key concerns centre around the use of the [psychiatric] intensive care unit which is poorly designed and when staffing levels are low, it is dangerous. Say for example ... let me think ... there's been some debate about what the actual bed numbers should be (002/2/p.3).

The above are selections only. There are many more examples to follow in later sections of this chapter. For the vast majority of the interviews for this study, the participants discussed *particular* ethical incidents rather than abstract ones. This observation has greater significance than may be presumed. Nurses use highly personalised stories, or narratives, to discuss ethical problems in the workplace. They do not easily generalise or apply ethical theories to these incidents. Instead, they tell each one as if it were a completely unique story in its own right. This phenomenon has been recognised as a familiar one in nursing ethics:

In general, reflections on ethics in the nursing context have focused on the discreet quandaries faced by individual practitioners. The most obvious reason for this is that nurses naturally desire help in resolving the moral problems they face in every day practice (Curtin & Flaherty, 1982, p.100).

However, experienced nurses are not void of more abstract ideas when considering their ethical practice, nor are they necessarily disinterested in them:

And often I react, and then I deal with it and then I have time to reflect on it afterwards, I can put the pieces together. So it's kind of an instinctive and automatic thing. I think that I probably see more ethical dilemmas now in different places. I see them in terms of mental health policy, nation-wide, in terms of interdisciplinary involvement and the nurses role within a multidisciplinary team, in

terms of resources and staffing. So I think my focus has moved away from the patient and what my nursing care should be of a particular patient, it has moved to much more global issues (002/2/p.7).

In response to the ways in which nurses choose to narrate particular ethical incidents rather than 'dissect' them as if they were merely academic problems awaiting solution, some nursing writers are using the concept of 'narrative ethics' (see chapter two). According to Rogers and Niven (1996):

In narrative approaches to ethical inquiry there is a focus on the concept of narrative per se. That is, we live our lives, professionally and personally, in deeply embedded stories. Our personal lives are described in narrative histories and accounts of how and why others matter to us (p.95).

However, as noted earlier (in the case of the student nurse), there remains the problem of those ethical situations that nurses feel they can do something about, and those situations in which nurses feel powerless to intervene. The phenomenon of the nurse's ability or inability to practice according to her ethic is of considerable interest to nurse ethicists. This is because it is one thing to correctly perceive and describe an incident requiring ethical input, but another to respond adequately when the 'barriers' to action are also perceived to be too difficult. It will be shown how *experienced* nurses attempt to overcome restraints to practice in chapter six, but all nurses must face barriers or obstacles to moral actions regardless of their abilities to circumvent them. Hence, the following section will consider these apparent obstacles to ethical practice.

PERCEIVED OBSTACLES TO NURSES' MORAL INVOLVEMENT

It is maintained that if the barriers to moral action are perceived to be too great by the individual concerned, then these barriers will affect the moral agent's (nurse's) ability to take appropriate moral actions. According to the participants of this study, such barriers do exist (and may therefore be incorporated into the perceptive/cognitive system of each nurse) from early days of training to the present day. These barriers present in many forms to different individuals, but they are identifiable in the following ways:

POWERLESSNESS WITHIN 'THE SYSTEM'

The notion that nurses are powerless to act morally within an authoritarian and hierarchical health care system begins in the early days of nurse training:

I felt badly about it [an unethical act performed by others of greater authority], but I'd been told on the grape-vine that if you said anything you'd be ostracised and probably your training would not proceed (007/1/p.2).

As student nurses, some participants were not encouraged to even consider the possibility of moral problems in their work:

... they got their dressings and they got what the doctor ordered, and that's why there was no moral dilemmas. Just follow the orders, follow the routine, the poor old patient really didn't feature in the conversation much (004/1/p.6).

Even in those circumstances when an ethical problem was clearly identified by a participant (as a student nurse), the perceived powerlessness to act was strong:

Yeah, they [nurses] did [hit the residents]. Well, when they were breaking up fights—you'd have to intervene—they would get a smack in here and there, the staff would, which was not necessary. I mean, I've seen quite a few instances like that and I did nothing about it at the time (007/1/p.2).

Even worse, when the problem is quite clear to all concerned, doctors, nurses and others, there was no guarantee that anything would be done about it:

[Re nursing a violent patient who assaulted the nurses everyday] Physically it was unsafe, but the other unsafe factor was that we were not given any coping strategies, any information to develop coping strategies to cope with the situation. We were expected to cope with it because we were there. And I have a whole question about the way I was educated, a whole question because ... I think my training in those sorts of areas, was actually detrimental (001/2/p.2-3).

Previous research amongst nurses in New Zealand has shown that, when confronted by moral difficulties involving others in the health care setting, nurses sometimes feel constrained from acting according to their moral values within their own sphere of practice (Woods, 1992). According to Yarling and McElmurry (1986), nurses are 'not free' to be moral in their practice because the policies and actions of the health care institutions undermine nurses and their relationships with others:

They are not free to fulfil their moral obligation to the patient when the interest of the patient is in conflict with the interest of the hospital. They are not free to act apart from the risk of serious harm to their own well-being. ...The fundamental moral predicament of nurses is that they often are not free to be moral because they are deprived of the free exercise of moral agency (p.65).

There is some support for this view amongst experienced nurses:

It's all quite interesting, their [nurses] concerns [about safety and other ethical issues] have been minimised by the manager of mental health services, who kind of says "nothing's changed" (002/2/p.3).

This phenomenon does not go unsupported in both nursing literature and in data gathered for this study. The need to conform, to 'fit in' with the health care system is strong amongst nurses. Contemporary research suggests that nurses experience what has been described as moral distress or outrage and loss of integrity when attempting to act morally in oppressive circumstances (Liaschenko, 1995). Wilkinson (1988) maintains that moral distress occurs when both internal and external constraints prevent the nurse from "taking the right course of action" (p. 16). Wilkinson's notions of external constraints in this instance are very similar to those previously noted (physicians, management, bureaucracy, and others) but, significantly, she also notes *internal* constraints as a barrier to good practice. These latter constraints will be addressed in the next section.

THE NEED TO CONFORM WITHIN THE SYSTEM

Unless a nurse is an entirely independent practitioner, which none of the participants were, data showed that even experienced nurses frequently feel the need to 'belong', or to 'fit in', with the group or system within which they work. This need may influence their moral decision making and actions, and is applied to patients as much as to other nurses and health workers:

She [a nurse] said "she [a 'difficult patient'] wants early discharge, she wants to do this, she wants to do that, she doesn't want to do things the way that they're done." So it's kind of care by authority and tradition and if you don't accept that, that's too bad. And similar examples in the delivery suite as well, yeah, women

who had birth pains or who didn't want medical intervention were treated by some midwives with much less empathy than obedient women (002/2/p.6).

Nurses are by no means immune from criticism when it comes to their own moral behaviour. The trend noted above appears throughout these data. Another example:

I just saw somebody that could be doing a lot better physically and mentally and knew that if somebody spent time with him, then he would do a lot better, so I did. *Why didn't the other nurses spend a bit more time with him?*

Well they couldn't be bothered because he was too much hard work, such hard work to communicate with, and you know, things like that ... It seemed to aggravate some people that I got on so well with my patients for some reason (008/1-2/p.3-4).

Nevertheless, some participants worked with other nurses who supported their moral idealism and conformity to the group became a pleasure rather than a cause for anxiety:

Yeah, it was actually a very unusual hospital that hospital, the nurses that worked there, they all seemed to be fairly compassionate people and very interested in the work they were doing. Because it was a specialist hospital I guess people chose to work there and they were all very interested in the work they were doing so it was quite a different way of approaching things for me because I found other people were interested in their work the way I was (008/1-2/p.11-12).

It should be noted that in the extract above, the participant identifies a feeling of belonging due to the presence of compassion and interest in practice in her co-workers. This observation will be discussed later in the chapter.

Overall, the connection between moral and professional behaviour is sometimes blurred due to an uncertainty in interpretation of good and bad behaviour as perceived by others. In the following excerpt, the participant is unsure if the issue that she has raised is an ethical issue or not. This uncertainty concerning the nature of ethical problems is a common theme throughout the data. It would seem that nurses were not familiar with the components of ethical analysis as such, but rather the need for moral behaviour in their relationships with others (memo item, 4/8/96).

Although I remember not getting on with one particular Charge nurse at all, and then I spent a lot of time with one of her favourite patients who'd been a patient for a long time. And worked hard at getting him rehabilitated, that was from a stroke and an amputation. And so because I took a real keen interest in him, the Charge nurse's opinion of me changed and I think that's a moral sort of issue because ... well maybe it's not (008/1-2/p.2).

THE DEMANDS OF EXPEDIENCY AND TIME FACTORS

There has always been a demand on nurses to practice under less than ideal conditions and circumstances, but when these circumstances become ethical issues, experienced nurses perceive their position to be very difficult:

[I perceived] a conflict between my own values and the values system of the organisation at that time ...They seemed to recognise that it was a problem and I'm not sure if they were able to effectively deal with the situation. They were very short staffed, they would still continue to go out and accept babies in some other areas and nurses were really split trying to cope with the workload. It was like you had to have one of you split in half to be at two or three places at once... Really, really difficult. And some of these babies were very, very sick and they should have theoretically had two nurses per one baby for some of them, rather than one nurse for two babies ...but then you can argue is that doing harm? And you're looking at resource allocation and the moral ethics of resource allocation. This baby was taking up bed space, equipment, nursing staff ... I think it is a nursing consideration (001/1/p.13-14).

When asked for further clarification on this issue, the participant had this to say:

From my own point of view I strongly believe that babies and their families were entitled to competent care, that was appropriate for that baby at that time ... So from my own personal view sometimes quality care for the baby is compromised by forces outside the individual's ability to have any influence on a situation. And I guess that's just where some nurses work very long hours, just to make sure that there was a pair of hands in the room to actually provide basic care for these babies (001/2/p.9).

The ethical consequences of the above situation are only too clear:

Oh, there were many times that the care became unsafe ... Like if a baby suddenly crashed you needed as many hands as possible to draw up medication and get bloods off to the lab etc. etc., for resuscitation. That would be the most critical situation, unexpected deliveries in the delivery suite was another one [laugh], we had to rush down for that one, space, resource allocation, not having time, quality time to actually spend with parents (001/2/p.9).

'RESPECTING THE DOCTOR'S ORDERS'

There is much that concerns nurse theorists and ethicists on the subject of the 'nurse-patient' relationship, but the 'nurse-doctor' relationship remains an area of much controversy (Benjamin & Curtis, 1992: Curtin & Flaherty, 1982). Benjamin and Curtis claim that there are numerous conflicts between the nurse and the physician, and that they arise when either the nurse or the doctor disagrees with the professional practice of

the other. Thus, ethical conflicts between nurses and doctors are not uncommon. In this study, nurses had quite a lot to say on the subject:

Very much so, one of the things I was really concerned with when I look back now ... was the fact that nurses were very much in the medical model and very much under a patriarchal model where the doctors made the decisions, moral as well as treatment wise, and we were to accede to their wishes. Nurses were not encouraged to discuss or criticise decisions that had been made (001/2/p.1).

If nurses do challenge a doctor's decision on ethical grounds, then the responses are frequently unsatisfactory to them, as the following excerpt from a participant shows:

If we questioned things, then we were [perceived as] being a bit aloof I think, and the socialisation thing had a big impact here. Yes, we did question things but we seldom got any sort of reasonable responses from them [doctors] (003/2/6).

One participant perceived this type of medical apathy towards nurses as a problem associated with the social standing and perceived lack of (ethical) decision making ability in other nurses:

That is the powerlessness ... It makes you realise that at the end of the day you can have every committee and every badge and everything under the sun, but basically you're powerless. They [nurses] wouldn't do it [challenge the doctors on ethical grounds], they're not able to do it (004/2/p.16).

The incidents concerning the doctor-nurse relationship and ethical actions or non-actions are numerous. However, experienced nurses will not abandon a situation in the face of adversity, even if it may bring them into disrepute. An example:

The baby was put in an incubator and I thought there was something wrong with it. I just felt this, I just had this really strong feeling that the baby's condition was deteriorating and it was in the afternoon and I was the senior person on and I phoned the house surgeon and he came and had a look and said there was nothing wrong. And I still had this feeling and I phoned the house surgeon again and he said there was nothing wrong and ... I think I phoned the house surgeon three times that afternoon and eventually I phoned the registrar and then eventually the baby started convulsing. And when the specialist came he thumped the top of the incubator with his fist ... he was very angry and why wasn't he called. And nobody said anything. None of them stuck up for me, none of them said I'd been calling them. It was quite funny (006/1/p.8).

This example is interesting for several reasons. The nurse would not accept the junior doctor's decision against further treatment, nor would she 'walk away' from the

responsibility that was hers within the nurse-patient relationship. She solved the dilemma by appeals to higher authorities, and then, when her actions could have been vindicated, she said nothing. This interesting phenomenon will be addressed in chapter six.

It seems apparent from data that some nurses do not always succeed in even entering into a sensible discussion with doctors over ethical care issues:

And he [the physician] came and said: "Hello girls" and they [the nurses] go, "Oh, ... isn't it terrible, they should let him die." ... He said, "Oh you can't say that." So he was saying you know this is just not on, and he was the one holding life or death over this kid. The nurses wanted to let him go and he was saying, "you can't do that, you've got to give him a chance to live and I know someone who survived", and all that sort of stuff (004/1/p. 11).

This lack of response from the medical staff in regard to genuine nursing concerns is an ethical problem because the (nursing) care perspective is arguably as important as the (medical) treatment perspective. However:

With certain treatments ['huge doses of steroids for multiple sclerosis, taking out parts of people's brains for treatment of long standing obsessional problems'] ... the nurses weren't very keen on them because they knew it was going to be hard on the patients, so they would try and say well we don't think that's appropriate. But they didn't get listened to very often ... (008/1-2/p.7-8).

In all of the above categories on nursing perceptions of obstacles to moral decision making, one aspect became increasingly more apparent within the data. This aspect is that of the importance that nurses place on their role as professional care givers. This role is perceived to be a professional one by the participants of the study because they frequently associate good ethical practice with expert practice; and expert nursing practice with professional practice. It is therefore useful to examine how the participants perceived and focused on the moral dimensions of the nurse-patient relationship.

NURSING METHODS OF ETHICAL REFINEMENT THROUGH EXPERIENCE

As seen in earlier discussion in this chapter and chapter four, the process of nursing moral decision making occurs within specific contexts. These contexts may be considered as those contexts that make up the nurse's 'world'. The most central relationship is that concerning the nurse-patient relationship because 'to nurse' is to

nurse *someone* or some others. Hence, the nurse's world is the world of contextual relationships with others.

Four key perceptions were identified from data that pertained to the participants' understanding of their relationships with their patients. These perceptions, it will be maintained in chapters six and seven, 'drive' an experienced nurse to overcome obstacles to ethical practice and to make ethical decisions that reflect the relationship between the professional nurse and the patient. These perceptions are therefore crucial to the development and refinement of moral decision making in nursing. The four key perceptions are:

NURSING AS A PARTICULAR TYPE OF RELATIONSHIP

Experienced nurses seek to establish and maintain a caring relationship with their patients. If they are unable to do so because of insurmountable obstacles in the workplace, then the result is often one of great dissatisfaction and disillusionment:

The reason why I handed my resignation in was that it was totally unsatisfying because I couldn't have the same close relationship with patients. I wasn't given specific patients, I was like an extra pair of hands in the ward (006/1/p.8).

The above extract almost mirrors Benner and Wrubel's words: "The consequences of delivering inadequate care due to work overload erodes the nurse's self esteem and causes real anguish" (1989, p. 384). As may be seen, such anguish could result in the loss of the experienced nurse because a morally committed nurse will not work in circumstances where professional caring is so undervalued.

The relationship between the nurse and her patients is a nebulous and sometimes highly involved one. Even experienced nurses do not always find it easy to explain this relationship in ethical terms but chose instead terms that are more personal or emotionally based:

... but I think it's the intenseness of the relationships you develop with the patients and their families as well, because ... when somebody's in intensive care it ... has an incredible impact on the lives of the people involved. More so than just a straight appendectomy or broken leg or ... [the] other reasons that bring people into hospital. When somebody is sick enough to be admitted to intensive care it has a huge impact on their lives and I think the intenseness of that I really enjoy...I enjoy the emotion of it. Because I'm not frightened of intense emotions at all and I like ...

I like to see people through those times you know. To be able, 'cause I've seen so much of it, to predict what's going to happen along the way, you know with different scenarios. And you can help people come to terms with what's going to happen, or just on a day to day basis, help them just get through it really and communicate with them what's happening, and what they can do to be a part of it (008/1-2/p.19).

The ideas expressed by the participant in the above extract closely resemble those of Campbell (1984), who suggests that his notion of 'skilled companionship' may assist in an explanation of the nurse-patient relationship. The concept of companionship "describes a closeness that is not sexually stereotyped; it implies movement and change; it expresses mutuality; and it requires commitment, but within defined limits" (p. 49).

A skilled nurse as a 'companion' may provide 'personal care' to her patient, and in doing so she may also be more than 'incidentally involved' with this patient. She may be committed to a particular type of caring relationship with her patient that is considerably more than what may well be described as a 'contract' of some sort. She is not, as may be seen from these data above, involved in a disinterested 'customer-provider' situation. She does, however, have a particular type of 'investment' in her patient. Basically, she has a special kind of relationship with her patient - as, it may be said, 'a good companion'. "The good companion is someone who shares freely, but does not impose, allowing others to make their own journey" (Campbell, 1984, p.49).

Within this relationship that is potentially a close and involved one, experienced nurses express a desire to alleviate the vulnerability of their patients. The relationship therefore has a psychological content as much as it has a practical content:

I think patients when they come into hospital are very vulnerable and [my role is] being able to, I guess help them in that state. You know I think the nurse can ... become the anchoring person when people are stressed or experiencing difficulties in that you can confront people about things that no other people can. You can discuss their death ... and you don't have to stand on ceremony because you're the nurse ... essentially you had that right, and patients I've found always respond to that. And so therefore I could cut to the chase really fast, you know. (005/1/p.2).

NURSING AS A PROFOUND CARING EXPERIENCE

Some experiences in caring for others have lasting influences on the nurse. These experiences are clearly relational and, to some nurses, philosophical ones:

I remember something he said to me that it was quite profound. It had quite a profound effect on me for many years to follow. He said that he wasn't frightened to die and dying was the last experience of his life and he wanted to experience that experience, he didn't want to be asleep or unconscious or you know. And I thought about that a lot over the years and I thought that was an incredible thing to say from a thirty year old. 'Cause I was only twenty at the time and I was sort of quite blown away by it, how could anybody think like that, I hadn't even thought about death and dying really, although I'd just started to see a lot of it with being a nurse (008/1-2/p.20).

This participant goes on to explain the philosophical importance of the caring relationship that she had with her patient:

I think it triggered off a lot of investigation into the idea of what death is and what happens and how we experience it and ... Some of my patients have had a profound influence on my life, they really have ... Sometimes I'd like to know if I've had some kind of influence on them but you never really know do you? (008/1-2/p.20).

