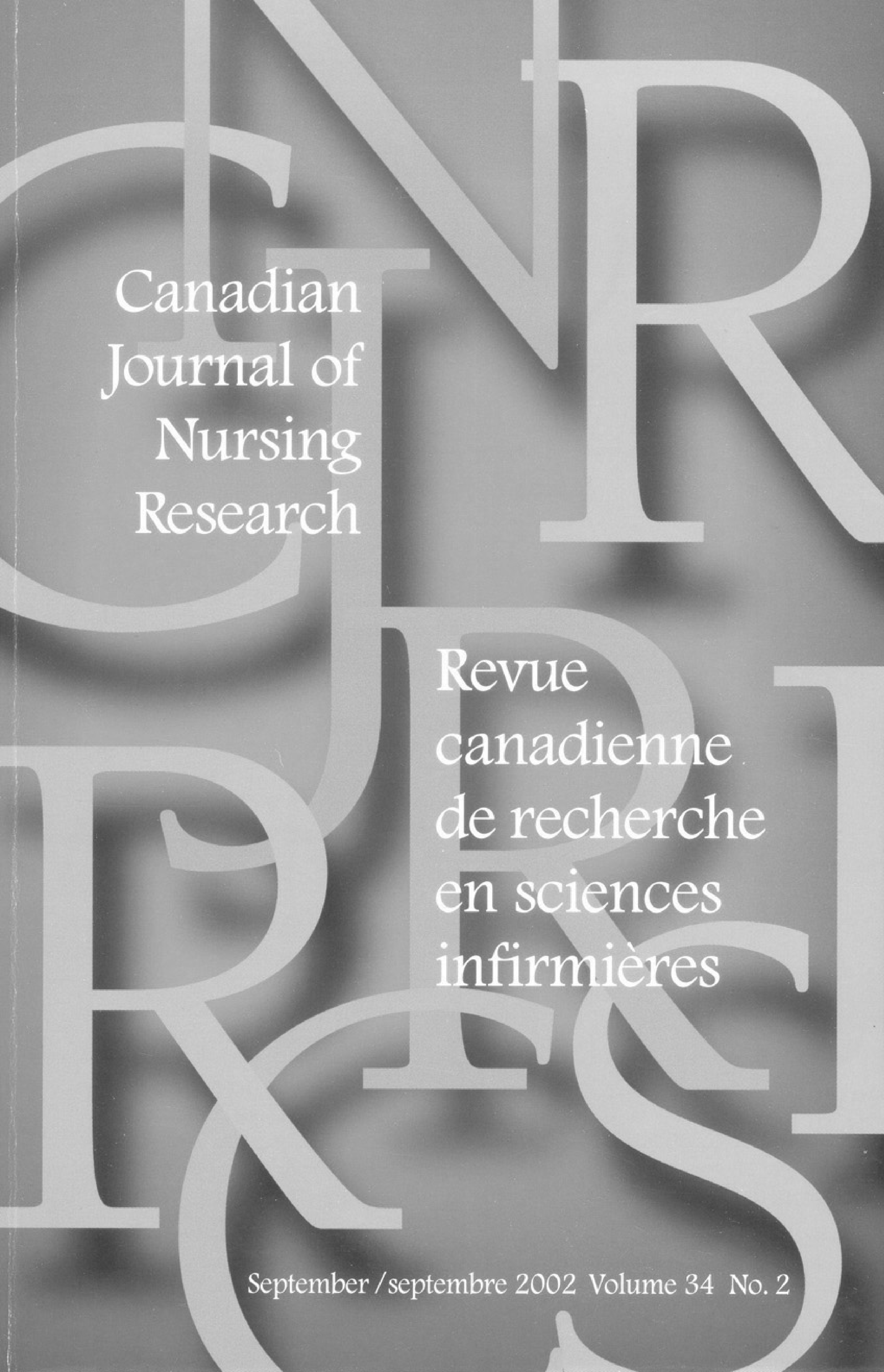

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EDITORIAL

Altering the *CJNR* Publishing Schedule

In this mailing you will have received two issues of *CJNR*. You might be wondering why this is so. There are three possibilities from which to choose: (a) Christmas has come early. (b) We have lost our mind — or lost track of time and didn't know which issue we were publishing. (c) We are altering our publishing schedule. If you chose (a), you are an optimist and love to get gifts. If you chose (b), I can assure you that this is not the case. Thus, we are left with (c), the correct answer.

Since assuming the editorship of *CJNR* 10 years ago, I have always been confused by our publishing schedule, with each new volume of the Journal beginning in June. To add to the confusion, we used to call this our Winter issue — while basking in 80-degree temperatures. Talk about a disconnect! We then stopped referring to issues by season and began to label them by month instead. However, we have continued to bring out the first issue of each volume in June. This has been our practice for 33 years.

During the past year we have been preparing to launch an electronic version of *CJNR* (we will continue to publish a print version). In planning for this milestone we have been looking at all aspects of the Journal. The editorial board has been committed to following the standard practice among quarterly journals of publishing an entire volume, numbers 1–4, within the same calendar year. However, the execution of this change in schedule presented some real challenges.

We had two choices: to reduce the number of issues (four) per volume, or to publish four issues within a relatively short period of time. The former could not be entertained as a serious option because it would send librarians and loyal subscribers off on a frenzied search for the missing issue. Our only option was to publish four issues within a space of 6 months rather than over 12 months. As we were considering how best to implement this decision, I was reviewing with Dr. Carnevale, the guest editor for Ethics, Values, and Decision-Making, the many excellent submissions we had received. Eureka! The answer became apparent: we would divide the focus issue into two — Ethics and Values *and* Decision-Making. (In December we will publish a special issue, number 4, featuring completed student research projects.)

So, in fact, those of you who chose (a) are also correct. Christmas has indeed come early. And those who chose (b) are correct as well. Bringing out two issues simultaneously could cause an editor to lose her mind. But thanks to the incredible stewardship of Joanna Toti, our managing editor, the staff have pulled it off with their usual professional aplomb.

Laurie N. Gottlieb
Editor

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GUEST EDITORIAL

Betwixt and Between: Searching for Nursing's Moral Foundations

Franco A. Carnevale

"Betwixt and between" is a term derived from van Gennep's (1960) transformative phase of a rite of passage.[1] This period is characterized by a significant unearthing of prior ways of understanding the world, giving rise to deep confusion and contemplation. For van Gennep, this is a necessary antecedent for what follows — the formation of a renewed coherent identity.