This extract mirrors Swanson (1991), who considers the nurse-patient relationship to be capable of such profundity. In her description of this relationship, she talks of nurses being prepared for a more 'intimate' relationship with each patient by "going the whole distance with the other person" (p.165). This type of intimacy may indeed be reflected in the previous data. A person who faces death in the near future may well seek out a nurse who can clearly meet his need for tenderness and understanding in his attempt to deal with his fate.

NURSING AS A SHARING/TRUSTING RELATIONSHIP

The concepts of sharing experiences with their patients in the health care setting, and of the need to establish a trusting relationship to achieve such sharing, was a common theme from the participants of the study:

I think people latch onto people that they can trust and for some reason he latched onto me that he could really trust me. I mean there is that whole thing about, yeah, I do feel I have an empathy for Maori patients because I can really understand them. I know what it is that they talk about, I have lived that experience, that is my lived experience. And it belongs to me as much as it belongs to them, so you can't deny that (005/2/p.5).

In the extract above, the reference to shared past socio-cultural values is both illuminating and explanatory. Experienced nurses perceive their relationships with their

patients on a deeper level than just a working relationship. Shared values within a trusting relationship are important to such nurses because they recognise that:

To trust, however, is to deliver oneself into the hands of another. This is why we react vehemently when our trust is “violated,” as we say, even though it may have been only in some inconsequential matter. Violated trust is trust that is turned against the person who does the trusting (Løgstrup, 1971 p.9).

The following participant reveals the fundamental necessity of trusting between two individuals as an essential part of good nursing practice. As the participant maintains:

At the end of the day, anyone, in theory, could have covered J [nursed him] and they don't mind, but to actually trust you to do your other duties, they've got to see that you're just like anyone else, that you wouldn't bend the rules (004/2/p.2).

In the extract above, the participant shows a grasp of the need to be constantly alert to the possibility that the patient expects certain standards of fair behaviour from the nurse. That is, if the nurse and patient are to have a trusting relationship, the nurse has to be trustworthy.

NURSING AS A PASSION FOR SOCIAL GOOD

The following participant maintains that within the nurse-patient relationship there is an all encompassing moral imperative that guides the nurse within her relationships with others who require her assistance towards a healthier lifestyle:

I think I really enjoy people and on another occasion, I was in a household where quite a lot of drugs were used ... And this day we were sitting in her sitting room and they were talking about using drugs and I said something like “I don't need to get drugs cause I get high anyway”. I said, “I get high on people”. And they looked at me and they could see, I was ‘high’ [laugh], they recognised that I was. She said, “yeah, you're high now aren't you?” And I think I get excited by seeing people get healthier, I love that, I love it (006/2/p.12).

To achieve these types of relationships with their patients, experienced nurses adopt a number of moral responses that enable them to maintain their role as ethical health professionals working towards the public or social good. These responses may be described as ‘being involved’ and ‘committed to caring’:

'Being involved' and 'committed to caring'

Participants in the study expressed their own interpretations of nursing as a 'passion for social good' in various ways. In the next extract, the participant explains this degree of involvement as follows:

One of the things that happened for me, one of the progressions that happened was that I started off and I was working one to one with people and I was getting more and more concerned because of the sort of social conditions that they were in. It seemed to me to be enforced on them by this very oppressive system, for example some families would go from crisis to crisis and I've often found that it was somebody working in a government department that put them into the crisis. ... By the end of my first year I felt I can't just keep on working with one person at a time, I have to work with more people or I'll just get nowhere. So I began to work more with groups and I also began to work in a more political way (006/2/p.11).

The commitment to provide professional care for others was a common theme in data. This commitment remained even under trying and difficult circumstances:

[I had] very interesting times with drunk alcoholics who were so abusive and then the next morning they couldn't believe that they would have said the things that they... just didn't appear to be those sort of people at all, they were usually very nice people the next day...Well I can remember one alcoholic telling me that I should never be working there because I wasn't an alcoholic myself. He said you're not an alcoholic, how can you know how I feel? [laugh] (007/1/p.6).

The nursing commitment to care includes the capacity to care for those that the nurse may not personally like. As the following extract maintains:

... a lot of people would say, 'I couldn't do that' [nurse people who I didn't like]. And he would say "that man over there is a vicious child molester, did you know that?" They'd say "no, 'cause he looks quite normal and he acts quite normal."
But once you knew that did it make any difference?
 Once I knew, there were one or two particularly nasty people that I probably gritted my teeth over a bit [but professional care was still provided (*field note*, 10/9/96)] (004/2/p.8).

Other participants explained the commitment to caring as being prepared to cope with a strained relationship:

Even though you do some things that people don't like, if they can accept you as a good nurse, or you seem to be clinically competent, then it's OK, it balances out in many ways (005/2/p.1).

Nurses explain their commitment to care in numerous ways, but this responsibility does not come *carte-blanche*:

Justice for the patients and the nursing staff [was the ethical issue in the case of the violent patient who disturbed everyone on the ward], there was no moral justification for what we were subjected to. Mind you they could argue that we were there to care for the clients and we had an altruistic responsibility to provide care for them whatever their circumstances. While in one respect that's quite true, on the other hand there were no support mechanisms for nurses in those situations. So what they may argue is the greatest good for the greatest number was in fact a fallacy. That the individual had rights, those sorts of areas, I think they were false in those circumstances (001/2/p.3).

In all, nurses perceive the delivery of good care within the nurse-patient relationship to be of vital importance to their work, regardless of inter-personal perceptions or difficulties. As Walton (1989) noted in a review of nursing practice in New Zealand hospitals, nurses consider this aspect of nursing to be the most important one: "It was not uncommon for this... [care] to be the only response; such answers stated, for example, 'to give the best care to my patients', or 'caring for my clients and their families'" (p. 24).

However, the perception of moral situations within this relationship depends upon more than commitment. As maintained previously, to perceive a moral problem, a nurse has first to 'learn how to look'. Some moral situations are easier to comprehend than others. In this regard, maturity and experience seem to be of most benefit.

THE IMPORTANCE OF MORAL MATURITY AND EXPERIENCE IN NURSING

The following is an outline of the main codes that emerged from the participants' descriptions of the processes that enabled them to gradually focus on and refine their ethical responses to moral experiences within practice:

REFLECTING ON MORAL PRACTICE

Most participants related stories about their experiences in nursing that suggested that after a period of time and reflection, their understanding of moral issues in the health care context changed from that of an unrefined moral perception to more refined and thoughtful one. This process is similar to the 'trial and error' approach that is familiar to students in any learning situation:

And what did you think about that [a patient dying alone on the ward]?

At the time [as a student], I just went "oh well, that's life". Now, ... I mean it wasn't really a dilemma then as I said, but this is all young people doing things that perhaps if there had been an older person around... Just perhaps if there'd been older people there, they might have gone: "Hey, this is not on team. You know we contact relatives, we do various things, we sit with dead people, we don't leave them dead in the bed for half an hour" (004/1/p.5).

The process of moral focusing or reflection becomes increasingly important for nurses as they develop professional nursing attributes. These attributes include an ability to clarify the moral issues that confront them in the health care context:

I think when you're working at an expert level, the only way I can describe it is to describe it as when you suddenly focus a kaleidoscope, you're looking down the barrel of a kaleidoscope and you go from having an unfocused, multicoloured array to having a picture which is patterned and focused and quite clearly you can see how things fit together (002/2/p.7-8).

PROMOTING ADVOCACY WITHIN THE NURSE-PATIENT RELATIONSHIP

As students of nursing, the process of speaking up for others or advocating on their behalf within a hierarchical and hegemonic health care context may be very difficult and fraught with disadvantages. However, according to the participants of the study, after a period of time and a range of effective and ineffective experiences, they learned that nursing's moral involvement in the plight of others requires a high degree of moral maturity that can only be gained through experience:

And the experience, you see. I now have the age, where as at twenty three I used to battle terribly when I was a ... Charge nurse of X ward, with these decisions, you know. Like going up for this kid who was seven [and dying of incurable leukaemia] ... he picked me out of everybody to be the person to fight his battles [over ceasing treatment] and that was a real traumatic battle, *and yet we won* (005/1/p.11, *italic added*).

Experience and moral maturity goes hand in hand with nursing expertise, but the personal moral values of each nurse do not disappear. Instead, they are assimilated into the nurse's overall ethical practice:

... as much of me is Maori there is a lot of me that is Pakeha, but it's all that stuff about, when I became the nurse as opposed to X, but the ... experience and the expertise that I have, gives me the right to stand up for those sorts of people. I don't have a problem with dealing with problems because I have the right, you know, whether it's a white uniform, whether it's a five pointed star, I have that right. If they want to employ me as the nurse, then I will do the job (005/2/p.5-6).

VALUING THE USEFULNESS OF EXPERIENCE

The phenomena of experience and reflection on practice emerged continuously from interviews with participants for this study. In the gradual process that is indicative of ethical refinement in nursing practice, it is very clear that an acuteness or preliminary refocusing of moral values and practices leads to a higher degree of ethical certitude:

What are your responsibilities? ... You know it's like now [as an experienced nurse], I find it really hard to ...walk past the room when I see somebody struggling. Where it's easy to walk away and say: "Oh well, maybe I just didn't see that." *I can't do that ...* (005/1/p.12, italics added).

The development of ethical certitude in nursing relates directly to practice rather than theory because, as emphasised again and again by the participants of this study, their emerging moral practice has much to do with experience and far less to do with the application of theory:

I was just thinking that maybe nurses learn ethical theory on the job? Like it's knowing how, but without going back and looking at the theoretical underpinnings of what they're saying (001/2/p.17).

However, this is not to maintain that nurses spurn ethics theory or literature. On the contrary, their experiences provide grounded *substance* for research and theorising in moral decision making in their practice:

I think because my [nursing] views are based on literature, generally research literature, I don't tend to express a view unless it's something that I have some kind of more objective knowledge about. So I keep my mouth shut unless I know what I'm talking about ... But I think it's also, it's when other people say sort of say "yeah, yeah that's right!" It's kind of that what they talk about in qualitative research, it's other people recognising it (002/2/p.11-12).

The recognition and confirmation of the moral experiences and actions of experienced nurses is thus a great impetus to ethical practice within nursing. This phenomenon provides not only encouragement for other nurses, but a reassuring degree of self confidence in one's own practice:

Well it was as a student [difficult to take a risk and say what you think], but as a staff nurse ... it doesn't create as many problems for me now because I'm seen as an experienced nurse who knows what they're talking about (008/1-2/p.23).

These methods are the ways in which the participants became experienced in moral focusing and refinement. In all cases the common theme of moral maturity through experience is paramount. Hence, this theme is an important one in the ethical perception of nurses.

The value of learning from experiences over time is a common theme in nursing discourses. In the perception of ethical problems, nurses who can learn from experience must certainly be in a better position to decide and act than inexperienced nurses, or those who are in caring situations but have no comprehension of the moral meaning of their experiences. Hence, experienced nurses relate that their experiences enable them to act morally because they have learned how to practice ethically within several difficult contexts by being open to learning through and with others in need. This ability is well recognised by Benner and Wrubel (1989) when they state: "This ability to presence oneself, to be with a patient in a way that acknowledges your shared humanity, is the base of much nursing as caring practice" (p.13).

SUMMARY

This chapter has presented material that has explored the concept of perception as a necessary precursor to ethical decision making and practice. The process of perception that occurs to assist the nurse to make an ethical decision has been explored in several ways. The value of experience and maturity in nursing practice has been examined. It has been maintained that experienced nurses both perceive and deal with ethical situations in ways that are different and more thoughtful than inexperienced nurses. The barriers or constraints to ethical nursing practice have also been considered in depth. It has been argued that these barriers are not insurmountable to experienced nurses. As a main catalyst for ethical practices, the nurse-patient relationship, and nursing methods used to maintain this relationship, have been discussed. Finally, it has been maintained that the attainment of a more refined moral insight through experience can make a considerable difference to the delivery of professional nursing practice.

CHAPTER SIX

NURSING LEVELS OF MORAL COMMITMENT IN THE HEALTH CARE CONTEXT

Yes we do have a voice, we are allowed to say things, doctors do not have the moral authority in decision making at all, they're only part of a team

(001/1/p.13).

INTRODUCTION

Previous chapters have considered the moral 'preparedness' of nurses to become involved in ethical situations in a variety of contexts, the ways in which these problems may be perceived by nurses, and the barriers to nursing involvement in ethical problems. However, so far there has been no description of the actual *process* or *strategies* that are used by nurses to become involved, or who *are* involved (either by choice or by circumstance) in ethical situations in practice. The degree of such involvement may vary considerably between nurses because each will perceive, interpret and commit herself to the resolution of an every-day moral situation in different ways. Hence, before any attempt can be made to show which central theme or process of ethical decision making that *experienced* nurses may follow in practice, the possible dimensions of nursing commitment to an ethical situation must be considered.

This chapter presents the main categories that emerged from the analysis of data following the discovery that the degree of nursing commitment or involvement in ethical issues is not the same thing as the overriding process or core variable of ethical decision making in nursing. The difference is a significant one because experienced nurses may be *presumed* to be more likely to be actively involved in ethical decision making, but it may not necessarily follow that they will be *committed* to ethical practice. Thus, the degree of commitment that drives nursing decision making, that leads to actions or practice that is ethically supportable from a nursing perspective, requires consideration.

NURSING INVOLVEMENT IN EVERYDAY ETHICAL SITUATIONS

From an analysis of the many stories related by the participants about their own and other nurses actions concerning ethical problems in practice, it was possible to code and then categorise what appeared to be a complete 'spectrum' of moral commitment or degree of nursing involvement in everyday ethical situations. An analysis of data therefore revealed that nursing involvement in ethical situations in practice could range from the avoidance of any apparent moral commitment or involvement whatsoever to complete and possibly risky commitment by the nurse. In all, eight main categories of moral commitment were identified. The degree of nursing involvement in ethical situations in everyday practice is related below. It starts from that part of the moral spectrum where commitment is at its lowest level, which is basically non-involvement, through progressively more actively involved levels to the final level which represents an intense but personally risky degree of nursing involvement in ethical decision making.

SILENTLY OBSERVING, AND NOT TAKING PART

There is strong evidence within the stories related by the participants that, at certain times, some nurses, many students and new practitioners in particular, simply do *nothing* when an ethical problem emerges within their practice. Indeed, there is the possibility that they simply *do not perceive* a potential ethical problem, or that they do not feel the need to be involved in it. There are several reasons for this form of response, and many have already been established in previous chapters. These reasons include perceived powerlessness, lack of awareness and a presumed deficiency in ethical skilfulness. The predominant theme to emerge in this category is 'silently observing', perhaps wishing, but not daring or being prepared to take part:

No, it was all very hidden and they went down to their little wee office, or where ever and came back with the decision and the Charge nurse went, or whoever, somebody went. But the nursing input was the silent observer status and when you came back and questioned the Charge nurse or whoever went you suddenly realised that, that this wasn't the right way to do things, that people actually needed to have a say in all of this. 'Cause it wasn't just the decision between the medical staff and the family. The nursing staff, in my opinion, should have had the most say in it because they were there for the day to day care. But at the same time it was recognised that we were not very skilled at eliciting information from the families of how they really felt about the situation (001/1/p.5).

Johnstone (1994) argues that this phenomenon is based on the still prevalent notion that nurses do not need to concern themselves with ethics in the first place. She suggests that the nurse's input is presumed to be unnecessary when an ethical decision is being made because of the supposed view that (a) it is not 'her place', or (b) she does not have the skills for it, or (c) she does not need to make an ethical decision anyway. She states:

Even today, in this new era of intensive and supposedly enlightened bioethical debate, morally condescending attitudes towards nurses continue to prevail ... Nurses are certainly not expected to have a substantive moral position on anything significant, and are most certainly not expected to express a view publicly (p.1).

Hence, in the 'silent observer' type of response, the nurse is either disregarded or eliminated from the situation, or *eliminates herself*.

SUBMITTING TO THE DECISIONS OF OTHERS

In those instances where nurses *are* involved in an ethical situation or problem, there is still the possibility that this involvement will be perceived as a minor or supportive one only. There are several reasons why this may be so, but data revealed that these reasons usually fell into two main sub-categories. These reasons are:

Because of nursing exclusion/inexperience

Yes, [the nurses were involved] but I don't think to any significant result. I don't think that... yes I did see it, but I wasn't a party to it. These are the sorts of things that would be discussions behind closed doors [by the doctors] (003/1/p.11).

In the above excerpt, the nurse's input was slight, merely 'being there' but in reality being not much more than an observer.

I didn't have, I just lacked self confidence, a total lack of self confidence really ... [in] ... being a registered nurse ... as a staff nurse it was all right. It was after I left X really, and going into other situations ... (006/1/p.7).

In this instance, the nurse herself had doubts about her own abilities, and so whilst able to respond to ethical dilemmas in an area or context that she was familiar with, could not, or did not perceive it possible to do so, in a newer or less familiar context.

There are those situations where the nurse will recognise that there is a potential ethical quandary, but that she has insufficient experience or knowledge within the new context to comment on or challenge the status quo:

I remember one chap who was an obsessive compulsive and they decided to do a lobectomy on him.

Did he ... agree to all of this?

Yeah he did, he did.

And was it all explained to him what it might mean?

I don't think so, no, I don't think it was.

Did you have an opinion about this?

It was all so new to me that I really didn't know what to think, I wasn't very keen on the idea of a lobectomy but ... they used to do it all the time (008/1-2/p.8).

The dangers in this instance are obvious because there is the possibility of a nurse being an unknowing accomplice to an act, sanctioned by the medical fraternity or not, that may now be considered to be, at best, ethically dubious. Most nurses are acutely aware of the everyday rights and needs of patients for fully informed consent, but when faced with the 'this is how we do things around here' climate, may choose to leave the hard ethical decisions to others. The nurse in this situation did, however, respond at an intuitive or emotional level. This phenomenon is well recognised in nursing practice (Paul, 1995). She was at least aware that something seemed wrong in the way that the patient had been possibly coerced into giving consent to an operation that was ethically disturbing. This response is an example of the degree of intuitive ethical responding that some, especially new or inexperienced nurses exhibit. As a response to an ethical dilemma, however, it achieved little in this instance.

Because of perceived powerlessness

Nurses may allow others to decide and act in ways that they may not approve of when the perceived barriers to challenging a given act are too great. In the world of student nurses, this often seems to be the case:

Well, it's funny because they [students] bring up these situations and sometimes I find myself defending the situation because I can see it from the point of view of someone who has been around for awhile. And they say "yes but, but, but" ... And I say, "OK then, perhaps you're right, what do you want to do about it?" [laugh] Or, "what do you want me to do about it?" Nine times out of ten they say don't want to do anything about it so I leave it (007/2/p.9).

Thus, the notion of allowing others to decide, or even, when an ethical problem is noted, to choose to do nothing continues to affect nursing practice. However, even when nurses do decide to take action, the expected response from those who may be expected to rectify the situation does not necessarily occur:

... unconscious women were examined vaginally by up to four students. She [the nurse] was not told whether the vaginal examination was part of that patient's treatment or not. Her concern centred on the possible discomforts the woman might experience later, and her anxiety that the patient's permission had not been sought. When she voiced her concerns, they were dismissed by her supervisor (Report of the Cervical Cancer Inquiry, 1988, p.191).

In this instance, the nurse voiced her ethical concerns but was unable to act further due to her powerlessness within 'the system'. Yarling and McElmurry's famous plea to "set the nurses free" (1986, p.73) continues to haunt nurses even now. The nurse in the last example *could* have done more, but the consequences of such actions are usually dire for nurses ranging from being ignored to dismissal.

RESPONDING WHEN ASKED

The third substantive code represents nurses' involvement in yet another ethical response that may be described as potentially unproductive or unsatisfactory. This code represents perhaps the 'hand-maiden' position that nursing has tried to shake off for so long (Kelly, 1985). It was once a common situation and may be described as a 'speaking when spoken to' mentality:

... before [ten-twenty years ago] I would never have ever contemplated going up to a consultant and saying, "hey, what are you trying to achieve with this form of treatment for this patient?" (005/2/ p.3).

In recent years, there is evidence that the 'wait until you're asked' notion has given way to a more subtle variation that seems to be acceptable to nurses on *some* occasions:

Do you remember going through any [ethical] process at all, like sitting down and making notes or working out ...

No there was never that formal system in place, never. And that actually didn't worry me because the medical staff actually targeted nurses who they knew that they could talk about things.

Things to do with...?

Ethical decision making (001/1/p.14).

Here it may be seen that the nurse is aware that she has a place in ethical decision making, and expects to be asked and is prepared to respond. In those situations when this process is an automatic one, then perhaps this method has some value, but what if the case is otherwise and the nurse merely waits to be given the chance to be asked to present her perspective? The following excerpt from a participant's description of a situation concerning a violent but confused head injury patient who assaulted the nurses daily loosely illustrates this point:

What was the doctor's justification for not moving this patient somewhere more safe?

I don't know. Today that still bothers me as to what was his reasoning was, I don't think he had a constructive reason unless he felt a moral obligation to keep this person here because of his injuries. Then again, I'm not sure if it was appropriately managed anyway (001/2/p.2).

The above examples notwithstanding, it would appear from data that in recent years, the idea of nurses 'waiting to be asked' for their ethical or even practical opinion has faded somewhat as newer understandings of the different roles and responsibilities of nurses and doctors is slowly emerging:

But there comes a stage in our practice these days when we can sit down with each other and say, "look can you explain to me...?" I think nurses are quite poor at that, and I think doctors are still quite poor at that. But there is that chance now when you can sit down and talk to them ... (005/2/p.3).

In their attempts to 'sit down and talk' to doctors about ethical problems relating to the care of patients, it is unlikely that nurses with moral insights through experience in practice will be easily satisfied with the notion of 'waiting to be asked' or involved. Hence, as in the two previous levels, the 'responding when asked' position was largely unpopular with the participants as an effective method of ethical involvement in the practice of morally committed nurses.

COMPROMISING PRAGMATICALLY

This approach to ethical decision making is perhaps closer to the method used by more experienced nurses after some years of 'trial and error' within a system that, as noted earlier, does not always lend itself to nursing inclusion in moral debates or decision making. This approach, an 'integrity-preserving moral compromise' (Fry, 1989a) perhaps, has already been outlined and noted as a possible nursing method of ethical decision making (see chapter two). It involves a degree of compromise in several ways;

a) **Between caregivers/semi-skilled staff and nurses:**

... they [members of the staff] chastise the [elderly] residents sure, and sometimes with good cause, but not always probably in the best manner. But I know I've done it on several occasions where you've had these outbursts and things from residents that you can really not treat any other way. But if I had walked in and heard somebody talking to my mother like that then I'd be upset (003/2/p.9-10).

In this instance, the nurse explains that her work with caregivers is not without conflict. However, in an attempt to correct certain behaviours that would normally be considered ethically debatable, she does not attempt to use the 'stand-over tactics' that may be sometimes noted in the nurse-doctor, nurse-manager relationships. Instead, she applies a form of simple logic, accepting that the situation is understandable, but that these behaviours would be different if the patient was her own mother. She later says that she gently encourages caregivers to be more respectful to the elderly by such appeals to personal rather than theoretical ethical behaviour. In short, she compromises, neither fully preventing nor fully accepting morally dubious behaviour.

b) **Between doctors and nurses**

The relationship between nurses and doctors is a sometimes inconsistent or hegemonic one. Certainly, it may be argued, the closer the working relationship between the two the more likely that both will listen to the other's point of view on an ethical issue. Both also need to meet the requirements of ethical compromise which include mutual respect between the involved parties, a shared moral language, and acknowledgement of the difficulties involved (Winslow & Winslow, 1991).

There are times when the nurse feels compelled to find the 'middle ground' of ethical compromise with a doctor and several others:

Some [nursing decisions at the 'shop floor' management level] are treatment decisions, some are management decisions. Things like 'are we going to stop this patient's treatment?' You know like a patient deteriorates and the nursing staff will ring me and say look we don't know what to do, so I go in have a look, assess whatever is the situation and say "look this is what I think is the best plan, let's go to the family, let's see what they want to do." Things like "do we want to proceed with treatment? Do we want to go on ... is this patient wanting to stop treatment?" And in many situations *I can be a catalyst* there and look at going to the medical staff saying, "this is not working, we need to do a B and C for this person, or this patient doesn't want to continue with treatment, we want to get them set up and discharge them tonight, and send them home, they want to die." So those sorts of things (005/1/p.9, italics added).

The nurse in this extract appears to fully understand the need to consult all interested parties in the desire to find a satisfactory ethical decision. This process is seen as being a 'catalytic' one by the nurse, which is, in essence, a major role for the nurse wishing to instigate ethical decision making that involves all parties.

There are times when the nurse attempts to use the moral compromise approach in situations that are very difficult. The nurse in the previous extract had this to say in a later interview:

The worst advocacy [situation] I find myself in is when the patient's unconscious and there's just you and the doctor.

Why?

Well, say you're in a trauma situation and the patient's arrested or the patient's come in deeply unconscious or brain dead, and the doctor wants to go about doing lots of saving stuff, and the family is not there. How can you say to the family "look we've got a, b, c here", and all these are really negative things.

Would you normally do that?

Yes.

Or would the doctor normally do that?

Sometimes it does come down to the [nurse] co-ordinator because the doctor doesn't have time to stop doing what he's doing to go out and talk to the family. And in some ways I do it, not in a sneaky way, [but in] a way that you can do it to a family by not asking them outright is to say, "look has the person ever expressed to you, that if they were in a terrible situation in a hospital what they would want done?" And a lot of people in actual fact have, and I've found in that situation that the husband or wife will say, look she'd never want to be kept alive on a ventilator or she'd never want to go through massive trauma, you know, all this sort of stuff, you know the hospital stuff (005/2/p.6).

The method may be similar, but the context and the particulars of the above situations have changed. Hence, using the moral compromise method is not as satisfactory as it might seem, for nurses and for others. Furthermore, even when collegiality and co-operation seems to be the *modus operandi* for the health care team, there is a danger that nurses themselves may overestimate their input to the possible exclusion of others:

It was done on a collegial rather than a hierarchy relationship which I found really quite fascinating because I was deliberately sought out one day 'cause I was part of this gang of four [laugh]. And when we got together, nobody, they wouldn't argue with us.

You'd all been there quite a while?

Yeah. It's not just length of service but also the fact that some of us had actually gone out and done philosophy papers, had an interest in ethics and actually had made an effort to develop some knowledge on all of this (001/1/p.15).

There are commendable aspects in the above extract such as the value of experience, knowledge and interest, but also less than commendable signs of the use of group pressure to force a moral decision. This variation goes beyond moral compromise towards a more militant and less sharing position. However, when pragmatic compromise fails, or when nurses are not sought out for their advice or opinion on a moral issue, then nurses may resort to more divergent means of moral involvement.

PROTESTING EXCLUSION/DEMANDING INCLUSION

As indicated above, some nurses, often in exasperation or despair at being excluded from the ethical decision making process, refuse to accept such rejection and *demand* input into the moral decision making process:

Oh yes, there was that sort of case conference down the hall but the nursing staff were actually excluded from the decision making process, until a few of us got together and started saying how would you make your decision [to the doctors] ... [the doctors' reply] "Don't worry about it, don't worry your little head about it." I kept thinking that's all right for you to say that, but you're not the one who's caring for this baby while they're dying or whatever ... or while treatment wasn't being implemented or whatever and you had to work with the family....Legally it's up to the medical profession because that's set down in the law and there's nothing that, that's where the buck stops to be quite honest. But nurses do have a right to have an input into that decision making and to present a nursing perspective (001/1/p.8-9).

In the above excerpt, the nurse did not seem to be making much progress when she protested exclusion from ethical decision making. This phenomenon was relatively common in these data. Here is another example:

With certain treatments I think the nurses weren't very keen on them because they knew it was going to be hard on the patients, so the nurses would try and say "well we don't think that's appropriate", but they didn't get listened to very often (008/1-2/p.7).

This type of patronising results in exclusion or tokenism and deserves an appropriate response, although such a response from nurses may be slow in coming. Nevertheless, it does eventually happen:

We were all there. This is years later the whole situation around the decision making process had changed by this time. That we were all in there, poor old medical staff, when they saw four of us around the [patient] they just kept out of it and did what they were told [laugh].

How did the change come about, I mean when you started there were medical staff and that was it you had to abide by their decisions, but later it had changed, and you said you'd changed ...?

By sharing that sort of information and actually challenging what's being said, other nursing staff suddenly realised, "yes we do have a voice, we are allowed to say things, doctors do not have the moral authority in decision making at all, they're only part of a team" (001/1/p.13).

Hence, demanding inclusion is a valid nursing response to ethical decision making, but often only for those nurses who are experienced, knowledgeable, aware of the need to be involved *and* prepared to fight for their right to inclusion. The value of the collective response is noteworthy in the latter case. Individual nurses are often less successful when attempting to use this method of ethical inclusion (see, for instance, the case study in Rogers & Niven, 1996, p.2-3).

COVERT AND/OR OVERT 'SUBVERSION'

The term 'subversion' cropped up on a number of occasions during the interviews for this study. At first, it was presumed to be a type of nursing slang for 'beating the system' or 'getting around problems', but it was to eventually emerge as a separate category in the description of nurses' moral interventions. The following example beautifully illustrates the technique in its covert or hidden form. It is therefore given in full:

Like one thing was, you know when I was in my first year [*as a student nurse*] I worked in a cancer, a lung ward, and essentially it was a lot of lung cancers we had. And there was this one guy who was 32, he was clearly dying, he had ascites [*abdominal fluid retention*]; the medical staff were trying to convince him to carry on with the treatment and they didn't want to pull out on him. And I had developed quite a relationship with him over the period of a week or two and he again, because I wasn't afraid to confront the issues for him. And he kept asking me "am I dying, am I dying?" And the medical staff had said that they didn't want him to know that, they didn't want him to know that he was dying and they wanted to carry on treatment. And he wanted to know whether he was dying and how long he had to live and if he was going to die then he needed to get all his stuff sorted out; you know he had a wife and two kids and he wanted to make arrangements and he didn't want to make arrangements if he wasn't going to die. But he was clearly dying. And one night, one afternoon he asked me again and this time I decided to say yes.

Why?

Because he was dying, I mean he was clearly dying and as a first year student I could see that and I knew it because I knew, you know. And nobody would say "you are dying", so I said to him on the Thursday, "you are dying". On the Friday he asked for leave and he went home and I saw him on the Monday. And I said to him "for God's sake don't tell anybody that I said this!" 'Cause I was really scared you know, because I'd *stepped out of the boundaries* and I'd put myself on the line for him. And on the Monday he said to me, really casually, because I guess he must've known I'd stepped out of line, and he said to me, "everything's OK now, I've sorted it out, my will's done and I'm happy." And he died on the Thursday (005/1/p.10, italics added).

It could be argued in this case that there may have been good reasons for not telling the patient that he was dying. Then again, it could be maintained that most people would want to know about their impending demise. In this situation, a young and still learning student nurse found herself to be in a major ethical dilemma because she was torn between her obligation to another human being to know the truth, and the will of the physicians to hide it from him. In a later interview, the participant had this to say about the incident:

...but in fact what it did for him was that it gave him the answer to his question. I mean I wasn't going to make any difference to what he did with that because what in actual fact he did with that information was that he then went home, sorted out all his affairs, said his good-byes', you know, did all the lawyer stuff and ...

And the general line from the medical people was that he wasn't to know?

That he wasn't to know, and I guess when you look back 17 years ago, there were still those people who believed you don't tell people that sort of stuff because it's too upsetting. But also now I think, nowadays we say to people, yes you may die, we have absolute *carte blanche*, especially where...[you say] "the treatments we're giving you may kill you." You see what I mean, so now we don't have to worry

about all that going behind the scenes stuff, we're better at being up front with our patients and saying to them, these are the consequences of your treatment (005/2/p.2-3).

However, the practice of covert moral acts was not only thought necessary among student nurses but also by qualified nurses working as Staff Nurses:

...a young woman [was admitted] who had ulcerative colitis. She was nineteen and they pushed her into a side room which is what they did in that ward when people were dying. And I felt very upset about what was happening [her colitis wasn't responding to the set treatment and the house surgeon would not change it {*memo item*}] ...My status was quite low, I was employed eight to four, I was a married staff nurse, I really had no authority in the ward ... But I waited until there was nobody else on... I didn't bother with the house surgeon I just went up higher ... and the Registrar set up a whole new regime for her and she began to rally, but she was quite close to dying ...

So were there any repercussions of your actions?

No ... (006/2/p.2).

In this example, the nurse's actions were certainly covert and possibly subversive, but also ethical. The participant explained the motivation for her actions in the following manner:

I just feel a great distress, I guess I want to save life, and I felt this baby [another case] was slipping away somehow, and also with this young woman. I was horrified at what seemed to be happening with her and I wanted to stop it. I wanted to get some help for her and for the baby, it was identical feelings with both of them.

Did you map out a plan of action when you did that, or did you just do things on impulse?

Very much on impulse.

Would you have gone to the consultant if the registrar hadn't come?

I don't know, I don't know. I remember them [these cases] because I felt that I was stepping out of line and it was not the done thing to do ...(006/2/p. 3).

The reason for her actions are therefore both compassionate and committed to the quality of another person's health care. This aspect of nursing is a central part of a long-standing nursing philosophy or ethic which, according to Wiedenbach (1964) is concerned with reverence for life, respect for the dignity, worth, autonomy, and individuality of each human being and a resolve to act according to one's beliefs. That the nurse felt compelled to act against her obligations to the 'hierarchical system' was a measure of the strength of this philosophy.

In the earlier example of covert subversion, the change over the years has not been the nurse's resolve to show honesty and compassion to her patients, but an improvement in the communication channels within the whole health care system. However, in the second example, the nurse maintained that she had learned to be 'covert' from earlier experiences (*field note*, 19/9/96), and continued to use this method if and when necessary. It is therefore possible that covert subversion is still being learned by student nurses. The following extract is an example of how a present day student nurse covertly uses a more senior nurse to respond to an ethical problem:

She [a student nurse] said "yes, I do want you to," [do something about an ethical situation] and actually I did want to do something about it too. Because if... [a student nurse] tells you something...and they don't want something done about it, it's very, very tricky to be able to do anything, because you're going against their wishes and they've almost told you in a confessional type situation.

I understandbut it concerns them ...

It concerns them enough to speak up about it and I just wonder how many things they've seen that they didn't speak up about (007/2/p.9).

Some subversive moral acts are clearly anything but covert and not always for the benefit of one patient but many others:

[On the refusal of a house surgeon to prescribe a higher dose of sedative medication for a disruptive and confused elderly post-operative patient].

I argued with him [the house surgeon], I argued and argued and insisted on a higher dose and I said that if he didn't prescribe a higher dose, a decent dose, I would ring the registrar.

And you needed a higher dose because?

Because this patient was distressed to, he was distressing to himself, if that's the right way to put it... He was yelling and banging things and carrying on and the nurses actually rang me from ICU to come over and try and deal with it because this house surgeon wouldn't do anything about it. So I came over and insisted on a higher dose.... In the end he charted it and he was terrified that the man was going to go to sleep and I said, "so what? If he goes to sleep for twelve hours it will be good for him." He was sleep deprived.

Yes clearly, so the more experienced nurse helped the young house surgeon basically.

Well, I don't know that I helped him a lot. But he was certainly intimidated by me and that was how I set out to get what I wanted, it was by intimidation because he wouldn't listen to anybody else... (008/1-2/p.22).

In this incident, the nurse admits using intimidation or stand-over tactics on a house surgeon, which is an interesting reversal to the usual stories of hegemonic struggle

between nurses and doctors. However, the nurse in this case explained the reasons for her actions as follows:

I was just, I was forceful, I wasn't rude or I didn't swear at him or anything like that. I just said to him "I have many years of experience with this kind of thing, I know the dose you've prescribed is not going to be worth giving him an injection for, it will not do anything to him ... And he said, "but what if it knocks him out?" and I said, "well, what if it knocks him out? He needs to sleep!" ... I think he realised that I was coming from a good deal of experience and that perhaps he should listen to me in the end.

Did he argue that he had the responsibility and you didn't?

(nod) ... that one is common.

What did you reply to that?

I said to him but we're the ones that have to deal with him, you can just walk out and I said, "the patient himself is suffering and the rest of the patients are suffering." And to me it wasn't a situation of just quietening him down just for the nurse's sake or for the other patient's sake, but it was more for his own sake because he was just getting so agitated, he was going to do himself an injury ... (008/1-2/p.22-23).

This type of overt action obviously reverses a situation that is normally in the doctor's favour rather than the nurse's. However, when the nurse's obligations are to the patient *and* other patients and nurses, that is, she is concerned for the wider welfare of others, then such actions are at least understandable. This type of 'responsible subversion' therefore remains a frequently chosen method in contemporary nursing practice (Hutchinson, 1990).

'WIDER' MORAL PROTEST

This category was less common in the data supplied by the participants than previous ones. In general, the notion of a 'wider' moral protest is based on the actions of one or more nurses against the actions, or intended actions of another health worker, such as a doctor or another nurse. Usually, in this category, the moral agent, i.e. the one who wishes to take action against the actions of another health worker, goes above and beyond those concerned and straight to an authority figure such as a manager or consultant demanding action. This act is mainly used when local measures fail; or when the original act was perceived to be grossly unethical, or when the situation between the two or more protagonists is getting out of hand.

The following incident relates to the actions of an experienced nurse when faced with an ethical dilemma caused by the disrespectful behaviour towards a patient by a senior nurse in front of a student nurse:

Now the student nurse told us [the participant and other students] this story ... [omitted for purposes of confidentiality] but I mean they obviously knew that this was not the thing to do ... the student was really, really upset. Now she was a mature student... and she knew it was really, really wrong. It was a big mistake being made here. She was concerned for the patient's sake, although the damage was done.