The ethical foundations of nursing are attracting a growing amount of attention in the literature, yet we are far from arriving at a widely agreed upon conceptualization of this moral domain. It has been tempting and most likely helpful to rely on developments in the field of bioethics (a distinctive discipline devoted to examining clinical and research ethical problems in biomedicine) to help shape what might be referred to as "nursing ethics." Bioethics has indeed enabled the development of decisional frameworks and principles that have facilitated the management of complex issues in reproductive health, end-of-life care, allocation of scarce resources, and mental health, among other areas. However, it could be argued that these have been predominantly physician-centred concerns — that is, that the types of problems and corresponding "solutions" have been framed in terms of medical discourse, attending to significant concerns encountered primarily by physicians. How suitable are these for nursing? Is there a place for a nursing-specific ethical outlook — a distinctive "nursing ethics"? Can it be argued that nursing ethics is in a "betwixt and between" state — trying to break away from the dominant bioethical model, striving to develop its own ethical identity?[2]

The papers presented in this Ethics and Values theme issue make an important contribution to this philosophical reflection. Hadjistavropoulos et al., in their linguistic analysis of codes of ethics, identify important distinctions in the formulation of the Canadian nursing and medical codes. Weiss et al. and Gaudine and Beaton highlight particular binds that nurses (direct caregivers as well as managers) encounter, wherein institutional goals conflict with fundamental nursing values. Peter and Watt-Watson argue (implicitly) that the prevailing "objectivist" language of pain management silences the subjective experiences of particular patient populations — calling for a more trustful stance towards such patients. Simpson turns to feminist care ethics for more adequate fulfilment of the nursing duty to foster hope. Hawthorne and Yurkovich broadly challenge nursing's position in relation to science, arguing that nursing is centred on the patient-nurse relationship, which necessarily implies oneness, closeness, and connectedness, in contrast with the differentiation, distance, and detachment required by the scientific paradigm. Carnevale calls for an authentic recognition of qualitative research in nursing that is grounded in the interventional commitments of nursing. Bergum proposes a relational conception of the ethical space within which nurses practise. These papers support the merits of considering the articulation of a discipline-specific nursing ethics in particular, and the recognition of a distinctive nursing epistemology in general — that is, a discussion of the ethical foundations of nursing can be related to an examination of the broader foundational values that define the discipline as a whole.

This discussion of a potentially distinct nursing ethics can be related to a significant debate that emerged within moral psychology. The prevailing psychological models in the early 1980s were centred on autonomy, rationality, and justice as the ultimate ideals of moral development. Carol Gilligan's (1982) research among girls and women argued that these models were based on male-centred empirical research that was generalized to women. In other words, the characteristic moral ideals identified among *men* were presumed universalizable as frameworks for *human* development. Gilligan proposed an alternative moral framework for women (which has become increasingly recognized as valid for men as well) wherein moral development strives towards relational interdependence (rather than independent autonomy) and is characterized by care and responsibility. Gilligan's work challenged fundamental values as well as the process of "reasoning" that underlies moral life.

Similarly, it seems plausible that an ethical framework could be elaborated for nursing, one that is particularly congruent with the "moral substance" of the discipline (distinct from the prevailing bioethical models).[3] How should such a framework be developed? Given the limits of our understanding of the moral lives of nurses, it appears necessary to promote empirical research that aims to identify the significant ethical issues that are encountered by nurses. Several papers in this issue provide excellent exemplars of such research. Indeed it seems particularly pertinent that a substantial proportion of such research should be qualitative, in an attempt to ensure a rich foundational understanding of nursing ethics from a "lived experience" perspective.

However, although empirical research is *necessary* for fostering an understanding of nursing ethics, it is not *sufficient*. For example, if a study demonstrated that a majority of nurses favoured euthanasia, such data would not determine that such a practice is therefore morally acceptable. The discernment of that which is ethically "good or bad" requires a normative analysis. That is, drawing on existing empirical evidence as well as ethical principles and norms that have been persuasively articulated (in nursing as well as more broadly in bioethics and moral philosophy), a philosophical comparative analysis should be conducted of all defensible ethical viewpoints, the aim being to identify which of these can be most effectively argued. Subsequent empirical research could, in turn, examine the lived experience (e.g., moral distress or gratification) of nurses and patients/clients in light of these favoured ethical viewpoints. I am proposing a circular dialogue between empirical research and normative analysis as a methodological structure for articulating a framework for nursing ethics.

The collection of papers in this issue help advance this initiative by presenting (a) empirical studies of lived moral experiences, (b) normative analyses of the values that ought to underlie the ethical foundations of nursing (as well as nursing epistemology in general), and (c) a systematic analysis of a normative articulation of nursing ethics (a code of ethics).

Such an endeavour may "unhinge" our prevailing conceptions of ethics for nursing — driving the discipline into what some may regard as a betwixt and between period of profound uncertainty. However, van Gennep's study of rites of passage suggests that such a transitional period is a necessary condition for the development of a substantively reformulated identity — in this case, the creation of a distinctive yet cohesive ethics framework for nursing.[4]

Notes

1. In his classic study of rites of passage in the cultural celebrations of numerous societies, van Gennep (1960) refers to this as a transitional stage of liminality.
2. A preliminary outcome of such an initiative is a favouring of *care* or *relationality* as a primordial moral value for nursing. Indeed, some work suggests

that the pertinence of these can be extended across all of the health disciplines (Schultz & Carnevale, 1996).

3. This would of course not exclude the potential for significant areas of convergence between bioethics and nursing.
4. In turn, this could illuminate ethical reflection in other disciplines, as Gilligan's work among women fostered a rethinking of moral development in men as well as women.

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Franco A. Carnevale, RN, PhD, is Associate Professor, School of Nursing and Faculty of Medicine (Pediatrics), Adjunct Professor, Counselling Psychology, and Affiliate Member, Biomedical Ethics Unit, McGill University, Montreal, Quebec, Canada, and Head Nurse, Pediatric Intensive Care Unit, Montreal Children's Hospital.