She didn't remonstrate at the time then and say what the hell's going on?

No she said she was so shocked that she couldn't say a word [laugh] ... Well it took her about a day, I think she thought about it that afternoon and then told us the next day when the opportunity was right, she felt it was right.

Anyway I didn't tackle the [offending nurse X] about it because ... I knew that I would get absolutely nowhere ... because of X's attitude towards me and X's attitude towards students, X's attitude full stop. So I went straight to the manager, who said that she would deal with it (007/2/p.11).

This example has similarities to the previous discussion concerning covert and overt moral acts. However, the repercussions of such a public act (involving several student nurses and nursing management) are less localised and more likely to be of a wider and more potentially damaging nature for those involved. It is a case of 'dealing with our own' which, in nursing and medicine, carries certain consequences that are different from localised disagreements. The story continued as follows:

And I don't know how she dealt with it, but she certainly spoke to X [the nurse responsible for the incident] about it and X approached me about a week later and said that what the student nurse had observed was completely wrong, that it didn't happen like that at all. And X did it in the corridor where other people around and ... I felt very uneasy about the whole business because I thought perhaps I should have tackled X first and probably I should have, but then again I thought "no, if I don't talk to X's manager no one is going to know that this is happening"... because it wasn't the only incident (007/2/p.12).

According to the participants, wider moral protest, that is beyond the local workplace into the wider arena, is not a popular action of nurses in general. To formally challenge another nurse's or doctor's immoral behaviour or unethical practice, or even to attack a morally dubious managerial directive, is to possibly plunge oneself into what one participant called 'the troublemaker' scenario. This scenario seems to occur in nursing

when one or more nurses act officially to draw attention to an ethical or legal issue within the institution or agency. Such attention is often viewed as undesirable by other nurses because it is seen as disloyal to one's colleagues or institute (Benjamin & Curtis, 1992). Yet, there are some nurses who are willing to go even further if their protest goes unheeded.

RADICAL RISK TAKING AND 'WHISTLEBLOWING'

There was only one participant who alluded to the existence of the final code of nursing ethical involvement in the health care context. This was the code of radical risk taking or whistleblowing. The following excerpt is taken from the participant's story concerning another nurse's wider moral protest within the organisation:

A nurse who had been around for quite a long time is probably the crux of it, X basically decided that [*gender omitted*] had had enough, and was going to look for work overseas. I think X got to the stage where X felt that X didn't have anything to lose. X was the one that organised the other nurses, basically, drafted the letter. There were also several, two quite bright new graduates who had been employed, one casual and one permanently. And I think behind the scenes they were both quite supportive of the particular nurse who was co-ordinating this. It was kind of like there was one person who felt they didn't have anything to lose any more, a group feeling freer to speak out and two other, new, quite bright young nurses (002/2/p.2).

This example is certainly a case of radical risk taking, because (as indicated by the participant) 'the letter' (outlining the serious state of affairs concerning safety standards within the unit involved) was sent to the health care management of the institution in question. Nurses generally consider such protests to be of a risky nature, those involved in the protest fearing unfavourable repercussions such as censure or dismissal. However, the incident is clearly not a case of extensive 'whistleblowing' because the wider public were not informed via the media or other channels.

Of all the revealed levels of nursing involvement in ethical issues or problems in their everyday practice, these were the least common in the data. In fact, apart from the example above, there was very little else in the data that related directly to this end of the 'moral involvement spectrum'. There are probably several good reasons for this phenomenon. It is likely that none of the participants had a) used these methods or b)

perceived these methods to be useful in their everyday practice, or c) if they had used such methods, were not prepared to divulge this publicly.

This ends the section on the various levels of nursing involvement in moral decision making in practice. A brief discussion follows that considers the possible usefulness of the spectrum of moral commitment within the practice of experienced nurses.

MORAL REFOCUSSING: THE NURSE/PATIENT RELATIONSHIP IN CONTEXT

From an examination of the data, it seems apparent that experienced nurses do not divide moral issues in their practice into nursing issues, doctors' issues, management issues and the like. Instead, the data suggests that they tend to consider each *specific* moral situation within the nurse-patient relationship as a potential problem that may commit them to ethical action in ways that may range from their full input to hardly any input at all. There are many reasons why this large variation in involvement or degree of commitment to ethical situations exists amongst nurses. Some of these reasons have already been considered in the previous chapter concerning the main category of perception in context.

However, it will be argued in chapter seven that *morally committed* and experienced nurses (morally competent nurses) tend to respond to moral problems in their practice by focusing on their involvement in those aspects of the patient's situation that will lead to effective moral decision making. Hence, to conclude this chapter, the essential aspect of *ethical re-focusing* within specific nurse-patient contexts will now be briefly outlined.

The consequences of all nurses adopting a 'silent observer' position or allowing others to make ethical decisions without their input would be unacceptable for several reasons. Firstly, a nurse who 'did nothing' when she witnessed an act, or a developing situation, that required an ethical response is behaving no differently than an ordinary citizen turning away from someone in immediate and real need. Second, a nurse is a member of a profession that carries certain personal and societal responsibilities and moral obligations. Third, to witness others in situations that require nursing input and then to ignore their plight would be tantamount to a gross abdication of the duty or commitment to care. In the second level of ethical commitment, which is the nurse's submission to the decisions of others who are usually in 'higher authority', the results are once more

ethically unsatisfactory. This situation is a perplexing one for nurses because many *seek* greater involvement in ethical decision making, but few claim to be able to do so *without conflict*. This problem is attributed to a number of causes including the 'social position' of the doctor and nurse within the health care system, the role and power of nursing leadership, sexism and paternalism (Davis & Aroskar, 1978).

Nevertheless, blind acquiescence to authority usually represents an insupportable ethical position. It is regarded as a poor defence in cases where human lives were at stake (as in the case, for instance, of the notorious *Bormann defence*, which was a common feature at the Nuremberg Trials [Barry, 1992]). Nurses are generally well aware of the consequences of poor judgement in their actions because their practice contains powerful obligations to those in their care. These obligations also extend to their employers who hold considerable power and influence. Hence, as Yarling and McElmurry claim (1986), nurses frequently face an uneasy conflict of obligations:

At stake in this conflict, for nurses, is nothing less than the nurse-patient relationship. The nature of that relationship is fundamental to the nursing process and to the human quality of a patient's hospital experience. Furthermore, *it is a necessary foundation for a nursing ethic* (p. 65, italics added).

Thus, for several reasons, minimal ethical involvement and submission to those in authority is perhaps a common but ethically dubious position for nurses. Subsequently, morally competent nurses would normally reject minimal involvement approaches in their ethical decision making.

It is possible that some experienced nurses may be prepared to consider the third method of ethical involvement of 'responding when asked.' If, for instance, a nurse had an excellent working relationship with the medical staff or others in authority who were concerned with making an ethical decision in the health care context, then she may use this method by arguing that she knows that she will be involved at an appropriate level. However, such an idea, and certainly such practice, is potentially risky in modern nursing practice. Arguably, nurses should not practice in such a way that they have to wait to become involved in an ethical situation concerning their patient. Such practice may lead

to the expectation in others (such as the medical staff) that the nurse is indeed a useful but less directly ethically involved member of the health care team. Hence, once again, morally competent nurses may not easily accept the method of only 'responding when asked'.

The data revealed that all of the above methods, including the 'responding when asked' method, were considered to be inappropriate for the ethical practice of experienced nurses. It must be accepted, however, that the participants were familiar with these methods from their experiences and practice as student nurses or beginning nurse practitioners.

Variations on the fourth, fifth and sixth methods of ethical commitment, i.e. 'compromising pragmatically', 'demanding inclusion' and 'covert or overt subversion' were much more common in data supplied by the participants for this study. These methods were the more favourable preferred methods in dealing with everyday ethical problems because they tended to produce generally desirable results. However, it was made clear by the participants that moral compromise was not always to their satisfaction. There is evidence that this problem occurs with some frequency (Grundstein-Amado, 1992). Nevertheless, from an analysis of the extensive data regarding this degree of ethical involvement, it appears that experienced nurses often employ the 'compromising pragmatically' method as a response to an ethical situation in the health care context. It is therefore possible that this method is very common in the ethical practice of several nurses.

If morally competent nurses find themselves having to continuously employ the 'pragmatic compromise' method, but even then discover that their moral input is largely ignored or patronised, they may become increasingly irritated and disillusioned. Such disillusionment may lead to the fifth level or method of moral commitment which involves 'protesting' when excluded from substantial ethical decision making or even when excluded at the level of the most basic consultation or consideration. The participants indicated that the method of protesting exclusion is sometimes successful in practice. However, they also maintained that if this process is unsuccessful, then there is a danger that 'good' nurses will be lost altogether from the health care arena. That is, rather than continue to unsuccessfully protest when faced by repeated and inconsiderate

responses from other health care professionals or managers within the health care context, some morally competent nurses choose to leave the institution, or even nursing itself. The participants indicated that morally committed and experienced nurses use the 'protesting exclusion' method, but they also inferred that the consequences of this method were sometimes very negative. Instead, it became obvious that yet another effective level of moral involvement was possible for nurses. This was the level that was coded 'covert/overt subversion.'

The phenomenon of value clashes between nurses and the institute or 'bureaucracy' in general has already been fully discussed in chapter four, but may now be even more relevant because it is clear that morally competent and professional nurses will always seek and use methods that allow them to continue to practice as morally 'good' or expert nurses. If they are thwarted in this commitment, then, as Hutchinson (1990) maintains, they will seek other methods through covert means to address the situation. Hutchinson concludes that: "Responsible subversion may result in positive or negative consequences. If responsible subversion is successful, the patient benefits and nurses continue their work without difficulty" (p. 14). However, if the consequences for the nurse are negative, then the result can be very traumatic and may lead to disciplinary actions or dismissal (see, for instance, the *Tuma case* [Tuma v. Board of Nursing of the State of Idaho], 1979).

Finally, it may be concluded that there are morally competent nurses who are prepared to pursue ethical issues in a more risky and potentially damaging fashion as may be evident in the levels of 'wider moral protests' or 'whistleblowing' levels of the spectrum. However, this course of action was an uncommon phenomenon in the data gathered for this study. Two reasons are suggested as to why this may be so. Firstly, morally competent nurses are unlikely to choose such methods of ethical involvement in response to everyday ethical problems in practice. Nevertheless, there remains the possibility that increasing numbers of experienced nurses may resort to such actions if the ethical situation demands it. The alternative, i.e. to ignore an unethical situation or handle it covertly when major actions are needed, is to risk more than personal moral discomfort. Yet nurses, like anyone else, often desist from 'rocking the boat' if at all possible. Secondly, it is possible that the action of publicising an ethical issue away from the

immediate context (i.e. by involving a much wider number of people either within or without the institute or context) *may* lead to misunderstandings, unnecessary publicity and loss of confidence in other health care professionals. The nurse's co-workers could have possibly made a mistake or, in hindsight, acted carelessly, but the incident could have been contained at that level. Thus, wider moral protests and even whistleblowing may be the last resort of morally competent nurses.

SUMMARY

This chapter has presented data and discussion that has examined the degree of moral involvement or moral commitment of nurses in everyday practice contexts. The collective experiences of the research participants, which span many years of nursing practice, have revealed that such input varies considerably according to several factors. These factors include those such as familiarity with the health care context, the perceptions and relationships between those involved, and nursing responses to working within 'the system' in general. It has also been shown that morally committed and experienced nurses prefer to be involved in, and commit themselves to, ethical situations within their sphere of influence by using a method of pragmatic compromise. Such compromise sometimes leads to unsatisfactory results, and it is then that morally committed nurses use other methods such as covert or overt actions to achieve an ethical response that satisfies their desire for an effective moral outcome. In the next chapter, the 'driving force' or central moral impetus that guides the morally committed and competent nurse will be considered in relation to the nursing process of moral decision making.

CHAPTER SEVEN

NURSING MORAL DECISION MAKING: MAINTAINING A NURSING ETHIC

I find nursing fascinating...because I really enjoy reflecting on my practice because it confirms for me why I'm good at what I do. And why I'm where I am, as opposed to somewhere else (005/1/p.12).

INTRODUCTION

Previous chapters have detailed the complex and multiple categories that represent the antecedents or developmental stages of nursing moral decision making. These categories included the impact of personal values, moral development and contextual influences, and the complexity of ethical perception and involvement under a variety of circumstances. These phenomena influence a nurse's desire and ability to commit herself, and effectively respond to, an ethical situation or problem in the health care context. In this, the last 'data chapter', an explanation is offered concerning the means by which all of these elements may influence and subsequently maintain the moral decision making approach that morally committed and experienced nurses (henceforth 'morally competent nurses') invariably employ in practice. In this chapter it will be shown that the more useful methods of ethical involvement that such nurses adopt are directly related to a central or 'intrinsic' ethic.

The emergence or discovery of a central nursing ethic that maintains morally committed nursing practice, and its grounded essence in the moral decision making of morally competent nurses, affirms the notion that nurses may possess an ethic that is both learned and refined through experience. By means of data analysis and re-analysis, through the methods of constant comparison and evaluation, the overarching and consistent main category of 'a nursing ethic' reveals itself. In this chapter, the main codes of this ethic are presented, discussed and re-analysed. It will be shown that a nursing ethic is represented by its own language and practice that differs from that of medical ethics. The chapter concludes with the presentation of a model that represents the impact of a nursing ethic in every-day nursing moral decision making.

THE EMERGENCE OF A NURSING ETHIC

The developing thesis within this study has constantly maintained that morally competent nurses do not make ethical decisions in practice by trial and error, as perhaps is the case involving uncaring, inexperienced, or beginning nurses (such as nursing students). Neither, it has been shown, do morally competent nurses merely mimic the moral decision making practices of the medical profession. The *modus operandi* of professionally experienced and morally competent nurses is more likely represented in an ethic that is traceable to early days in nursing, but then adapted, modified, improved and developed into a truly professional nursing ethic.

The ethic that serves as the central *guide* or *driving force* behind every moral decision and action of morally competent nurses has therefore an origin, development and an effect in practice. From the early development of moral values in nursing training to the development of professional values in practice, several refinements have been adopted by the morally competent nurse. These refinements include an appreciation of the contextual influences on nursing decision making, the perception of moral problems and obstacles to moral decision making and practice, and an appreciation of the importance of commitment to the nurse-patient relationship. Those nurses that develop such understanding through constant refinements of their moral practice, and are able to cope with contextual 'obstacles', are capable of maintaining a nursing ethic. Six theoretical codes that underpinned such an ethic emerged from the process of constant comparative analysis and substantive coding. These theoretical codes are as follows:

ESTABLISHING A PURPOSEFUL RELATIONSHIP

In chapter five, the participants of the study identified the role of nursing in their relationships with patients as the maintenance of *a particular type of relationship*. Without *some* sort of relationship with their patients, nurses find it harder to know what their needs are, and advocate on their behalf if necessary:

I used to take... the time out to get to know them and ask them what they wanted, a lot of the time the decisions would be in line with what they wanted.

Even though others didn't agree...

Yeah. I always stood up for my patients you know, I always used to find out what it was that they wanted, even in my early days when decisions were made for patients, and not with them, I would still say "but, but he doesn't want that" (008/1-2/p.24-25).

In the excerpt above, the nurse can more definitely promote her patients' needs and wishes through her efforts to form effective relationships with them. In the promotion of their patients' welfare, experienced nurses maintain that such relationships are essential in their work. For instance, in her research on nursing caring in New Zealand, Euswas (1992) maintains that the carer and the cared for are in a unique relationship.

Some nurses find that the establishment of an effective relationship that leads to skilled caring is not always an easy task with certain patients:

I think she was about 17 or 18 and she'd had a motorbike accident and she had multiple injuries and she didn't get on with any of the staff, she was very angry and used to lash out and swear and kick and hit and all this kind of thing. I was doing a dressing on a toe ... and I hurt her by accident, and she kicked me and winded me and so I slapped her [laugh]. Just on the leg, I said, "don't you do that to me" as I was sort of falling onto the floor and that made her laugh for some reason. She thought that was hilarious that I'd stood up to her and nobody else had, everybody else was really scared of her and we just started getting on really well after that... And we're still friends, still we have contact with each other quite regularly, even though we live in different towns (008/1-2/p. 4).

Such examples of extended friendship between nurse and patient are, perhaps, less common, but nurses do respond to the needs of others in times of crisis or need because they have established a relationship with their patients to enable effective practice.

Sometimes such relationships bring a heavy *but shared* burden:

We were trying to find her [the mother of a dying child]. She told us to go ahead and do it [allow her baby to die] and she was trying to get her children ... some of the nursing staff who were living close next door knew her, where she lived and that was really nice. And they got her children out of school. She cried when she got there but she was quite happy, she bathed her baby and said good-bye and all those sorts of things. But at the same time I was thinking this nurse, she was also grieving too, that was really hard on her, really hard (001/1/p.12).

There are instances when the nurse-patient relationship is not established due to a variety of reasons. In these cases, ethical decision making becomes more difficult:

I was, by this stage [involved in the decision making process]. But it was all of a sudden, it sort of was a Friday afternoon when the Paediatricians and the Charge nurse got the family together and presented the evidence [of child assault and battering].

Were you there for that?

No, no. Pretty horrendous.

So you were nursing this child and the parents were just sort of there. How did you feel towards the parents?

... absolute revulsion, that this child who was defenceless couldn't even be looked after by two competent adults.

Did you feel like you were responsible for nursing wider than the child, like the parents, some nurses see their ...?

That role, at that time I was just a new staff nurse and ... that sort of context was actually quite new for me and ... while I made appropriate noises to the mother, I didn't actually establish a nurse/client relationship with her.

Do you think at any time you shouldn't have been nursing this child, you didn't want to have anything to do with him?

I don't believe that I had the appropriate skills to actually deal with the situation at that time. I think that this family actually required a very experienced, well educated nurse who was able to present the issues to the family in a non-threatening manner. *Which you could do now of course.*

I could do now, I couldn't do then (001/2/p.6-7).

In this extract, the nurse freely admits that experience is a great teacher. She also indicates the need for a nurse-patient relationship to support the family, even under very difficult conditions. Such is the role of the nurse, and such is a nursing ethic that inspires that role.

Not all nurses seek to establish therapeutic relationships with their patients, or see this arrangement as a moral necessity:

...there was an Aboriginal guy there who was an alcoholic and lived on the streets and he was in and out of the unit that I worked in and the others [nurses] just used to laugh at him, they didn't take him particularly seriously. But I used to, he used to tell me lots of stories about his life and living on the streets and he had a really good sense of humour and he and I used to laugh all the time...I mean I could see he was black and Aboriginal and had lived a fairly poor life and he was an alcoholic, but it didn't really make any difference to me. He was, he was a good person, I liked him, I got on really well with him, and spent time with him (008/1-2/p.12).

In the excerpt above, the concept of a meaningful relationship is illustrated quite well, but a second main category of a nursing ethic is also in evidence. That category is concerned with the moral character and values of the experienced and committed nurse.