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Discourse

Ethical Challenges of the 21st Century: Attending to Relations

Vangie Bergum

A woman had a dream. In this dream she dreamt that Life stood before her and in her hands Life held two gifts — in the one Love, in the other Freedom. Life asked the woman to choose. After a long deliberation, the woman finally chose Freedom. "And Life said, 'Thou hast well chosen. If you hadst said, 'Love', I would have given thee that thou didst ask for; and I would have gone from thee, and returned to thee no more." But "now, the day will come when I shall return. In that day I shall bear both gifts in one hand" (Schreiner, 1890, pp. 99–100). Does Schreiner mean that with Freedom as the choice, Love is possible as well, while with Love only, there is a danger of losing Freedom? I am intrigued with such a proposal and tend to think that in health-care and nursing ethics, as in Life, we need both of Life's gifts. We need both freedom and love. We need the individual freedom to make decisions and choices for ourselves, and we need love and compassion for others within a community.

Since the beginning of the 20th century when Schreiner wrote about this woman's dream we, as a society, have focused on freedom — individual autonomy, human rights, and the liberal philosophy that individuals can have anything they want — it is up to each person to be a success in life. Now, as we begin the 21st century, our challenge is to integrate our belief in individual freedom (autonomy) with a strong and deliberate commitment to our connections and love for one another (community). Freedom without the temperance of love has the danger of loss of freedom, and love (for self, ideology, God) without the container of freedom has the danger of intolerance of those who are different — different beliefs, different culture, different language, and different expertise. In this discourse I invite us to equally value freedom for

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Vangie Bergum, RN, PhD, is Professor, John Dossetor Health Ethics Centre and Faculty of Nursing, University of Alberta, Edmonton, Canada.

individual choices and love and understanding for the difference we find in ourselves and in others. These are the gifts of Life in its wholeness.

Discourse is the perfect opportunity to continue to hold the tension between individuality (freedom) and community (love). The word discourse comes from the Latin *discursus,* conversation, or "a running back and forth," a place of movement (Morris, 1978, p. 276). In this discourse let us move back and forth between individuality and community — without getting stuck in one or the other. In this ethical space, dialogue and conversation can continue to hold that movement, in spite of our differences, so that we can learn how to live and care for each other more effectively. In our global world we vividly recognize our interdependence, and it is in this world that we can realize our ethical responsibility to hold the relational space where the tension of both individual freedom and community responsibility can be contemplated. In such a space of ethical dialogue there is a melding of the micro and the macro, a melding of ethics for the bedside and ethics for the globe. How can we tend to the needs of our patients and at the same time be aware of the needs of the hungry and the poor in our community? How can we attend to differences in others while learning about the strangeness (and differences) within ourselves (Kristeva, 1991)? "Accepting and recognizing differences is a process fraught with apprehension and anxiety, either working together towards a community-in-difference (where justice and compassion flourish) or a falling apart into islands of opposition (and the spread of rancor and hate)" (Olthuis, 2000, pp. 5, 6).

Relational Ethics

Nurturing the space between us *as an ethical focus* is our task. In nursing we talk about the importance of the relationship with people (patients, clients, colleagues, and families) who are often different from us in culture, language, life experience, or knowledge. In fact, nursing is characterized by its commitment to relationship. Within a relational ethic, we want to give relationship between people primary consideration. We want to acknowledge and give attention to the space between us. Let me take the rather simple hyphen, the hyphen that connects the nurse and the patient as in nurse-patient relationship. When we focus our attention on the relation itself, it might be more useful to move away from the short horizontal line of the hyphen (nurse-patient) and create two vertical lines (nurse| |patient) to give renewed attention to this space. The vertical lines provide a space that stirs us to contemplate the interconnection of human life. Note that the vertical lines (nurse | .. | patient relationship) give more attention to the individuality and separateness of each person in the relationship.

We call this space the *relational space* or ethical space that is described by ethical themes such as mutual respect, engagement, embodiment, uncertainty and possibility, freedom and choice, and environment (Bergum & Dossetor, in press). Consider the thematic notion of mutual respect. How might the notion of mutual respect be developed within this relational space? We propose that mutual respect can be expressed only in a space or moment that gives equal attention to the needs, wishes, expertise, or experience of both parties to the relationship. Mutuality, as such, is not something that can be applied by the nurse to the relationship. Rather, mutuality and mutual respect develop between nurse and patient — in that back-and-forth movement of relational space.

If our ethical interest lies in the quality of our relationships rather than in the quality of our minds or bodies, then intersubjectivity or interconnectedness needs to be a primary focus of attention (Taylor, 1993). This ethic of relationship bridges the duality of the traditional Kantian ethic of justice and equality and the care ethic of compassion (Jeffko, 1999). In 1943 Gabriel Marcel wrote about the need for moral renewal and called for "centres of example," which could be "nuclei of life around which the lacerated tissues of true moral existence can be reconstituted" (Marcel, 1978, p. 164). Let us look for current examples of our moral commitment to learn how to live together in spite of diversities and differences.

Centres of Example

We discuss three centres of example that search for change through a focus on the quality of relationships between and among individuals, families, and communities.

Individuals

We begin with a story of a dying patient (D. Pullman, personal communication, December 24, 1998): "During the last [18] months of my mother-in-law's life, my wife spent much of her time caring for her. Finally, near the end, we decided to put her into the hospital and found a bed on a palliative care ward. Once again my wife was introduced to yet another professional and prepared herself to tell the whole sad story of her mother's illness in all its gory detail as she had been forced to do so many times to so many different caregivers over those 18 months. But this time there was a difference. The professional who sat down with my wife said, 'Tell me about your mother. Don't tell me about her illness. Tell me about her as a person. What kind of a woman was she? What did she do in her life? What were her joys and sorrows?'" While this story describes just a moment in health-care practice, such a moment can be enlivening or defeating. Little moments (just one conversation) can make a difference to the dying person's life and death. Nurses know the need to understand the person as a person, not only as a disease, or symptom, or condition. Nurses know that a dying woman is still a person who wants to live her life as fully as she can.