EXHIBITING APPROPRIATE NURSING VALUES AND MORAL CHARACTER

It has been shown (in chapter four) that nurses are capable of high moral ideals because they bring them into the profession, and develop within the profession, a hierarchy of moral values that underpins their practice. In chapter five, the participants indicated that

their role in the nurse-patient relationship was driven by *a passion for social good*. For morally committed nurses, this passion is expressed in compassion and empathy towards those in their care. These virtues or character traits may present difficulties for a nurse who practices according to a nursing ethic if she experiences bad, or morally reprehensible, practice. In the following example, the participant was appalled by the lack of respect shown towards still-born or dead premature babies. The nurse's values were challenged, but, following a period of contemplation and reflection on the ethical nature of professional nursing, she discovered that this inherent value was one that she would not wish to surrender:

I actually thought it was my problem in dealing with death. That was what I thought the problem was. I thought that because of my immaturity or lack of life experience or whatever that I was just too sensitive about babies dying [laugh]. Whereas I've got over that, and I still feel the same way. So it was an ethical or a professional issue, and I think it's sort of to do with beliefs about what should happen to dead people (002/2/p.5).

The issue for this participant was an ethical one because it infringed her personal value system and the *learned* value system that is, at least to her and most likely society as a whole, part of good nursing practice. Nurses who practice according to the appropriate moral values and ethical characteristics that professional nursing represents recognise that their patient's freedom to choose is an important issue in health care. As a general rule, morally competent nurses are always aware that the patient, or their immediate family if necessary, should be supported and encouraged to make their own ethical decisions whenever possible. In the following excerpt, the mother of a seriously ill baby made such a decision and was supported by the participant:

Do you think they were equally involved, the nurses and the doctors?

No, I think the mother was the leader.

She said to the doctors, "this is what we're doing?"

Yes.

The nurses agreed?

[nod] And the doctors agreed.

And the nurses agreed with the decision do you think?

Some of them will argue from the fact it is futile treatment, some will argue that it's a waste of resources and things like that. But I would actually argue it was in the best interests of the baby ... (001/1/p.14).

Deciding to support those actions that may enhance the moral values and 'best interests' of others is not necessarily a question of the possession of the appropriate moral virtues or characteristics alone. In the next example, the nurse is appealing to a general principle or rule, but only inasmuch as the use of such principles supports the underlying notion of refinement of good nursing practice. In this regard, some nurses appear to use principles and rules as 'tools' for decision making rather than as a general position or method of decision making. The following extract highlights this notion:

...I can categorise what I'm doing slightly better than I ever did before. I do unto others as you would have done unto yourself...I know that there's an element of the population that obviously don't understand this principle, and I don't always know where it came from to be honest, but I am using what I learn and refining it in my practice, sure yeah (003/2/p.14).

Experienced nurses view rules, ethical or otherwise, in the same way that they view other aids to living. That is, they will use rules if appropriate, but only if this use suits their desire to offer skilled and effective nursing care in those ways that make sense to them:

I agree with the rules and I go with them cause they seem like common sense. If they weren't common sense I wouldn't bother with them, I'd just ignore them (003/2/p.4).

Thus, the possession of the appropriate personal values and moral character is a necessity in skilful and morally committed nurses. Furthermore, such nurses are quite capable of choosing which 'ethical aids' are best to achieve the task of delivering good nursing care, but these devices are *not* the central focus in nursing moral decision making. They are merely 'tools' to assist in the greater process of moral decision making in practice. The central guide or driving force remains a nursing ethic. This ethic, by the very values and experiences that have re-shaped and refined it, reveals itself most ably when the experienced nurse exhibits personal involvement in the lives of those receiving her care.

BEING PERSONALLY INVOLVED

The degree of personal involvement that a nurse exhibits when caring for a patient is obviously variable depending on the length of the relationship between nurse and patient, the degree of shared ideals and perceptions of events, socio-cultural aspects, psychological and other factors. However, a nurse who is responding to the driving force

of a nursing ethic within the nurse-patient relationship is responding to personal and professional commitment towards the health related needs of others. Essentially, she is part of a *sharing (and socially involved) relationship*. An example:

Well there was one thing in relation to what we've been saying about my identifying with these people [the underdogs, the disadvantaged]. I also felt responsible. I felt that like in my first year there was a household with a brand new baby, and I was doing the infant welfare, the Plunket type work in that household and the baby 'disappeared.' And I went to see the principal public health nurse about it ... and she said, "oh, don't worry about it." ... "with Maori families if the grandparents have any concerns, they take the baby, and you know this would just be normal." But I felt very responsible, I felt that if anything happened to the baby it would be my fault and when I went on holiday after my first year I found myself lying awake every night, worrying about these people (006/2/p.6).

In this instance, the baby had gone to its Grandmother's house for some time, which is a recognised and not uncommon practice amongst certain Polynesian cultures. However, for this participant, the developing nursing ethic guided her to better practice. In the nurse's own words,

...all I [thought] I have to do is care about these people and be friendly and that will be sufficient. And then I decided this was rather arrogant and that I had better start to learn something about their cultural way of being and their system of thought. So I started to do that... I was learning all the time. I think we learn in any encounter with another person (006/2/p.7).

Personal involvement clearly has a price, but such involvement is often considered as a necessary adjunct to nursing or caring for others. Some nurses argue that an understanding of ethical principles *assists*, but does not '*guide*' them in this task.

...I felt armed to be able to discuss with the daughter of this particular lady a lot better because of my understanding of the ethical principles and in particular what I'd learned through that particular assignment that I'd written. And that might be only one demonstration, but it did really make me aware of what was the best for the majority of the people (003/2/p.15).

In other ways, even a preparation in ethics and ethical concepts cannot save the nurse from deep disquietude or soul searching when in a therapeutic relationship with another:

My dearest old friend was ... a chap [who had an irreversible and painful disease], and there were so many times that I wished I could have ended his life for him. He was wonderful and I loved him to bits, but he constantly day-in and day-out was in pain with rheumatoid arthritis, he was one of these cases that if anything could go wrong, in the hospital context, then it did for this particular man ... It would be

times like that that you really would think I wish I could help you. I wish that I could do something that would end this misery for you... And I mean there were days when I wished that I could have and it would have been an act of love, but trying to explain that to anybody would have been difficult ... If it had of been something like, my child or somebody like that I can see where it would have been more difficult not to say no (003/2/15-16).

Such dilemmas are a part of a nurse's everyday contexts, but a nursing ethic cannot exist, and nursing cannot take place, without this potential cost to the nurse herself. In this instance, the participant entered upon an extensive philosophical introspection that led to insights concerning her own mortality, and that of those closest to her. Other nurses are equally prepared to accept ethical or philosophical problems in their work because they expect them as a consequence of maintaining a nursing ethic within the nurse-patient relationship:

When people want to talk the serious stuff I don't shy away from that, I don't have any qualms about life, death or the afterlife, you know anything like that. And I'm quite happy to discuss the really important things in life and for people who are facing their own death, whether they be seven or seventy, I don't, I don't have any qualms about it. It's just, it's just for me a part of life (005/1/p.11).

The maintenance of a nursing ethic is also a commitment towards the goal of a nursing ethic. This goal is the delivery of skilful, knowledgeable and professionally ethical nursing care.

COMMITTING TO EXPERT CARING

Nurses have a type of 'investment' in the form of a commitment to care for the welfare of their patients. This arrangement is sometimes nebulous, and therefore difficult to describe, but this commitment is not seen as capricious, but purposeful and privileged. In chapter five, the participants described this commitment and degree of personal involvement as *a profound caring experience*. In this regard, Benner and Wrubel (1989) identify nursing as being in a 'privileged place' because nurses "provide [ing] care for people in the midst of health, pain, loss, fear, disfigurement, death, grieving, challenge, growth, birth, and transition on an intimate front-line basis" (p.xi).

Hence, the nurse's purpose in society seems reasonably straightforward. Good or effective nurses aim to offer skilful care to their patients; they seek to be rational in their actions; they are concerned that their actions will be of benefit to their patients; they

show concern for the total well-being of their patients, often far beyond the type of 'basic' care that may be given by others. Most of all, effective nurses strive to conduct their practice sincerely and with moral certitude. In this regard, nurses offer a particular type of caring in practice that relates directly with a moral commitment to care. This is, unmistakably, a nursing ethic, as the emphasis is clearly upon meeting the needs of others with compassion and empathy in the context of professional nurse-patient relationships:

I think patients when they come into hospital are very vulnerable and being able to, I guess, help them in that state [...is what nursing is about]. You know I think the nurse can be quite an anchoring position, can become the anchoring person, when people are stressed or experiencing difficulties in that you can confront people about things that no other people can (005/1/ p.2).

The nurse's commitment to professional care for others in this way is a moral commitment because the patient is obviously vulnerable, and the nurse is certainly in a more advantageous position to help them. On admission to hospital, for instance, most people enter a world that is largely alien to them. They are there because they have a health problem of varying severity, and they are naturally apprehensive. The one person that they come into contact with most often (health care 'reforms' notwithstanding) is the nurse or nurses allocated to their care. This situation is, as inferred above, both a challenge and an incentive for committed nurses. However, it does not follow that all nurses are equally committed to their roles of professional carers. Some choose to care in ways that are most likely reflective of *their own* moral commitment towards others as much as the perceived societal duties as nurses:

The first person I nursed was HIV positive ... It was in the Intensive Care Unit and the question was asked of all the nurses, "do you have a problem with looking after this patient?" and I just went, "no, not at all", and the others went "mumble, mumble." So I was assigned to the patient (008/1-2/p.10).

The moral nature of caring in nursing, even to the point of possible risk to the carer but with the opportunity to learn from, or establish a relationship with others, is perhaps reflected in the term 'to care about...' According to Blustein (1991) caring about someone involves an attitude, feeling, or state of mind that is directed towards another's *situation*. Briefly, nurses may be said to care *for* and have a care *of* others because they care *about* another's situation, whatever that may be. That is, nurses have a distinct

moral *commitment* to care about the welfare of their patients regardless of the given situation, difficult though it may be.

The commitment to care is a strong force in some nurses. When the nurse's commitment to care is placed under pressure or is forbidden, then the effects can be severe for both nurse and patient:

I looked after a Jewish woman whose husband wouldn't let her have any pain relief, she had cancer. And I was left in charge of her twelve hours a day while he was at work and I was basically told if you do you will be in big trouble, I wasn't even allowed to give her Panadol without his permission ... And I used to argue with him, "she's in a lot of pain, she needs pain relief, she needs it regularly and she needs it stronger than Panadol." And I got in contact with her GP and he agreed with me, but there was nothing he could do without the husband, you know we tried to convince him... He knew she was dying of cancer but he didn't want to believe it, that was a really hard situation (008/1-2/p.16).

In this instance, the nurse's desire to care for someone who needed her expert attention and interventions by means of a trusting and committed relationship was seriously threatened by an unexpected and, to her, an unexplainable 'barrier' to caring. This situation became intolerable for the nurse who, after several attempts to state her case, felt compelled to leave the situation. She felt terrible about her decision for a long time afterwards, *and still does* (field note, 8/10/96):

I ended up leaving, walking out of that situation because I just couldn't handle this man, he was awful. I thought he was cruel and I said "your wife has got cancer that's giving her a lot of pain and I can't do anything with her without hurting her and I don't like hurting her and I think she needs pain relief." And in the end I said, "look I'm sorry I can't look after your wife under these circumstances, I just can't do it because I feel like I'm inflicting pain on her and I'm very sorry but you'll have to find somebody else." And I'm not somebody who runs away from situations like that, it just got so bad (008/1-2/p.17).

According to Christensen (1990) nursing occurs within a series of partnerships between the nurse and the patient that acknowledges the need for an effective relationship between the carer (nurse) and cared for (patient). This relationship has been described, perhaps optimistically if earlier discussion is taken into account, as "mutually empowering" (Montgomery, 1993). If nurses offer care in the form of the nurse-patient partnership described above, then this form of moral commitment may come at a price because there is a potential for 'non-caring' when dealing with 'difficult patients' in

nursing practice. Nevertheless, it has been maintained that morally competent nurses will not exhibit an uncaring attitude even under difficult circumstances. In this regard, a nurse would require strength of moral character based on high personal and professional values such as may be found within a nursing ethic.

MAINTAINING TRUST

The word 'trust' and the notion of trust appeared a number of times in data gathered from the participants. In chapter five, the establishment of trusting relationships with their patients was seen as essential by the participants. Their use of the concept was nearly always within the realm of the establishment of relationships and the delivery of professional caring:

By this time I think I would have established a trusting relationship with the family. Like one family knew that their baby was going to die and they could see how hard we tried and tried and tried with their baby. They felt more sorry for us [laugh] and I kept thinking, these people, they've come to terms with it, they've let go, why can't we? (001/2/p.13).

In the next extract, the need for a trusting relationship is seen as of paramount importance to the nurse. Without it, she seems to imply, the nurse cannot enter into an ethical discussion with the mother or the family of a dying child:

The mother brought the whole thing to a head by saying I don't want you to do anything else.

So, was the mother's request, was that just out of the blue or had she talked to nurses or ...

No, that was from out of the blue, and to me that was another problem, that is, how did we develop a trusting relationship with the family? 'Cause she didn't talk to us about that and we didn't approach her either.

So you don't know who she talked to?

She did, she went straight to the medical staff, she didn't even talk to her family, she made the decision by herself as we found out later talking about it ... she could see her daughter was struggling, she could see that her daughter wasn't getting better ... She didn't want her daughter to suffer (001/1/p.11).

This incident was of ethical concern to the nurse because she discovered that the lack of contact and essential communication between the mother and her primary nurse led to a breakdown of the nurse-patient/family relationship. Trust is a reciprocal phenomenon, and its establishment is often considered as desirable whenever possible. Through trust, desires, needs and usually private ideas may be expressed to another. For experienced

nurses, the failure of another nurse to establish a trusting relationship with her patient or patient's family is a major ethical problem:

From my point of view there was a major problem, it was that the concept of primary nursing and the nurse's role in interacting with the family ...Well she was the one who was initially against us withdrawing the treatment, and I said to the Charge nurse, "how come she didn't know what the mother wanted?" And I was thinking that is extremely, from my point of view at that time that was an extreme error of judgment (001/1/p.15).

In general, nurses seek such relationships, but patients sometimes choose for themselves who they will trust, and who they won't. Nurses have discovered that it is not necessarily the case that their patients trust them because they are nurses, but because of *who they are* and *what they do*. Such, perhaps, is the nature of trusting relationships:

There was one incident in which a child had a continually discharging ear and I found that he'd been going up to the ear, nose and throat clinic at the hospital and I'd made an appointment for him, and he hadn't been for a long time... I'd been working [with them] I think for a year and as... I took them up to the hospital ...I put my medal on and my name tag ... And she said, "Oh are you a nurse?" [laugh] *She wasn't sure?*

Yeah, I just was that person that came in and weighed her babies and talked to her about how things were going.

I wonder who she thought you were?

Well she knew that I was ...

Something to do with health...

Yeah.

But it didn't matter?

She trusted me, I guess she trusted me (006/2/p.9-10).

The element of trust between nurse and patient or nurse and family is essential to nursing. Without trust, the role of the nurse would be no more than perfunctory. The trusting relationship invariably presents challenges for the experienced nurse. To maintain the trust of her patient, a nurse must promote his or her interests at times when other health professionals, such as doctors, may seek to promote their own interpretations of the patient's *best interests*.

ADVOCATING FOR OTHERS

The participants maintained that value differences between nurse, doctor and patient as to which moral actions may produce the best 'therapeutic' results may sometimes lead to conflicts of opinion. The experienced nurse, as a 'pragmatic compromiser' par excellence

perhaps, may attempt to resolve the differences. When these differences are not easily resolved and become issues of increasing moral concern for the nurse, then she may resort to an ethical stance that is reflective of the trust placed on her by her patient. In any event, as the data collected from the participants in this study show, it is not common for nurses to be an integral part of *medical* moral decision making:

I don't recall *any* situations where I was actually involved in witnessing a doctor's moral discussion, I don't remember... (003/1/ p.11).

This situation can, however, be challenged and changed by nurses who are morally aware of their role as advocate both for their patients *and for their peers*:

There was that sort of case conference down the hall but the nursing staff were actually excluded from the decision making process, until a few of us got together and started saying how do you make your decision? ... [The other nurses] ... kept silent, this silence was one of the things they were very good at.

But once you had the person, the catalyst ... making her voice loud and clear...

Some of them were quite scared, "well you shouldn't do this" or "you shouldn't do that", and I turned around and I said to them, "well you make decisions in your life and it effects other people and you consult them, why can't they consult us?" (001/1/p.5, italics added).

The idea of advocacy in nursing is often promoted by appeals to the notions of moral commitment and empowerment of others (Curtin, 1979; Gadow, 1980; Winslow, 1984). That nurses themselves feel frequently dis-empowered in health care settings (see chapter five), *regardless* of their commitment and desire to care, is of interest. Nevertheless, it is frequently maintained that the pursuit of goals such as equality and fairness for all members of society when receiving health care is the basis of the nursing relationship with society:

Ensuring all client groups, irrespective of age, cultural background, sexual orientation, gender, location or health status, should have access to competent nursing services. ... Being true to the commitment made to society when receiving the right to practise, that the nurse will fulfil society's expectations of a nurse (NZNO, 1995, p.20).

In their role as an advocate for those in need, the *essential* element in the nurse-patient relationship has to be the *partnership* that should exist between the nurse and the recipients of nursing care. As noted by Guilliland (1995), "partnership ensures a

profession looks outward at the reasons why it exists rather than turning inward and becoming self serving" (p. 4). Hence, a wider commitment to society remains ethically important to experienced nurses:

...I felt I can't just keep on working with one person at a time, I have to work with more people or I'll just get nowhere. So I began to work more with groups and I also began to work in a more political way... so I started getting people to go to [local council] meetings. And so there was more contact with people in that neighbourhood directly with the city council (006/2/11).

This 'wider moral view' is the overarching moral view that serves as an approach to the ethical relationship that nurses have established and seek to maintain with society. This is because nursing is a professional activity that, like other 'helping' professions, is based upon the notion of the health professional responding appropriately to desired social values (Bayles, 1989). In nursing, this arrangement or requirement has been sometimes referred to as a social covenant that is in the form of a social mandate to practice. According to Madjar (1992), the social mandate can be traced back to Nightingale who fought to gain "...not only the approval of the authorities, but perhaps more importantly, the social mandate for nursing - the unequivocal stamp of approval as a needed and socially valued profession" (p. 1).

Promoting this mandate within the health care context is therefore a necessary consequence of adopting a nursing ethic within nursing practice. However, to promote the social mandate is to also promote the expectations of every individual that is nursed. This expectation, which is based on trust, includes the anticipation by each patient that the nurse will act on their behalf if necessary. For the morally committed nurse the maintenance of a nursing ethic in a rapidly changing and complex health care system is sometimes problematic. Hence, to maintain this ethic the nurse is prepared to act as an advocate for her patient if, and when necessary. In the sometimes difficult socio-political context of health care, such a task is not always a simple one for nurses. This is because nurses have personal and professional values, moral interpretations and limited power to change every situation in health care. There are times, for instance, when they inevitably face the prospect of having to support, or advocate for, a patient's decision that they themselves do not concur with. This presents a definite moral quandary for nurses:

I would have accepted that she made that decision, I'm not sure if I could really support it fully. It depends, it would actually depend on why she wanted it [ongoing but medically 'futile' care] (001/1/p.16).

Such tensions are perhaps inevitable. That morally committed nurses manage to maintain a nursing ethic and advocate for their patients, even if their patient's values or desires are sometimes contrary to their own, is probably attributable to the use of pragmatic compromise (see chapter six).

A NURSING ETHIC

The main phenomena of a nursing ethic, the establishment of purposeful relationships, the possession of moral character and nursing values, personal involvement, the maintenance of trust and professional caring, and advocacy, serve to not only assist the morally competent nurse in the sometimes difficult process of moral decision making, but also in the nurse's overall moral view or 'position'. As such, a nursing ethic may be distinguished from other moral views or positions. The following is a brief outline, based on a synthesis of the appropriate data, of four of the main distinguishing features of a nursing ethic.

a) As an intrinsic moral viewpoint in nursing

It has already been shown that nurses sometimes, if not often, appear to have different perceptions of specific moral situations. If this is the case, then it is also likely that nurses will exhibit individual differences in cognition and reasoning when making moral decisions. These differences are due to many factors such as personal and learned values and expectations, moral preparation for practice, experiences in caring for others, and many others. The following is an excerpt from data that neatly illustrates how experienced nurses generally perceive these differences:

I think nurses tend to want to say people are dying sooner than doctors are... I discussed this with a ...consultant the other day. And he said that in actual fact, nurses see patients that are... almost taking their last gasps, and the nursing staff will clearly say: "Look this patient's dying, let's look at palliative care, let's look at getting them home". Whereas the consultant may in actual fact have seen people recover from that very same position, that very same disease with a specific antibiotic therapy or something like that...but there comes a stage in our practice these days when we [doctors and nurses] can sit down with each other and say, look can you explain to me?

...So how has this come about do you think?

Through a level of clinical expertise. Through my years of practice and through having enough confidence in myself and my practice to be able to ask those questions (005/2/p.3).

The differences between the nurse's interpretation of events and the doctor's are not necessarily straightforward. If anything, these health professionals may differ in their ethical interpretations *between themselves*, i.e. between nurses and nurses, doctors and doctors, and nurses and doctors:

From some of the nursing staff, depending on which camp you were in, there was an absolute sense of relief, an absolute sense of relief. Some of the medical staff, they had a sense of loss, that their science didn't do anything, it did not provide the cure for that baby...I kept feeling there was a sense of defeat, which was then tempered by the sense that they had actually done their best (001/2/p.13-14).

Hence, the process of interpretation of events and their meanings is not always an easy one for anyone. In ethics, this phenomenon is compounded by differing sets of values, understanding of events, contextual factors, and many more. It may be concluded that the nature of moral decision making is sometimes a complex one for both doctors and nurses, and no doubt for the patient or his family. Nevertheless, morally competent nurses exhibit a moral viewpoint that is reflective of *their* (nursing) ethical values as experienced health professionals. They will seek to maintain these values as a moral viewpoint that is well represented by a nursing ethic.

b) As a distinctive moral language in nursing

In an attempt to show the nursing interpretations of events that have for them, an ethical content, the following excerpt from data is offered. Significant sections in the story have been given in **bold** print to emphasis the central themes. This has been done to illustrate and make more understandable *the nurse's perspective* in moral decision making.

This was a **specific child** who was ...dying, but he was still having to undergo transfusions. There comes a point where the chemotherapy has stopped working, but what happens is because the malignancy is growing out of control you have to top them up with blood transfusions and that actually keeps them going, so it extends their period of life. But for this child, he'd had two previous transfusions and he was coming in for a third and he could have gone on like this for another three, four months, coming in every week and having a top up, which would have then made, he would have then gone home and sat around and done whatever he wanted to do. But he would have been fairly limited because he would still have

been required to keep coming back, and the thing that he found really traumatic was having the needle inserted for his transfusions. And he didn't want them anymore, he never liked having blood transfusions and he never liked the needles that were associated with them ... So he came in for his transfusion and he got me, this is a seven year old remember, a little seven year old Maori boy, and **he got me aside and he said, "I don't want this."** Really simple seven year old language, "I don't want this anymore." And so **I explained to him** what would happen if he didn't have it, the **consequences** of 'I don't want this.' And that was all this sort of stuff about instead of dying in another few months time, you will actually die in two weeks time and he seemed to grasp all that. And I tried to con him, like it's only one needle and all the bribery and all this corruption that you do, but he was very, very adamant that it wasn't what he wanted. And he asked me to then say to his family, which was his father who was there at the time, and to the consultant and the registrar, that this was his plan of action. Because for him it was **quality of life, he didn't want to live that way.** So then together him and I got the consultants and the doctors and the father in and we talked to them. And there were lots of tears, and the father got really angry, and I think he got really angry because the child took control, because in actual fact **the child had made a decision** that this was how he wanted to end his life, rather than the father saying "look I really want you to live, I really want you to have the treatment, I don't want it to end." **And the child's expectation of me was that I would be his 'back up', you know his adult.**

Yes, which you were.

I was, and it was so successful.

So he got his way?

He got his way. I mean it was very traumatic and **to be really strong and to stand up to** not only the father, but the consultant as well and say this is what is needed. **And I think doing things like that gives you strength** (005/2/p.5).

This story provides a rich and ethically profitable amount of detail. It is a nurse's story primarily concerned with a *particular and purposeful relationship* between a nurse and a child who *trusted* her to *advocate* on his behalf. That the nurse did so was a credit to her and an example of her degree of *personal involvement*. The child got his wish, or his *need* to be free of any further pain and discomfort from a treatment regime was met. This regime was, to him and the nurse, a terrible and unnecessary thing at the end of his life. The nurse chose to help the child overcome enormous barriers to his wishes, and did so because she realised that this was his considered choice, and that she must support him in that choice. The *caring commitment* shown by the nurse owes much to the presence of a *nursing ethic*. This story *could* be interpreted in more traditional ethics language—such as autonomy or justice—but the nurse did not use such language overall.

This she did not do, but why? Very few nurses would claim to “eschew all moral principles” as Kuhse (1993, p.40) maintains. Instead it is apparent that most nurses may prefer to use an acceptable alternative, i.e. an ethic based *within nursing* to justify their actions. In the use of this ethic, the nurse sometimes shows less concern for her own welfare than otherwise. She is, in short, a compassionate and caring nurse who expressed her ethic through her practice.

c) As an interpretation of moral practice in nursing

The nurse participant in the previous story clearly participated in moral discourse of a kind that explained her personal caring relationship with her patient, a young boy dying of an incurable disease. Her values guided her actions in that she valued the relationship she had with the child and wanted to help him to be free from further pain and discomfort. The nurse’s skilled care and inherent ethic enabled her to support her patient in circumstances that were difficult for her and her patient. That she did so irrespective of these difficulties suggests that her *modus operandi* was based on the desire to show a distinctive moral commitment to the needs of her patient regardless of the consequences.

What matters to the nurse is that the patient’s needs are being met or not in a way that is reflective of *his* interpretation of *his* situation. In short, she:

- a) Responded appropriately to the particular situation that her patient now faced due to the close and trusting relationship that existed between them. A trustworthy advocate in the form of his chosen and skilful nurse was his best hope for a peaceful death.
- b) Met her patient’s need for compassionate and tender care, to alleviate his distress, and assist him at this time to face the inevitable with dignity and a sense of acceptance.
- c) Adjusted the caring context to incorporate, as far as possible, the child’s need to have as much control as possible over his care. This would have to be the case even if it meant the norms and rules of the unit were challenged by such an adjustment.

The moral justification for these actions would include the nurse's sensitivity to a complex moral situation, even, if necessary, at the expense of the relationship between herself and the physician. In *this* particular context, with *this* particular patient, such adjustments are both necessary and morally supportable. They are supportable because moral judgement in this instance refers not only to an epistemological act, but to the particular perceptiveness of the nurse to the needs of her patient. In this regard, moral principles or rules may become secondary to the nurse's perceived characteristics of good or ethical practice.

d) As a theoretical position in nursing ethics

Until quite recently, most nursing ethics textbooks and other literature has analysed ethical stories from nursing practice as forms of 'case studies' (as in, for instance, Veatch & Fry, 1987). This analysis usually, but increasingly not always, involves some form of explanation in terms synonymous with the traditional theories and language of ethics. Such theorising may be useful overall, because it provides a common method of interpretation and understanding that can be shared by ethicists and nurses alike. The nurse participant in the preceding story could have presented a principled and lucid argument in the language of traditional ethics to explain her moral viewpoint and subsequent actions, but overall, she did not present such an argument. Indeed, she did not present an ethical argument so much as a *narrative* with considerable ethical significance. Hence, nurses seek more appropriate ways to describe (narrative or story telling) and respond to ethical issues by explaining their conceptual viewpoint as a nursing ethic. It has been maintained that nurses frequently use stories to link their views on nursing practice, ontology and epistemology (Boykin & Schoenhofer, 1991).

MAINTAINING A NURSING ETHIC: THE MODEL

The gradual emergence of the core variable in the study was found through constant comparison of the data that yielded nursing perceptions of the meaning of moral practice. By this constant process, the grounded theory method has revealed not only several substantive codes but six broad categories that unify and connect the substantive codes within the study. These broad categories therefore emerged through theoretical coding. This activity yielded the *core variable* that is **maintaining a nursing ethic**.

Data collected for this study revealed fruitful and detailed information. This information provided the antecedents, processes and practice of nursing moral decision making that is nurtured and maintained by a nursing ethic. This ethic may be represented by means of a model or conceptual framework. The model on page 156 represents the development and maintenance of a nursing ethic from the early moral development of the individual, to full adulthood and entry into nursing, and eventually to the process of constant moral re-focusing that occurs when the individual is exposed to the wider socio-political and narrower nurse-patient contexts during professional nursing practice.

The model has three main sections. Each section contains essential nursing phenomena and moral processes (main categories and codes from the study). A brief outline of the key features of these main sections is now offered;

1. The development of personal and professional moral values (antecedents of a nursing ethic).

The antecedents of the professional moral values in nursing include:

- a) The personal moral values of the individual that are shaped by early childhood experiences and learned socio-cultural values.
- b) Preliminary development and focusing on the nature of professional moral values that leads to a refinement of ethical values in nursing.
- c) The development of a modified 'perception' of ethical issues in nursing practice based on preliminary experiences in the health care context that leads to the development of a nursing ethic.

2. *The maintenance and further development of a nursing ethic in the health care context (refinements of a nursing ethic).*

Refinements of a nursing ethic include:

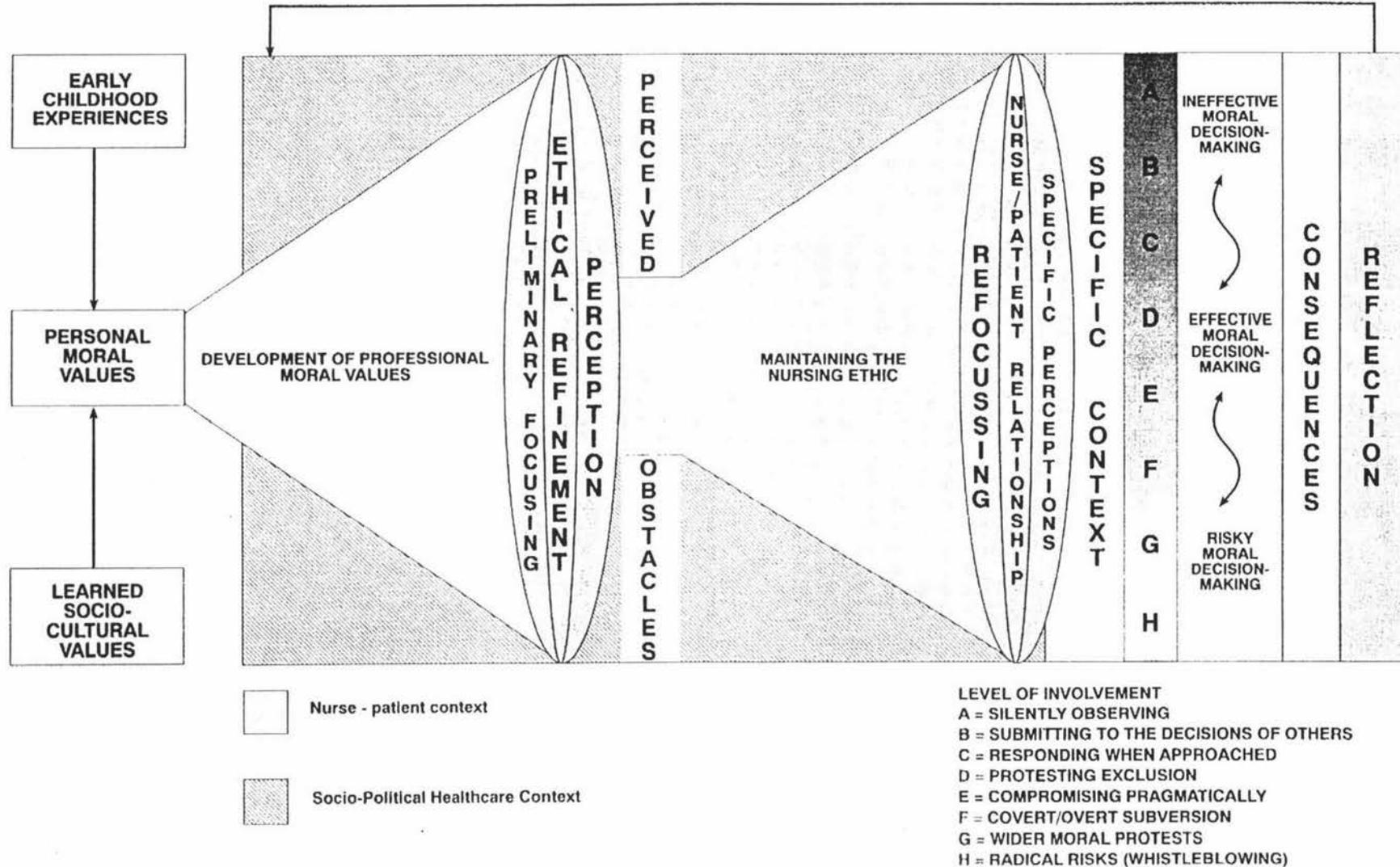
- a) Perception beyond the possible obstacles or barriers to professional moral values by means of the maintenance and application of a nursing ethic.
- b) Refocusing on the nurse-patient relationship by means of a nursing ethic approach.
- c) The process of 'specific perception' as each patient's situation within context is considered. Actions C, D, E and F may be considered to be the most commonly effective when a nurse is 'pre-focused' by a nursing ethic.

3. *The practice of moral decision making in nursing using a nursing ethic (application of a nursing ethic).*

The application of a nursing ethic within the specific nurse-patient context includes:

- a) Ineffective nursing moral decision making and actions
 - or b) Effective nursing moral decision making and actions
 - or c) Risky/radical nursing moral decision making and actions
 - and d) The consequences for patient and nurse of nursing actions.
 - e) A reflective phase whereby the nurse immediately (short term) and distantly (long term) reflects on her moral decision and actions. This process affects the previous processes described in the first and second sections of the model.
- NB. In c) above, the element of higher risk may produce effective *or* ineffective results.

**FIGURE 2: MAINTAINING THE NURSING ETHIC:
MORAL DECISION-MAKING IN EVERYDAY PRACTICE**



SUMMARY

This chapter has examined the core variable of this study, which is 'maintaining a nursing ethic', and its six main categories. This ethic is characterised by the nurse's commitment to moral competency and skilful practice within the nurse-patient relationship by means of personal involvement through purposeful relationships with their patients. This chosen involvement is a reflection of the nurse's personal values and moral character, which develop in childhood and are further refined on entering and practising nursing. The maintenance of trust within the nurse-patient relationship and the high moral value that is placed by the nurse on skilfully caring for others in need are essential components of a nursing ethic. It has been maintained that this process takes time and maturity, because experiences in context shape a nursing ethic rather than theory. It has been shown by re-analysis that a nursing ethic is a viable ethical position or moral approach within nursing, having its own language and distinctions from medical ethics. Finally, a conceptual framework of nursing moral decision making based on the data supplied by experienced nurses has been offered as a model. It now remains, in chapter eight to re-examine moral decision making in nursing in light of the emergence of a nursing ethic.

CHAPTER EIGHT

DISCUSSION AND RECOMMENDATIONS

We shall not cease from exploration
And the end of all our exploring
Will be to arrive where we started
And to know the place for the first time.

T. S. Eliot, *Little Gidding* (1969, p.197.).

INTRODUCTION

In this the final chapter, discussion is presented on maintaining a nursing ethic amongst nurses, its theoretical and practical value to both nurses and ultimately to those nurses care for, and its usefulness in nursing research and education. The usefulness and limitations of this study and the implications for future research are also considered.

It has been maintained that the previously identified core variable, '*maintaining a nursing ethic*', is the central stimulus of all that precedes, accompanies and reflects the actions of morally competent nurses in their moral decision making. Hence, the discussion in this chapter will not only concentrate on the professional and practice based applications of such a study, but also on the development of a substantive theory. In this way, it is hoped that nurses, as professional carers in the highest degree, will recognise *their* voices and *their* vision in the crucially important moral endeavour that is nursing. It is also hoped that others, such as doctors, health service managers and alternative health workers, will discover that in maintaining a nursing ethic, nurses are involved in nothing less than the pursuit and maintenance of a moral perspective and practice that represents the inherent caring nature of excellent nursing itself. In this regard, an appreciation of a nursing moral viewpoint, as an integral part of a wider professional ethic, could be of considerable benefit to all health care recipients and providers.

A NURSING ETHIC IN THE MORAL DECISION MAKING OF NURSES

The findings of the present study suggest that the maintenance of a nursing ethic is a core variable that was commonly experienced by all participants. When acting as morally competent and committed nurses, they exhibited this ethic in a variety of personal and collective ways. These nurses may share common professional values, but maintain a nursing ethic by different means or levels of involvement such as pragmatic compromise, moral protests or by covert or overt subversion. Nevertheless, it is also likely that they will attempt to maintain this ethic irrespective of the difficulties of contextual obstacles. Morally competent nurses do not focus their thoughts on their practice or their moral decision making within that practice in an unreflective or random fashion. The participants in this study, for instance, often contemplated *in great detail* certain ethical events that they had been involved in up to twenty years ago. Their recollections of these events did not appear to have faded in time. On the contrary, these recollections appeared to have been enriched by time and further experiences, allowing them to reconsider and reflect in ways that were suggestive of psycho-social and cognitive processes that had already begun as they entered nursing. The basic psychological and moral developmental notions of Kohlberg (1981) and Gilligan (1982), *as noted in chapter two*, are therefore reaffirmed in this study. However, the reflective nature of morally concerned and experienced nurses may be more fully elucidated by a brief outline of the ideas of Schön (1987).