Families

James Olthuis (2000) describes research that points to a need to rethink the philosophy of the family. Through individual interviews and group discussion with street youths, researchers listed listening, understanding, and assurance of worth as the top three unmet needs of youths within their families. The youths lived on the street "because they had not been welcomed, recognized, embraced, blessed, or shown mercy" within their families (p. 128). This research challenges standard theories in which families are discussed in terms of function, role, or type and proposes that what is really at stake is the presence or absence of intimate connecting. Speaking about families in terms of functional effectiveness (that is, as dysfunctional) dehumanizes the reality of the pain, darkness, and suffering they experience. "Being cared for within the family, we experience belonging, trust, empowerment, connection — and learn to be at ease in the world. It is in the family that compassion begins to root in our souls" (p. 135). Healing and recovery occur not in isolation but in relationships, where compassion rather than judgement is needed. Do we not dismiss families too easily with the word "dysfunctional"? How can we see dysfunction as a condition of all families and not a category for just some? Most families, I suggest, need the back-and-forth movement between good functioning and dysfunctioning. It takes conversation. It takes attention.

Communities

As we begin the 21st century we find ourselves in a world of great disparities (great wealth and great poverty) and clashes between cultures, ideologies, and religions. The violence and killing are escalating in many parts of our world. A small "intentional" community, Neve Shalom/Wahat al Salam (NSWAS – http://nswas.com), situated equidistant from Jerusalem and Tel Aviv-Jaffa, is another example of how to light the fires of change. This cooperative village of Jews and Palestinian Arabs of Israeli citizenship, begun in the early 1970s, demonstrates the possibility of coexistence between two divergent and historically hostile groups. The "intention" of this community is mutual acceptance, respect, and cooperation. A number of activities (Village School for children, School for Peace for youths, House of Silence for spiritual reflection for people of all creeds and cultures) are informed by a vision of a humane, egalitarian, and just society that can evolve out of interaction with each other. Although the NSWAS, or Oasis for Peace, is a small community — just a moment in the bigger world — its vision has the potential to spread. In 2002 NSWAS was one of two recipients of an annual award presented by UNICEF, whose aim is to produce a better future for children.

In these examples, the intention is to build understanding, not judgement, in order to hold both of Life's gifts — understanding what it is like to be the person in their wholeness who is dying, is homeless, or even is violent. The intention is to create opportunities for understanding who we are, as well as the sharing of ideas, hearing different points of view, valuing all points of view as worthy of attention. These opportunities for understanding can lead to greater responsibility for all. These examples point to the moral commitment of nursing to understand the lived life of the person we care for, which, of course, includes knowledge of symptoms or circumstances, disease processes or cultural disparities, as well as the meaning of the experience for them (Bergum, 1994): "Tell me about your mother. *Who* is she?" In the book *Before Ethics*, Peperzak (1989), in pointing to relations with wanderers and strangers, suggests that the simple "hello" is enough to initiate a morally important event. Cameron (1992), too, shows how the question *How are you?* has moral significance: "When a nurse turns a 'How are you?' into an ultimate gesture of being present for someone, she lives the essence of caring for someone" (p. 184) — the essence of ethical discourse. We need to take the time and effort to together create opportunities to understand experience by asking questions *(What is it like for you? What are you going through?)* in order to bridge gulfs that can occur between us. The nursing *How are you?* can be an ethical question as well as a common greeting.

A relational ethic is a community ethic rather than an individualistic one. Jeffko (1999) states that the principle of community is one in which people are treated as subjects ("who" one is, as a whole person) and not only as objects ("what" one is, as a symptom or condition). "Since the field of morality is the field of interpersonal actions and relations, the principle of community refers to the good and well being…of each and every person, in both their relational and individual aspects" (p. 21). The relational aspects have to do with understanding and caring for each other (love), and the individual aspects have to do with understanding and caring for the self (freedom). Jeffko also reminds us that "since the self is as much a person as another, how one treats oneself has moral significance" (p. 22) — a particularly pertinent reminder to nurses and other health professionals. Because the nature of our communal life is one in which differences are wide and deep, the principle of community challenges us, as nurses, to relate to each other in mutual respect, to suffer with others, to exercise power with (as opposed to over) others — to be together in diversity and difference, in spite of adversity (Olthuis, 2000).

Conclusion

Nursing is a leader in relationships, and if we can think of relationship as our ethical responsibility, relationship will be given as much attention as other outcomes. Are we not at a time when recognition of our common humanity needs to override the religious differences, ideologies, and history that keep us apart? "The greatest challenge to the world community in this century is to promote harmonious relations between peoples of disparate origins, histories, languages, and religions," says George Erasmus, a Canadian Cree leader, in a newspaper article entitled "Why can't we talk?" (Erasmus, 2002). *Discourse* is the place for talking. I offer this contribution to the discourse (the talking together) that needs to happen in order for us to move towards lofty goals of good relations and peace between peoples throughout the world.

I invite readers to engage in discussion about what a relational ethic might look like within specific nursing practices. How can a principle of community (treating each other in our wholeness) be explicitly related to nursing? Can this kind of approach to nursing ethics be at all meaningful or useful?

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Employed to Go Against One's Values: Nurse Managers' Accounts of Ethical Conflict With Their Organizations

Alice P. Gaudine and Marilyn R. Beaton

Cette étude qualitative descriptive se penche sur la question des conflits déontologiques en milieu de travail, tels que vécus par des infirmières gestionnaires. Quinze de ces professionnelles œuvrant dans sept hôpitaux d'une province de l'Est du Canada ont été interviewées dans le cadre d'entrevues semi-structurées. Les données recueillies sur les conflits déontologiques ont permis de dégager quatre thèmes : l'impossibilité de participer aux décisions, les désaccords quant aux priorités budgétaires, les droits des individus par opposition aux besoins de l'organisation, et les pratiques injustes exercées par la haute direction et / ou l'institution. Les auteures identifient les facteurs qui atténuent ou exacerbent les conflits déontologiques et présentent les dénouements du point de vue des infirmières gestionnaires. Elles discutent aussi des conséquences pour les infirmières, les hôpitaux et la recherche à venir.

This qualitative descriptive study examined ethical conflict in the workplace as experienced by nurse managers. Using semi-structured interviews, 15 nurse managers employed by 7 hospitals in 1 province in eastern Canada were interviewed. Four themes of ethical conflict were identified in the data: voicelessness, "where to spend the money," the rights of the individual versus the needs of the organization, and unjust practices on the part of senior administration and/or the organization. The authors identify factors that mitigated or worsened the ethical conflict, as well as the outcomes for the nurse managers. They also discuss the implications for nurses, hospitals, and future research.