According to Schön (1987), useful practice based knowledge is obtainable from a process of reflective practice. Such practice may be 'reflection-in-action', which refers to the thinking an individual has during an incident or experience; and 'reflection-on-action', the reflective thinking that occurs after an event. The difference between the two types of reflection is noteworthy, because nurses may be involved in an ethical dilemma that is immediate or sudden and experience reflection-in-action, but will later experience 'reflection-on-action'. This process is thus a cumulative one, leading to changes in actions or practice in similar but obviously different situations (due to differences in those involved, contexts, perceptions of the event and other factors). In nursing moral decision making, the value of experience cannot be underestimated. In the model (*figure*

2), reflection is the *final* product of the process of moral decision making. In a curious but perhaps cyclical way, it is also the beginning of future decision making.

THEORETICAL PROPOSITIONS ON THE NATURE OF A NURSING ETHIC

The general aim of this study was to discover how eight experienced registered nurses made moral decisions in their everyday practice. In the process of describing those ethical issues and contexts that nurses consider to be of central importance, and undertaking the extensive reflection that is necessary for data analysis, it became obvious that such nurses do not make moral decisions and act accordingly because they are following a personal whim or a haphazard exercise. Such experienced nurses are experienced in life, first and foremost, and also in nursing practice. They bring with them, right from the early days of training to the present day, a way of being, a philosophy, a knowledge base, and an ethic that is, as in all other cases, a continuously evolving, reflective and maturing one. The study revealed some intriguing but potentially useful propositions or observations on the nature of ethical competence amongst the group of eight experienced registered nurses. The main propositions are as follows;

Nurses develop an understanding of professional moral values within the socio-political and health care contexts by focusing and refining their moral perceptions through a variety of experiences in training and in beginning practice.

The development and maintenance of a nursing ethic could be thought of as a lifelong process (*see chapter four*). It is by no means clear why a young or even older person should decide to become a nurse. In the case of the participants, these reasons were as diverse as any other reasons for seeking employment. Nevertheless, one aspect of the *pre-nursing* individual stands out above the others. This aspect is a commitment to caring for others in need. This commitment takes many forms. There is the commitment to self, to the family, to one's friends and to society. In those who seek to become nurses, the commitment seems strongest when there is a preliminary set of values that focus the individual on caring for the health needs of others.

Fulfilling the needs in others is a process that requires certain skills and attributes. As people enter nursing, these already learned skills are modified and altered to allow the individual to meet the health needs of others in ways that are sanctioned by society. There are very few professions or occupations where an individual is allowed to

professionally care and meet the needs, of whatever type, of another individual, if necessary, from birth to death. Indeed, the lives of very few professionals, health or otherwise, are so privileged.

Nurses refine and attempt to maintain a nursing ethic throughout their careers by a process of constant refocusing on the nurse-patient relationship in specific contexts.

The commitment to meeting the health needs of others must be strong in nurses because there are numerous 'barriers' to be confronted as each nurse faces the realities of the health care system (*see chapter five*). Some obviously drop out, some modify their values and beliefs to incorporate newer ones, good or regrettably, bad. Those who 'survive' their student days now become the new practitioners in a 'brave new world.' They take with them, from their education and from their experiences as student nurses, a view of nursing that is not only ontological, theoretical and practical but also *moral*.

Good nurses, or skilled and efficient but also *morally committed* nurses, may also share an approach to their work, their patients, their colleagues and others within and without the health care services, that is reflective of a vague or ill-defined phenomenon. This phenomenon is the ability to remain 'a moral person' regardless of the pressures placed upon them. The phenomenon has identifiable qualities. These are an ability to be sufficiently involved in those matters that are important to their patients, to 'be there' when the need arises, and to offer support and compassion if, and when, required. In this regard, such nurses are not necessarily only active when an ethical 'situation' or dilemma is occurring, but throughout the whole period that they are caring for others. This involvement sometimes calls for responsible and thoughtful interventions, because the nurse's world is not the world of pure thought or meditation, but the world of very real and very unpredictable discomfort or pain.

Morally competent and experienced nurses commit themselves to specific ethical problems in their practice by adopting focused and effective levels of involvement.

Effectively dealing with moral problems in nursing practice depends on many variables, but a morally competent nurse must firstly possess a moral viewpoint that guides her immediate and reflective actions. However, 'the moral view' in nursing is not one entity or universal view, but many. Each nurse represents a unique combination of her own

experiences, values and ways of being in the world. In this may be found an explanation of the differences in perception and chosen levels of commitment that exist between nurses when they deal with the moral problems that inevitably face them in their practice (*see chapter six*). Some nurses commit themselves to nothing when faced with difficult ethical problems, some await an invitation to comment, others protest exclusion and others enter the debate and then fade. A morally committed nurse, a nurse who sees her work as of benefit to others regardless of the constraints that confront her, attempts to find appropriate ways to bypass the obstacles to maintain an ethical relationship with her patient. She will, by various means, continue to meet their needs, and attempt to hold fast to the driving force within a nursing ethic. This ethic is usually both necessary and sufficient to achieve the task of good nursing, but there may be exceptions.

No nurse, however committed, may be able to hold to her commitment to a nursing ethic in those situations when powerful forces, such as hegemonic or political, are in strong ascendancy. In these cases, rather than accede to these forces, some nurses resign their positions, create localised or even wider protests, or take their case to the public by 'whistleblowing'. These steps, however noble, are not options that many nurses are able to take. Those nurses who are desirous of continuing to work in health care even when under considerable pressure and stress continue to maintain a nursing ethic by employing a range of options to maintain their involvement. Some options, like 'doing nothing' or 'submitting to the decisions of others' are out of the question for nurses committed to a nursing ethic. The most commonly used options of morally competent nurses appear to be those of pragmatic compromise, protesting exclusion or covert/overt (but responsible) subversion. These options, far from perfect perhaps, at least guarantee that the nurse continues to care for patients, and influence the delivery of nursing care within the health care arena.

Morally competent and experienced nurses provide skilled and professional care that is guided by a nursing ethic.

The key elements of a nursing ethic, the establishment of a purposeful relationship with each patient, the possession of appropriate nursing values and moral character, personal involvement, a commitment to skilful caring, the maintenance of trust and the desire to advocate for others if necessary, are evident in the professional care offered by morally

committed nurses (*see chapter seven*). If the essence of any given helping practice is action directed by communal ways of being which is aimed at promoting human good (Gadamer, 1960), then the moral component of nursing practice is a crucial one. Indeed, it could be argued that nursing is an entirely moral endeavour, and that this moral enterprise *is* nursing. As Penticuff (1991) maintains, good or excellent nursing practice is, by necessity, moral (as it is the 'good' of patient directed care).

There is support in nursing and ethics literature for the key concepts within a nursing ethic as described in this study. Several nursing authors support such concepts (Benner, 1984; Benner & Wrubel, 1989; Bishop & Scudder, 1991; Bradshaw, 1996; Curtin & Flaherty, 1982; Gadow, 1985; Goodrich 1973; Henderson, 1966; Leininger, 1988; Nightingale, 1964; Orem, 1985; Watson, 1985, 1988). Thus, the art of nursing is to practice morally for the welfare of those in need. As such, the focus of nursing moral decision making is the focus of *morally good or excellent nursing*, a *commitment to care* through the establishment of a *trusting relationship*, and the *practice of skilled and reflective nursing*.

A nursing ethic underpins the purposeful and meaningful relationship between nurse and patient. It is the maintenance of trust regardless of other pressures and circumstances; it is a form of advocacy even when advocacy is derided or unwelcome by others. The nurse's decision to be personally involved with the lot of others is made without candour because the nurse possesses the necessary personal and moral character to achieve this. Most of all, the nurse who practises within a nursing ethic does so because she is committed to professionally caring for others. Thus, a nursing ethic is a humanistic ethic based on care, which is a universal phenomenon, and commitment, which is a specific phenomenon. Therefore, such an ethic may describe how nurses care for others effectively, but does it prescribe *how* they should (morally) do so?

THE THEORETICAL IMPLICATIONS OF A NURSING ETHIC

In this conceptual framework or emerging theory, one factor remains that continues to disturb and threaten the apparent simplicity of the conceptual or theoretical framework of a nursing ethic. This factor is the now perennial argument concerning the value in nursing of the use of an 'intrinsic' nursing ethic, or similarly a nursing ethic of care,

versus the use of methods that are the mainstay of traditional ethics. This study cannot ignore or bypass this debate because there are strong connections within the data and subsequent discussion to an ethic of care. Hence, if the theoretical propositions of a nursing ethic are to be challenged, then they must stand up to analytical scrutiny. The research in this study is no exception.

The theory of an 'intrinsic' nursing ethic has been challenged as being misguided or misleading. It is perhaps the notion of a nursing commitment to care, often interpreted as an ethic of care in nursing, that has caused a great deal of debate and argument both within nursing and bioethics in recent years. Critics of an ethic of care in nursing (Allmark, 1995a, 1995b, 1996; Kuhse, 1993, 1995) often in a general attack on both the notion of caring and the notion of a nursing ethic or an ethic of care in nursing, claim that nursing is more than 'just a type of caring' and that care theories are reinforcing negative stereotypes of women. They also maintain that a nursing ethic of care is a great ideal/attitude, but is deficient in moral objectivity, theory and means of justification.

Thus the main problem with any notion of an ethic that is predominantly based within the professional caring practice of nursing seems to be that the use of such an ethic merely describes what nurses morally do, but does not ethically prescribe *what they should do*. That is, a nursing ethic is a desirable overall attitude, but does not theoretically explain or predict the 'necessary' ethical method. This argument is a non sequitur for several reasons that will now be examined.

A nursing ethic is more than an attitude, position, method or approach to moral practice in nursing. Yet it would no doubt be described by its critics as being perhaps an adequate non-normative or descriptive ethic, but not a normative or prescriptive one. The notion that any ethic that includes the element of judgement has to be more than descriptive, in that it must also be prescriptive, has troubled nurse ethicists in recent years. The reasoned arguments of those ethicists who promote traditional ethics methods for nursing decision making base their arguments on the premise that any ethic that is suggested for nursing, or any other health profession, is only worthy if it has predictive qualities. Hence, if the suggested ethic (such as an ethic of care, or a nursing ethic, as proposed in this study) does not include justification of actions, or attempts to justify

actions in ways that are other than rule or principle based, then that ethic is condemned as being too vague or obscure for actual use in practice.

A number of replies to this problem have been mooted (see Bradshaw, 1996), but each reply has then been responded to in kind, and often with more elaborately reasoned arguments (Allmark, 1996).

However, there is an alternative to the seemingly endless and protracted arguments noted above. The following suggestions are offered as a reply to the problems outlined previously, and as a set of concluding remarks about a nursing ethic itself.

Rationalist or objective based ethics seeks to assess and justify moral actions as if there was an actual *solution* to the ethical quandary in question. This notion is based upon the argument that the rational application of moral principles or rules should lead to 'the solution' of the dilemma and thus morally justifiable actions. On the other hand, from a grounded and more subjective viewpoint, such as is proposed in this thesis, it could be argued that there is no ultimate moral justification or clear moral solution to a practice based ethical dilemma, but a range of effective ethical possibilities or 'best options.' Hence, a nursing ethic that recognises the unique factors that may influence moral decision making *in practice*, such as the nurse's commitment to her patient's needs, the establishment of a trusting relationship, and the desire to provide skilful care, may be as capable of assisting a nurse to make effective moral decisions as any entirely objective based ethic. In any event, a process of moral cognition or reasoning is a necessary precursor to actions in the practice context. This process may be supported by a consideration of moral principles or rules, but it may also be served by an underlying and enduring nursing ethic.

The argument that nursing actions that are based on an intersubjective ethic has no means of justification is basically a misunderstanding of the meaning and uses of an ethic. Indeed, an ethic of nursing, or, alternatively an ethic of care in nursing, is an integral part of nursing ethics, but it is not the *same thing* as nursing ethics. That is;

a) It is the ethic that nurses use and make manifest when they are committed to excellent nursing care. It is the 'outward sign' of moral involvement in nursing practice. It is not a detachable option or one of several ethical approaches to nursing ethics.

b) It explains what nurses do (descriptive) *and* it provides the narratives and stories that nurses use to understand moral decision making, and the difference between *effective* moral decisions and practice, and *ineffective* moral decisions and practice; in this regard, it is prescriptive.

c) Thus, It *guides* rather than dictates nursing decisions and actions in ethical quandaries. It is both the *goal* and the *means* of competent ethical practice in nursing.

An ethical problem/situation is perceived to exist by the nurse because of her understanding of the patient's situation. This understanding is based on the relationship between the nurse and the patient, and the commitment that she has made to that patient to support his needs through acts of skilled caring and advocacy.

In the case of the patient requiring the ethically competent nurse to meet a need that is contrary to her practice, such as supplying him with illicit drugs, the nurse uses the learned personal and moral characteristics or virtues that enable her to distinguish real needs from false or devious ones. The nurse in society has a social contract/commitment to be a *nurse*, providing skilled care in response to need, but not a provider of 'false needs'. Hence, the insistence in nursing literature and research such as this that the nurse-patient relationship is *the* paramount relationship. Other relationships, including nurse-doctor, nurse-nurse, and others, are less so. Hence, the nurse should strive to meet all of her patient's *reasonable* needs. Reasonable needs are those needs that may be ascribed to anyone (food, warmth, comfort, freedom from pain, etc.), and also to a particular person if, and when, the need most closely relates to that person's freedom to choose his own way of being in the world *without* compromising the needs of others (nurse included) to do the same.

To be a nurse, or more precisely to be a competent or effective nurse, one must possess certain qualities, moral as well as others. These qualities include skilfulness, wisdom, and the capacity to perceive the needs of others. Indeed, a nurse without these qualities, moral qualities included, is but a caricature of a nurse, a pretender, an inauthentic being. To be a nurse requires one to place oneself in a position based on trust, and to continuously strive to maintain that trust, otherwise 'nursing' as defined cannot take place. Hence, authentic nurses *choose* and *decide* which needs will most support the patient's best interests because she has a relationship with the patient that is based on trust. If the patient trusts the nurse, he anticipates that she will make several professional decisions that include (a) caring for him in those matters that he cannot attend to himself until he is restored to a sufficient level of health, (b) meeting his reasonable health care needs, (c) using her knowledge, wisdom and decision making skills, and (d) making moral decisions in regard to assisting him to meet his own health related needs.

A nursing ethic does not abandon the use of ethical principles or rules. They are sometimes very useful tools for the nurse as she considers her possible actions and their possible consequences. However, as an entire approach to an ethical problem between the nurse and the patient, the theory and concepts of traditional ethics are less useful. She does not, for instance, 'stand back' in a neutral fashion from her patient's situation, nor does she necessarily perceive every patient as having exactly the same 'rights' or 'obligations' as any other person in a similar situation. Furthermore, she cannot put aside the trust that her patient has in her (and if there is no trust then there cannot be 'excellent nursing,' as previously defined). A nursing ethic is at least an ethic that recognises the relationship between nurse and patient, the context as a supportive or non-supportive one, the situation as a particular situation, and the needs of the others as being dependant upon the moral qualities of the nurse.

It remains to conclude that the notion of an 'intrinsic' nursing ethic 'versus' the ethics of principles and rules is basically an argument based upon two quite different notions. The reason why this may be the case will be further elucidated in the next section on the main implications of this study for nursing.

IMPLICATIONS FOR NURSING PRACTICE

In 1980, Henderson pondered on the true nature or essence of nursing and asked what kind of education would help preserve this essence in 'a technological age.' As well as listing several science subjects, of both the natural and social kind, Henderson also listed philosophy and other 'humanities' subjects. On the issue of the use of humanities in nursing, she had this to say:

We need imaginative and bold nurse researchers who can, through demonstrations and sound evaluative research, bring about radical changes in the basic health care of the chronically ill, the mentally retarded, the prison population and the institutionalised aged—but to mention a few categories of society that are conspicuously neglected and whose fate might be radically altered by expert humanistic nursing (p. 256).

It has been the aim of this study to discover how a group of eight experienced registered nurses make moral decisions in their practice, and the antecedents and possible consequences of those decisions. In pursuit of this goal, these nurses have provided a wealth of material in the form of data for this study. On several occasions, the participants have provided evidence that they can and do make competent and humanistic ethical decisions in their practice. In some instances it has also been shown that there were instances when a participant may not have made an ethical decision, either because she could not overcome the obstacles to her involvement, or because she felt that she did not have the necessary understanding of suitable ethical methods in decision making.

There is evidence, for instance, that some nurses remain stubbornly loyal to the decisions of physicians, even in matters of predominantly nursing ethical issues (Buckingham and McGrath, 1983). Recent research in New Zealand suggests that the legacy of obedience to the institution and the physician is still a powerful influence for nurses (Woods, 1992). Thus, if nursing is to promote autonomy as a necessary component of professional and *ethical* responsibility, then a realistic appraisal of those contextual issues that affect nurses' autonomous practice must be addressed. Greater philosophical concentration is especially needed on the nurse-patient relationship within the context of their

professional practice. As it was in Nightingale's time, nursing is a *caring* profession, with its own carefully evolved theories and discernible practice. There is no particular reason why nursing should not also be able to develop its own ethical approaches, even if sometimes related to other more standard ethics approaches, to those ethical problems that nurses face on a daily basis. It is though, important that nursing ethics is not plunged back into the general bio-medical ethics arena, as this may herald a return to the decades when nurses were no more than dutiful handmaidens to the medical ethics of physicians. In short, nursing has its own moral focus, and this is predominantly patient care orientated rather than cure orientated.

The implications of this study for nursing practice are that nurses already have in their ranks a core of experienced and committed nurses who often go about their everyday skilled work unnoticed or unheard. If nurses wish to improve their chances of meaningful involvement in both their own ethical debates and the wider debates of health care ethics, then it is to these nurses that they must turn for guidance.

IMPLICATIONS FOR NURSING EDUCATION

In nursing and nursing ethics education, it is suggested that much may be gained from a re-examination of the reflective and analytical benefits and significance of narrative or story telling in nursing. Such a move may encourage the quicker return to a refocusing of research on ethical nursing practice as a basis for theorising. Schön (1987) suggests *in the case of the education of professionals* that 'real-world' practice does not present itself as a series of neat structures that respond to various theories. 'Real world' practice is, as the name suggests, thought to be the practices that occur in actual situations in context. In this world, knowledge is gained by experiences in the learning situation rather than through rational attempts to apply theory to practice. This notion has strong similarities to the previously discussed ideas of Dewey (1920/1957), Mead (1934), and others (*see chapter 3*) in that a great deal of learning occurs through experiences *in context*. Such learning depends on adequate reflection and analysis of practice (or cognition) which then serves to enhance or guide future practice. Learning via the means of the 'theory first' approach will only lead to a negation of real world events because of the misguided emphasis on structure or method over choice (or choices) in practice.