An individual's personal values, often held passionately, are an integral part of one's self-concept (Rokeach, 1973; Uustal, 1978). They provide the framework for one's view of the world and one's place in it, and for distinguishing right from wrong (Rokeach, 1968).

Personal values may conflict with the values of professional associations and employing organizations. For example, while the nursing profession socializes nurses to provide the care that is best for each patient (Jameton, 1984), nurses may not be able to fulfil this obligation

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Alice P. Gaudine, RN, MScA, PhD, is Associate Professor and Associate Director, Graduate Programs and Research, School of Nursing, Memorial University of Newfoundland, St. John's, Canada. Marilyn R. Beaton, RN, MN, MBA, is Associate Professor, School of Nursing, Memorial University of Newfoundland.

when employed by organizations charged with the distribution of scarce resources.

When an individual's personal values clash with those of the employing organization, the result is ethical conflict. Rest (1994) notes that professionals are especially at risk for ethical conflict because of their dual role, as a member of both an organization and a profession. Ethical conflict can affect individuals, organizations, professions, and society at large. Rodney and Starzomski (1993) suggest that ethical conflict experienced by nurses can lower morale and increase burnout and turnover, while Gaudine and Thorne (2000) suggest that it can affect commitment to the organization or profession and increase absenteeism and turnover.

Studies that have looked at ethical conflict as experienced by nurses have focused on the conflicts that stem from clinical decision-making (e.g., Butz, Redman, & Fry, 1998; Redman, 1996; Redman, Hill, & Fry, 1997, 1998; Rodney, 1998; von Post, 1996; Wagner & Ronen, 1996). Very little is known about ethical conflict between nurses and their employing organization or their professional association. However, a recent study (Gaudine & Thorne, 2000) described the ethical conflicts of 12 direct-care hospital nurses with their employing organizations and professional associations. It found three themes of nurses' ethical conflict with their employing organization: compromised safety and/or quality of patient care due to heavy workloads, lack of value for human resources on the part of management, and ineffective or inappropriate actions on the part of the organization. The authors note that most of the value differential between nurses and organizations represented ongoing situations, wherein nurses perceived they had little power to resolve the conflict. In addition, the study identified three ways in which professional associations represented ethical conflict for nurses: lack of visibility, distance from the realities of direct-care nursing, and lack of support for nurses.

While Gaudine and Thorne (2000) describe the ethical conflicts between direct-care hospital nurses and their organizations, the issue of ethical conflict between hospital nurse managers and their organizations has not been explored. Nurse managers are socialized as nurses but speak on behalf of their organization. Recent cost-cutting measures in health care have led many hospitals to make difficult budget-allocation decisions, placing hospital nurse managers at particular risk for ethical conflict with their employing organizations. Knowledge about such experiences is essential if we are to work towards the resolution of ethical conflicts and towards the mitigation of negative outcomes for nurse managers, their organizations, and the nursing profession.

The current study adds to our knowledge by describing nurse managers' ethical conflicts and value differences with their employing organization and their nursing associations. Its main objectives are: to provide rich descriptions, themes, and patterns of ethical conflict between nurse managers and hospitals; to describe factors that mitigate or worsen this ethical conflict; to identify outcomes associated with this ethical conflict; and to describe ethical conflict between hospital nurse managers and their nursing associations.

Methodology

Design

This was a qualitative, descriptive study based on the belief that events and feelings are best described by the person who has experienced them. In addition, the study used a grounded theory approach (Glaser & Strauss, 1967) to data collection, in that analysis was ongoing throughout data collection as recommended by Merriam (1988) and emerging themes helped to guide subsequent interviews.

Sample

A convenience sample of 15 nurse managers in an eastern Canadian province was recruited with the help of two senior nurse administrators and two nursing professors. The nurse managers were asked if they were willing to be interviewed on the topic of ethical conflict with organizations. (In addition to the 15 nurse managers in the sample, two other nurses were approached: one did not wish to be interviewed and one agreed to be interviewed but later became too busy to schedule a meeting with a researcher.)

Three of the 15 participants were employed at two different centres that had recently been merged under one hospital administration. The remaining 12 worked for six different organizations. Three participants were the senior nurse administrator in their hospital (henceforth referred to as "senior nurse managers"). The other 12 were responsible for two or more departments, including intensive care, emergency, obstetrics, pediatrics, rehabilitation, long-term care, peri-operative and operative nursing, and medical and surgical nursing. All but one of the participants were female. One participant was between the ages of 30 and 39, 12 were between 40 and 49, and two were between 50 and 59.

Two participants had 5 years or less of management experience, two had between 6 and 10 years, seven had between 11 and 20 years, and four had between 21 and 30 years. Ten participants had a diploma, three had a bachelor's degree, and two had a master's degree. Four of the participants with a diploma were enrolled in bachelor's studies, and two of these also had a diploma in departmental management. One other participant with a diploma also had a diploma in departmental management. One of the participants with a bachelor's degree was enrolled in master's studies.

Two nurse researchers, the authors of this paper, each conducted approximately half of the interviews. The meetings with potential participants began with the nurse researcher describing the purpose of the study and the role of the participant. Due to the sensitive and confidential nature of the interview data, potential participants were informed that the data would be collected from a number of different organizations throughout the province in an effort to preserve anonymity. The potential participants were informed that the interviews would be audiotaped and transcribed by a secretary and that they would be mailed a copy of the transcript along with a summary of their interview, to allow them an opportunity to identify material that should be disguised or removed and to verify accuracy. All of the nurse managers who listened to this detailed description of the study agreed to participate. They signed the consent form and provided demographic information.

The interviews lasted approximately 60 to 90 minutes and took place in a private room at the participant's workplace. The study used a semi-structured interview methodology. The participants were asked if they had any ethical conflict with their organization or with their provincial or national professional associations. An ethical conflict was defined as a situation wherein the nurse manager's values differed from those of the organization and the nurse manager experienced conflict as a result. All of the participants were readily able to describe at least one current situation of ethical conflict and to identify their own values and those of the organization. For each ethical conflict identified, the participant was asked to describe factors that eased the ethical conflict, factors that worsened the ethical conflict, and personal outcomes resulting from the ethical conflict. These questions were included in the semi-structured interview guide in an effort to elicit a full description of each nurse manager's experiences of ethical conflict.

After each of the first six interviews, the two researchers met to review the transcript in depth, in order to make a preliminary identification of codings and to identify any potentially important areas for exploration in subsequent interviews. They also reviewed their interviewing techniques with respect to facilitating participants' comfort in sharing sensitive material and with respect to avoiding bias in the experiences participants chose to share. After each of the remaining nine interviews, the researchers held brief meetings to share any areas for exploration in subsequent interviews.

Analysis

The interviews were transcribed verbatim. In order to verify the data, each nurse manager was mailed a transcript as well as a summary of his or her interview. Several weeks later the researchers phoned the nurse managers, all of whom were in agreement with the summary.

In first-level coding, the transcripts were reviewed for material related to the five areas covered in the semi-structured interview guide: ethical conflict with the employing organization, ethical conflict with the professional association, factors that mitigated or resolved ethical conflict, factors that worsened ethical conflict, and outcomes for the nurse manager. In second-level coding of ethical conflict situations, themes or categories were identified from the first-level coding. Finally, the data were explored for patterns of ethical conflict.

This study used step-wise replication (Guba & Lincoln, 1985), in which the researchers separately analyze the data, then cross-check each other's categories, themes, and interpretations. The transcripts were first analyzed separately by each of the two nurse researchers. The researchers became immersed in the data by reading and rereading the transcripts. Separately they developed codings for each of the five areas. The two researchers compared their codings and sought agreement on themes and patterns. Differences in the two analyses were minimal and were readily resolved through discussion.

Results

Four themes of ethical conflict between nurse managers and their organizations were identified: voicelessness, "where to spend the money," the rights of the individual versus the needs of the organization, and unjust practices on the part of senior administration and/or the organization (see Table 1). The theme of voicelessness was identified in every interview, suggesting conflict with the participants' value of collaboration. Many of the participants felt that their organization wanted them to be invisible and made an effort to recruit nurse managers who would

Table 1 *Nurse Managers' Ethical Conflicts With Hospitals*

Voicelessness

- nurse managers hired because they are perceived to "toe the party line"
- nurse managers not present during decision-making on issues that affect nursing
- nurse manager positions radically decreased, resulting in minimal nursing input
- nursing not valued
- nursing not understood
- no effort made to understand nursing

"Where to spend the money"

- spending on acute care instead of long-term care; failure to invest in staff development; focus on short-term issues instead of quality of nurses' work life
- sacrificing of quality (e.g., substandard patient care; patient/family rights secondary to balanced budget)
- crisis management instead of long-term budgetary planning

Rights of the individual versus needs of the organization

- policies that support the hospital's legal needs as opposed to patients' and nurses' needs as perceived by nurse manager
- nurse manager forced to make decisions that serve the needs of the organization but have negative implications for nurses

Unjust practices on the part of senior administration and/or the organization

- unfair policies for the promotion and termination of nurse managers
- unfair workloads for direct-care nurses and nurse managers
- failure to act even when senior administration is aware of a problem
- centralized versus decentralized decision-making
- non-nurses given priority over nurses for first-line supervisory positions
- punitive absenteeism policy
- punitive medication-error policy
- underpaying of nurse managers
- hospital's stated values (e.g., integrity; consultation) not upheld by administration and board
- lack of interest and lack of information on the part of board of directors

"toe the party line." The majority of the participants felt that they were not always included in decisions that involved nursing, and that neither they nor nursing were understood by administrators. Further, several participants believed that administrators did not want to understand nurses and did not intend to act on nurses' needs. A major outcome of this theme was that the nurses felt devalued and powerless.

The following excerpts illustrate the voicelessness theme and the sense of powerlessness experienced by the nurse managers:

> *There doesn't seem to be knowledge with regards to why we need nursing, why we need to have a good float pool, why we need to have permanent staff versus casual staff, that kind of thing. And there never seems to be a will, either, for them to understand it. The bottom line is always the dollar and the cents and I keep going back saying, "Well, you know, this is a business, but it's a health-care business, and when you forget that you have forgotten why we're here." And of course everybody looks at me like I'm from another planet... In senior administration, yes, I really don't think that they want to get it.*
>
> *I was a senior manager but was not included in the decision-making because they knew that I would not support that decision... When I became aware of [a particular decision], that is when I started asking questions. I was told at that time, in words that I can remember, "I don't want to hear any more about it. This is the way it is going to be."*

This senior nurse manager was actually disregarded through a lack of dialogue, and she felt she had to speak out about this decision. She and the nurse managers who reported to her made presentations to senior administrators:

> *Right after that I found myself in significant difficulty and [my assistant] and myself were both terminated from our positions. Now, I was terminated and not given any reason. In the letter they said that it was due to restructuring.*

This senior nurse manager reported that consequently the remaining nurse managers seldom shared information with hospital administrators or board members.

The second theme of ethical conflict, "where to spend the money," was identified in all of the interviews. This theme reflects differences in mission: for the nurse managers, meeting the needs of each patient, family, and staff member; for the hospital, staying on budget and maintaining services. All participants were distressed when they saw unmet patient or family needs and difficulty in recruiting and retaining nurses. This distress was aggravated when their attempts to have senior administration understand a situation proved unsuccessful.

A senior nurse manager responsible for acute and long-term care in a hospital said:

> *If it's an acute-care issue, okay, we have to call an ambulance to bring someone to [referral hospital], or we have to call extra staff because we have a motor vehicle accident. Well, it seems like people can understand the acute side, but heaven forbid that long-term care should have a reason to need extra staff.*

The three nurse managers who had responsibility for both acute and chronic care shared the view that hospitals valued acute care more than chronic care.

The theme of "where to spend the money" is also illustrated by the fact that a number of participants noted the frequency of budget cuts in staff development. The nurse manager of a specialty unit explained:

> *In order for me to keep critical care and all the changes in [specialty unit] front and centre, I do need an instructor. Then again, they only have a limited [amount of money] to give out and that is not high on the priority list.*

Similar to "where to spend the money," the theme "the rights of the individual versus the needs of the organization" reflects the nurse managers' valuing of individual rights through their concern for the needs of each patient, family, and staff member. A common outcome in this theme was the participant feeling caught between the needs of the organization and the rights of patients, families, and/or nurses.