The parallels that may be drawn from the above discussion with the preparation of student nurses for a career in professional nursing are quite strong. Students of nursing are often educationally prepared from a nursing curriculum that is based on humanistic, care-based nursing theories (such as Benner & Wrubel, 1989; Swanson, 1991; Watson, 1985), although it is still possible (and probable in some cases) that ethical issues in nursing are still being taught to nursing students as largely a matter of idiosyncratic commentary within other topics or subject material (Aroskar, 1977). However, the realities of the 'real world' do not always match the idealism of the 'theoretical world', or the speculative commentaries of various lecturers in educational institutes, however well intentioned these may be. The curriculum is still a normative curriculum in some regards, even if it is a humanistic one. In the case of nursing ethics education at an undergraduate level, this observation could be a 'real world' (of education) dilemma in itself. For instance, it has been presumed that nurses, like any other health care professionals, *should* be educated in ethics by learning to use a variety of principles, rules and/or ethical norms to help them reach a decision that will support their subsequent actions in practice. According to van Hooft, Gillam and Byrnes (1995), "...this is still one of the most common and popular ways of framing an ethical argument" (p. 205). These rules and/or principles are often incorporated into theories such as deontology or utilitarianism which then serve as a general guide to action (Beauchamp & Childress, 1994; *see also chapter two*). Yet this approach, the 'technical' or traditional approach to ethics, could lead to several problems for nursing students before and even after graduation.

Firstly, under the present educational system for nurses, student nurses are frequently unable to relate such theory to practice. This is because they are not *in practice* for approximately half of their training. When they are in practice, they are *students of nursing* only. That is, their primary role is to *learn to be* nurses, rather than *being* nurses as professional and experienced nurses in practice. Subsequently, student nurses are expected to apply 'new' (to them) nursing theory to several 'new' practice settings, *and* apply 'new' ethical theory to often 'new' situations. This, as indicated in previous chapters, is asking a great deal from people who are often still developing an appreciation of professional moral values. There is a grave danger in such an approach

because student nurses may attempt, as could be expected, to *make* the theory fit the practice. Such attempts cannot be supported either educationally or ethically.

According to Bishop and Scudder (1990), such a careless adherence to the 'technical aspects' of ethics and not to the *nursing* aspects of ethics could be detrimental to nursing and nursing ethics. The consequences of placing nursing students in the situation of even attempting to resolve an ethical problem by the casual and inexperienced application of ethical principles or rules are daunting. This is because even the calculated use of ethical principles in the consideration of specific moral situations in clinical practice may lead to 'solutions' that lack any consideration of the systemic relationships that exist between those involved in a given context. Thus, there is a real danger of the expeditious use of major moral principles by nursing students as a 'quick solution' to what is often a complex human situation. This process has been termed 'principlism' (Hanford, 1994).

Second, if Schön's (1987, 1995) assertions concerning the nature of learning a profession through reflection in and on action are correct, then student nurses, and perhaps practising nurses in general, are significantly educationally disadvantaged. The previous discussion on the inappropriate or casual application of nursing and ethics theories notwithstanding, it could be argued that if nursing theory emanates from good nursing practice, then nursing ethics theory should emanate from the same source. Yet, there is considerable disagreement amongst educators of nursing ethics over this issue (Allmark, 1995b). The disagreement is an argument based on the 'theory-practice' method as opposed to the 'practice-reflect-theorise' method. Bishop and Scudder (1990, p. 136) appear to have few doubts on this issue, maintaining that "the situational, relational ethic is the one required in health care as practised." As such, the only way nurses can learn how to respond to ethical problems in practice is *to practice*, that is, to be in those situations and those relationships that lead to the necessary insights. Student nurses, however, have neither the experiences or the reflective capabilities of experienced nurses.

This study has demonstrated that, as student nurses, the participants were often unable to respond adequately to ethical problems in practice. They felt that they had neither the experience nor the appropriate education to do so. It has also been demonstrated that even as highly experienced nurses, they sometimes had to struggle against many constraints and barriers (both internal and external) when faced with a difficult ethical

dilemma. However, the study suggests that morally competent nurses are at least supported by a nursing ethic that is deeply ingrained in their personae.

The educational implications of this study are that undergraduate and post-graduate nursing education may require further research and possible adjustments to enable nurses to successfully reflect on their ethical practice. Certainly there should be a significantly strong emphasis on the importance of values, both personal and professional, contexts, perception of ethical problems and moral decision making. The implications for nursing education in this study suggest that the use of narrative ethics combined with education in relationship ethics, ethics of care and situation ethics may be of great benefit to nurses. This in turn would enable improvements and new developments to occur in their own practice and in nursing ethics education. It is *not* suggested, however, that nurses and nurse educators should shun the methods of the traditional ethics approach. If nurses are to cope in the 'real world' of health care, then such methods will undoubtedly be part of that world. To pragmatically deal with this phenomenon, nurses need to understand it *even if* it is not their chosen *modus operandi*. Such methods may also have their uses as useful 'tools' in the difficult process of deciding, even if they are not the 'tool-box' itself.

IMPLICATIONS FOR NURSING RESEARCH AND FURTHER RESEARCH

In keeping with the emerging but comparatively recent developments in nursing ethics, nursing ethics research is still in its early stages when compared to research on medical or health care ethics. These fields themselves are hardly over-researched, but according to Fry (1994) and Johnstone (1994), there is still much to be done in nursing ethics research. Fry expects "rapid development of nursing ethics research in the 21st century" (p. 281), whilst Johnstone warns of the possible dire consequences for nursing if ethics in nursing is not recognised as "a research category of its own" (p. 508). This study may, at least in a small way, satisfy Johnstone's request, but it is also hoped that it will be accepted as a contribution to research in nursing ethics in New Zealand. It would be very reassuring to think that it will at least encourage others to undertake research with similar or new methods into the 21st century. New Zealand, perhaps surprisingly to other nursing researchers world-wide, is a very commendable place to perform such research. It is a small but unique country where 'Western' technology and vigour meets Polynesian

tradition and values. This combination has contributed to nursing practice that emulates the concepts of partnership and participation with remarkable accuracy and perceptiveness.

Research undertaken to study the use of principle based ethics or care based ethics for ethical decision making in nursing practice has often, but not always, focused on seeking out the use of *predetermined* main concepts, including ethical principles or rules, in the *hypothetical* situations or case studies given to nurses (Cox, 1985/86; Gaul, 1986/87), rather than on *descriptive narratives* taken from personal clinical experiences (Omery, 1985/86). The former type of research has been repeated or reproduced in numerous other research projects, and the results *still* generally indicate no more than nurses appear to have a 'mixed' ethical orientation (Duckett, Rowan-Boyer, Ryden, Crisham, Savik, & Rest, 1992) or 'slightly prefer' caring ethics (Peter & Gallop, 1994). Even more recent reports using the case study/hypothetical method continues to produce results that are inconclusive (Lutzen & Nordin, 1995).

Because of the highly subjective and interpersonal nature of a specifically nursing ethic, it is likely that research on this concept will only produce more illuminating results if it is performed through the use of a more subjective, narrative based methodology. Increasingly, such research is now becoming a reality (Dewolf, 1989; Uden, Norberg, & Norberg, 1995; Viens, 1992). It is noticeable however, irrespective of the research method employed, that nurses do not commonly appear to use the language and/or methods of principles or rules based ethics when giving reasons for their ethical decisions based on commonly recurring moral dilemmas of their practice (Woods, 1992). In any event, it is more than likely that nurses in practice do *not* use the methods of moral reasoning in anything like the abstract ways of ethicists/academics. This does not mean, however, that they do not have a moral language or are unable to make moral decisions in practice, *or* that nurses do not practice according to a shared or overarching ethic. It has been shown in data chapters, and especially in this chapter that this is clearly not the case.

There are several implications for nursing ethics research within this study. These implications range from the possibility of a major rethink about the ways in which nursing ethics research is perceived, performed and applied to nursing practice and

education, to minor changes in the minutiae of such research. These implications are as follows:

Firstly, this study suggests that some of the hitherto accepted methods of nursing ethics research (*as discussed in chapter two*) may not be as beneficial to nursing as was once presumed. These methods comprised of the application of various tools of measurement of ethical reasoning and were largely based on Kohlberg's (1971, 1981) theory and ideas on moral development (Chrisam, 1981; Rest, 1974). Hence, throughout the 1980s research in nursing ethics was undertaken in ways very similar to the methods used to study the ethical thinking and behaviours of the general populace. As Gilligan (1982) and others made transparent, such application of the preconceived and 'scientific' methodologies of moral reasoning to professions such as nursing is at least a dubious enterprise. This, it will be remembered, is because such methodologies *presume* that the rational, principled and abstract use of ethical concepts in moral reasoning such as justice or beneficence is the norm for everyone.

Second, the whole notion of taking the moral reasoning tools or concepts, both general or specifically tailored, of one discipline into another (nursing) to discover how nurses make their moral decisions in practice is at least contestable. As Melia (1994) maintains:

We should ask questions such as: 'Do moral philosophical debates have relevance for practice?' and 'What are the concerns of those working in the areas of patient care?' rather than simply taking the works of Kant, Mill and Rawles... and then trying to make judgements about nursing practice through the particular approaches of those philosophers. Starting with the practice rather than the philosophy might lead us to other texts (pp. 10-11).

In short, research into the moral practices of nurses should *start with* an examination of nursing practice, and then an analysis based on the categories found within that practice. This study has aimed to do just that. The implications of this type of approach to research methodology are that the *nursing* voice, the *nursing* perception and a nursing ethic will emerge.

Third, it is suggested that it would be unwise to leave the current debate concerning the value of some of the more non-traditional ethics approaches (such as relational, situation or narrative ethics) to only the philosophers or academics. If nurses wish to promote their profession as a skilled and expert practice based on caring ethics, then nurses themselves must examine their own practices. Such a move will not guarantee a resolution of current debates over the best method and approach for the analysis and practice of ethical nursing, but it will at least maintain the necessary focus on *nursing* perspectives in ethics rather than *ethical* perspectives in nursing. This distinction is more than slight, it is crucial to nursing.

The implications of this research for future studies are therefore that further studies should pursue the field of nursing ethics by *starting* with practice, both in nursing and nursing education, and moving through suitable analysis towards theory. Narrative ethics has been mooted in this study as a recent but interesting development in ethical analysis. Other developments, such as situation ethics and relational ethics may also be fruitful avenues for nurse researchers to explore. Because of the rapidly growing interest in the work of Schön (1987, 1995) on reflective practice, it is also highly likely that his work will inspire others to research the professional practice and education of nurses, including nursing ethics. There are signs already that those closely involved with the future directions of nursing education are using Schön's ideas as a starting point in such research (Teekman, 1997).

It has been suggested to the author that there is an underlying 'hint' of existentialist ethics in this study. This field of ethical thought has not been a major influence on most nursing ethics developments to date, but it is suggested that this may change in the future. In any event, the influence of existentialist moral thought (Merleau-Ponty, 1945; Sartre, 1956) and/or the phenomenological ideas of Heidegger (1962), in the form of the use of hermeneutical narrative and analysis, is noticeably growing in nursing research and theory (Diekelmann, 1993; Sandelowski, 1991; Widdershoven & Smits, 1996).

THE LIMITATIONS OF THIS STUDY

As is usually the case with *all* research of whatever type, qualitative or quantitative, there are limits to the amount of time and effort that can be devoted to every possible avenue of inquiry within this study. This study is no exception. Hence it is limited by its chosen method and design in that other research methods, such as the phenomenological approach, may have yielded equally appropriate findings. The small group of experienced nurses within a confined geographical area who provided the data is also a limiting factor because the study is clearly (but candidly) of limited generalisability. Because all of the volunteers for the study had also undertaken (or were currently pursuing) further academic studies, it could also be argued that the chosen participants represented a more articulate and professionally committed group of nurses. The inevitable problem of the need for closure of the thesis within a given time frame is also significant.

The study would, as perhaps previously indicated, have been a fascinating one if only some particular parts of data were explored. The value systems of nurses, the ways that nurses perceive ethical dilemmas, the contexts that they work in and the barriers to their ethical involvement, to name but a few, would have all made interesting research topics in their own right. In nursing ethics education, the stories from data of eight experienced registered nurses would still hold much interest as a research study. However, the scope in nursing ethics research is vast, and this study can only represent a fraction of that vastness.

It could also be argued that the stories told by the participants refer sometimes to events or situations that were once the case, but now had changed. In this observation, there is some truth, but the past and present and even the future aspirations of the participants were not always presented in neat chunks of time. They were presented in some instances as if the events were yesterday. In this may be seen the reality of these events for nurses even to the present day.

Finally, it is likely that, no matter how much any researcher claims to 'stand aside' from his or her research to view data impartially, there is always an element of the researcher within. For this, I make no apology, because it is inevitable that my interest and involvement in the ethical practice of nurses is but another aspect of simply *being a*

nurse. If the maintenance of a nursing ethic means anything, it means that *all* morally committed nurses wish to share and debate an ethical view of their professional practice with their peers.

CONCLUDING STATEMENTS

This study used the methodology of grounded theory to explore the phenomenon of moral decision making amongst eight experienced registered nurses. This provided the means whereby the antecedents and methods of nursing moral decision making could be not only described but also synthesised within the greater conceptual framework of ethical nursing practice. This conceptual framework provided the structure upon which a conceptual model could be presented of the complex process of effective, ineffective and personally risky nursing moral decision making. Following data analysis, the core variable, *maintaining a nursing ethic*, emerged as the central category within the conceptual model that influenced and guided eight experienced registered nurses in this process.

This study has shown that individuals enter the socio-political health care context with an already established hierarchy of personal moral values that are ethically focused and refined during an extensive period of professional nursing development. Various contextual barriers or obstacles influence nurses as they attempt to practice according to their moral cognition of the meaning of ethical nursing. In this attempt, nurses refocus their moral values upon the nurse-patient relationship within specific contexts. The presence and guidance of a nursing ethic provides the means whereby nurses may make effective moral decisions in practice. Each nurse must choose which moral decision will be the most effective for her patient, but in this choosing, the influences of the health care context, her own moral values and the overriding responsibility of providing professional care cannot be ignored. Therefore morally competent and experienced nurses strive to be not only ethical but expert nurse practitioners.

Nursing faces many challenges in the future, but perhaps none so challenging as the maintenance of a nursing ethic within an rapidly changing health care context. If this study has any moral value at all, then it is hoped that it is in its validation of the meaning and practice of good nursing.

APPENDICES



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**FACULTY OF
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APPENDIX TWO

RESEARCH INTO MORAL DECISION MAKING IN NURSING PRACTICE

INFORMATION SHEET

Thank you for your interest in the proposed research project which will examine the ways in which nurses make moral decisions in practice settings. The study will involve separate interviews with up to ten experienced nurses about their experiences in clinical practice that involved them in ethical decision making.

Typical questions that you may be asked will include:

“Do you recall any incidents from your practice that, in your mind, had a significant moral content?”

“Would you please describe your involvement in these incidents?”

“How did you decide which course of action would be ethically appropriate in your response to these incidents?”

If selected, you will be invited to ask any further questions you may have about your input in the project, and to sign a Consent Form if you then wish to proceed.

A series of interviews with the researcher, each one between 1 and 2 hours in duration will then be arranged. Each interview will be audiotaped, with your permission, to allow transcription of the data at a later time. It is expected that up to 3, possibly 4, such interviews on different occasions between June and July 1996, will be necessary for the gathering of the necessary data for the research.

The research data gathered from you will be treated with confidentiality. Your name or other identifiable material will not be available to anyone other than the researcher and the transcriber of the tapes. The transcriber of the cassette tapes will sign a separate confidentiality agreement before commencing. Every effort will be made by the researcher to maintain your anonymity throughout the research project. Each participant will be referred to only by a pseudonym or a number.

Please see next page...

If you decide to take part in this research, then you are reminded that;

- a) You have the right to decline to take part or to withdraw from the research at any time.
- b) You have the right at any time during your participation
 - to ask any questions about the research
 - to refuse to answer any question
 - to ask that the cassette recorder be turned off
 - to examine any notes taken
 - to read any subsequent transcriptions
 - to terminate the meeting at any time
 - to be informed of the results (on completion of the research).
- c) The proposed research has no connection whatsoever with your role as a student of the Nursing and Midwifery Studies Department.
- d) The proposed research may be of benefit to you, in that it might assist you to reflect on your ethical practice; *or* it may possibly cause you some mental distress if these reflections are of a disturbing ethical nature. If the latter does occur, then measures will be suggested to help you to cope with this distress. **Under no circumstances** will your researcher ignore your request for help. If you require support in this regard it will be given, or sought on your behalf with your permission.
- e) Any cassette tapes, notes or other material relating to you will be stored for the duration of the research in a secure place. On completion of the research, the cassette tapes will be returned to you, or, if you desire, will be destroyed. All other materials used in data gathering, such as transcripts or notes, will be stored in a safe place and either returned to you or destroyed following the usual requirements of research protocol.
- f) A summary of the research will be made available to you at the end of the study.

Please see next page...

g) A thesis will be prepared from the completed research, and this may be followed by academic papers, journal articles and conference material based upon this research.

If you wish to consider taking part in this research, or would like to hear more about it, please contact me, preferably by phone;

Martin Woods
The Department of Nursing and Midwifery
Massey University
Private Bag
Palmerston North
Tel. (06) 3504325

You may also, at any suitable time and for any appropriate reason regarding this research, contact either of the following supervisors;

- Dr. Jo-Ann Walton Department of Nursing and Midwifery
Tel. (06) 3504326
- Dr. Andrew Brien Department of Philosophy
Tel. (06) 3569099, ext. 8835

Thank you for your interest in this project and for taking the time to read this information.



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APPENDIX THREE

CONSENT FORM

I have read the Information Sheet and had the details of the study explained to me. My questions have been answered to my satisfaction, and I am aware that I may ask further questions at any time.

I am also aware that I have the right at any time to withdraw from the study and/or to decline to answer any particular questions.

I agree to provide information to the researcher on the understanding that my name will not be used within the research, and that the researcher will undertake to take adequate precautions in regard to anonymity when using direct quotations or commentaries within the thesis. These precautions will also be extended to any other named persons or institutes.

I am aware that any disclosure of information that relates to an illegal act of a serious nature may, under certain circumstances, be subject to the due process of the law.

I agree/do not agree to the interviews being audio taped.

I also understand that I have the right to ask for the recorder to be turned off at any time during the interview.

I agree to participate in this study under the conditions set out in the information sheet.

Signed

Name

Date



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APPENDIX FOUR

CONFIDENTIALITY AGREEMENT

I,

have accepted the task of word processing the research data collected by Martin Woods in order to complete an M.A. (Nursing) at Massey University.

I understand that the data gathered for this research is confidential, and agree to take all necessary steps to ensure that any material on cassette tapes¹ or computer disk² containing data from interviews relating to the research will be:

- a) Heard only by me, and transcribed to disk in private¹
- b) Stored safely until return to the researcher^{1,2}
- c) Treated as confidential in all respects.

Signed

.....

Witnessed

.....

Date

.....

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