One participant described a situation in which a nurse with a suspected substance addiction was transferred to a specialty unit and the nurse manager was not told of the suspected addiction:

> *I think the value of the organization was autonomy for this individual. I mean, nothing had been proven although there had been an awful, awful lot of suspect behaviour... However, I think it put me in jeopardy, and it put my patient care in jeopardy. Unfortunately, we had incidents...where drugs were stolen.*

This nurse manager also spoke of the conflict between hospital policies and the rights of an aboriginal woman who had assumed responsibility for her sister's child:

> *We had an example where the child came in for [surgical procedure], not a big deal, certainly correctable... We treated the child metabolically with IV and got him...ready for surgery and the surgeon came in to get consent from the parents. That is when the mother said she did not give birth to the child, [the biological mother] gave the child to her because she only had one [child] and [the biological mother] had five. [The biological*

> *mother] was up in [location] on the hunt, so the surgery was delayed for almost a full day... But [the biological mother] had given this child to this other woman. This is their culture and they accept it and to [the biological mother] these other people were the parents... I don't think we have come far enough in appreciating culture; these people are in our own province.*

In referring to the hospital's need for beds, one participant said:

> *Our beds are blocked today because of the patients that we have waiting for beds in long-term care. I don't know if I can say that administration does not appreciate the right of the patient — we have to keep them until they go somewhere. But there is a stipulation in medical discharge so that they pay here in the hospital the same as they would in a long-term facility. Sometimes that would be assumed to be the deterrent for the family to keep them here. But if they do take them home, are they going to take care of them as well as they need to.*

The theme "unjust practices on the part of senior administration and/or the organization" was identified in several of the interviews. The usual outcome was the nurse manager resigning or wanting to resign and feeling frustrated, angry, or concerned for the well-being of the nursing staff.

One nurse manager described a progressive disciplinary policy for medication errors that had been developed by human-resources and nursing consultants:

> *Now, I know people have to be held accountable for their practice and everything else, but we are into a process that a nurse makes one medication error and you have to tell them, "Look, consider this your verbal reprimand." The next one, they get a letter of reprimand, which is on file for 18 months, and if they make another one in the same year they are suspended. I have concerns with that. I do have concerns with safe medications...but I have an ethical dilemma with this whole disciplinary process. It sounds so punitive, and it is punitive.*

One senior nurse manager described the board of directors of a hospital as "not terribly effective":

> *They did not attempt to find out about quality of care, about advocating for patients, and so on. I felt that there were a few board members that would get involved and ask questions and research, but I found for the most part that the board was there for tokens and did not really have the interest of the organization at heart.*

Table 2 summarizes the wide range of factors that worsened the nurse managers' ethical conflicts with hospitals. These factors include having to deal with fallout from actions the nurse manager did not agree with, being constrained in resolving the ethical conflict, situa-

Table 2 *Factors That Worsen Nurse Managers' Ethical Conflicts With Hospitals*

Fallout from decisions the nurse manager did not agree with
- poor or unsafe patient care
- poor treatment of friends/relatives
- increased number of patient complaints about poor nursing care
- downsized nursing management that results in increased costs elsewhere

Inability to resolve ethical conflict
- inability to speak out or to act
- unwillingness of staff nurses to speak out, often due to fear
- inability to make the needs of nursing understood
- knowing that senior management is aware of a problem but will do nothing
- knowing that documenting required changes has been a waste of time

Situational factors
- fear that situation will escalate if nurse manager speaks out
- poor communication with senior administration, either because of organization's size or because the administration does not value nursing management
- persons who refuse to negotiate
- opinions of physicians more valued than those of nurses
- uninformed boards of directors
- salary inequities among nurse managers
- new nurses for whom nursing is just a job
- difficulty in recruiting and retaining nurses
- nurses who complain instead of taking constructive action
- unfair comparisons to other hospitals regarding staffing levels
- knowing that other hospitals have better resources or have eliminated their deficits
- knowing that other hospitals go beyond the contract
- seeing money spent on physician retention
- silence on the part of professional associations and other directors of nursing on an issue they are aware of
- knowing that nurse manager's situation is not unique and that nursing in Canada is in trouble
- smear campaign against a nurse manager

Factors relating to the nurse manager
- inability to identify what is right and what is wrong
- remembering when nursing used to be valued
- needing to have a mentor
- feeling trapped because of number of years in nursing management
- not knowing if one is doing the right thing
- feeling responsibility to improve the situation
- inability to inform staff nurses of one's efforts to resolve issues of concern to nurses

tional factors, and characteristics of the nurse manager. Table 3 summarizes the factors that mitigated nurse managers' ethical conflicts with hospitals. These revolved around support, problem-solving, and refocusing. Table 4 summarizes the outcomes of ethical conflicts for nurse managers personally. These include a wide range of negative feelings, a desire to leave nursing management, and learning to remain silent about one's ethical conflicts with the organization.

Several participants said they wished their professional associations would be more vocal about ethical issues faced by nurse managers, explaining that sometimes a situation could be improved by a few timely questions addressed to a hospital. Several mentioned the moral support they got from knowing that their professional association shared their values and would stand behind their actions. The majority of participants said they had no ethical conflicts with their professional associations and believed their actions were "in tune and on track."

Table 3 *Factors That Mitigate Nurse Managers' Ethical Conflicts With Hospitals*

Support

- support from other nurse managers, hospital administrators, physicians, hospital ethics committee, staff nurses, family, public
- internal strength gained from knowing that one is morally right
- internal strength gained from knowing that one is following the Canadian Nurses Association's *Code of Ethics*

Problem-solving and growth

- problem-solving with other nurse managers, hospital administrators, physicians, hospital ethics committee, staff nurses
- learning to separate personal values from professional responsibilities
- developing and presenting a proposal to senior administrators

Refocusing

- hoping that the next generation of (better-educated) nurses will improve nursing
- focusing on one's own goals and on what one can do
- focusing on the high quality of care that nurses do provide
- dwelling on the positive when senior administration begins to address a problem

Table 4 *Outcomes of Nurse Managers' Ethical Conflicts With Hospitals*

Negative feelings

- frustration, anger, fear, stress, burnout, loneliness, demoralization, powerlessness and/or lack of fulfilment
- concern for well-being of nursing staff
- poor self-image as manager when over-budget
- unsupported and unvalued
- fear for patient safety
- torn between viewpoints of staff nurses and those of senior administration

Turnover, resulting in a changed profession

Learning to remain silent

Discussion

The themes of ethical conflict were associated with distinct outcomes: "voicelessness" was associated with feeling devalued and powerless; "where to spend the money" with distress at seeing unmet patient, family, or staff needs; "the rights of the individual versus the needs of the organization" with feeling caught in the middle; and "unjust practices on the part of senior administration and/or the organization" with resigning or wanting to resign, feeling angry, and being concerned for staff well-being. However, all four themes of ethical conflict were associated with distress and frustration. We have tried to capture the participants' experiences in the themes identified in the data and in the selection of excerpts from the transcripts. Nevertheless, it is difficult to convey the extent of the frustration, stress, pain, and powerlessness expressed in the interviews. The nurse managers shared the concern of their staff nurses when quality care could not be delivered, and they perceived themselves as the person responsible for improving patient care and for alleviating staff concerns.

The distress expressed by the nurse managers may reflect what Jameton (1984) refers to as moral distress. Jameton defines three types of ethical conflict: moral dilemmas, moral distress, and moral uncertainty. A moral dilemma occurs when the person sees more than one right thing to do, moral distress when the person knows the right thing to do but is constrained in doing so, and moral uncertainty when the person is uncertain about which moral principles apply. The ethical conflicts between the nurse managers and hospitals were primarily ones of moral distress: the nurse manager knew what should be done but was unable to make it happen. The ethical conflict between the nurse managers and their organization represents ongoing, unresolved situations, with the potential for long-term stress and feelings of powerlessness.

While distress and frustration were common outcomes of ethical conflict among the participants, "wanting to resign" is a particularly troublesome outcome for the future stability and recruitment of the nurse manager work force. Some of the participants were thinking of leaving nursing, and some stated that they remained in their current position only because they had few employment options. Several participants stated that they could not encourage any of their staff members to go into nursing management.

The nurse managers described their own values as providing quality care, or doing what is best for each client, family, or staff member, and the fair treatment of nurses and nurse managers in the workplace. These values reflect the ethical principles of beneficence and non-maleficence — or the moral imperatives to do good to others and to not cause harm to others (Beauchamp & Childress, 1994) — and justice. The nurse managers described their hospitals' values, in contrast, as balancing their budgets and protecting their legal position.

The majority of nurse managers did not experience ethical conflict with their professional associations, and a number spoke of feeling supported by their associations, either through the simple sharing of values or through the association speaking out on an issue. In contrast, the majority of staff nurses interviewed by Gaudine and Thorne (2000) felt that their professional association was insufficiently vocal and visible. It is possible that nurse managers, because of their administrative tasks, have more access to information about the activities of the association than direct-care nurses and are more comfortable contacting the association when an issue arises.

The ethical conflicts described by the participants have serious implications for nurses, hospitals, and all those responsible for the provision of health services.

The theme of "voicelessness" has disturbing implications for nurse managers and direct-care or clinical nurses. It is demeaning for nurse managers to feel that they are not supposed to speak out and that decisions are being made around them. Further, being voiceless goes against their values of collaboration and inclusion. Direct-care nurses working in hospitals where the contribution of nursing leaders is devalued are apt to feel that their own contribution is devalued as well. In addition, these nurses may believe they lack the opportunity for meaningful advancement within their organization. Current and potential nursing students may have second thoughts about entering a profession in which they will not have a real voice in decision-making.

The theme of "voicelessness" also has disturbing implications for hospital administrators and boards interested in attracting and retaining excellent nurses. The development of quality nursing services in any hospital requires nurse leaders who are visionary and assertive. In order to recruit and retain such persons, administrators and boards will have to ensure that nurses' voices are valued. Nurse leaders ought to be included in senior administrative and board decision-making, and staff nurses should be represented as well. A few of the participants said that in cases where a senior nurse manager sat on the board of directors, he or she was there only to answer questions and was under pressure not to disagree with the chief executive officer of the hospital. The public should be made aware of such situations, because the stakes in health care are too high to allow the stifling of nurses' concerns.

Policy-makers will have to ensure that organizational structures facilitate communication among nurse managers, senior hospital administrators, and board members. For example, the inclusion of direct-care nurses on the board of directors as well as on all hospital committees may serve to increase communication. Since it is relatively easy for an organization to take sanctions against non-unionized employees, unionized nurses may be more apt to provide information that goes against the views of senior administrators.

The participants were distressed to see nurses as the object of unjust administrative or human-resource practices. If nurse managers are to ensure quality nursing care, they will need to be in positions of authority concerning hiring, staffing, staff development, and human resources.

Nurse managers need help in their quest to provide a nursing voice at senior organizational levels. Several participants spoke of feeling isolated because their attempts to influence decision-making at the hospital could not be discussed with the direct-care nurses: unaware of the extent of the barriers facing the nurse managers, the direct-care nurses often harshly judged them for failing to produce results.

It is doubtful that direct-care nurses are aware of the extent of nurse managers' feelings of distress and powerlessness, or their need for support from their staff. A few participants noted that affective support from their staff was critical in mitigating the negative effects of ethical conflict. Nurse managers also need other types of support from direct-care nurses. The findings suggest that nurse managers feel alone and overburdened in their search for solutions. Budget cuts have forced hospitals to make changes that go against nursing values. The participants felt they shouldered the burden of attempting to influence hospital decision-making. It is time this burden was shifted to direct-care nurses. We need to develop councils or associations of direct-care nurses that will speak for nurses at senior administrative and board levels. Such associations should be separate from nursing unions, in order to prevent senior administrators from discrediting their voice to board members on the grounds that they represent union self-interests.

Nursing leadership and management courses should cover ethical issues faced by nurse managers and the ways in which associations of direct-care nurses can influence decision-making. Nursing students need to learn that direct-care nurses may be in the best position to influence hospital nursing. Inservice educators, nursing managers, and professional associations ought to educate direct-care nurses about effecting change and influencing policy. Nurse managers need to learn how to share their burden and their role as nurses' voice within the hospital. They should support the efforts of direct-care nurses to form their own association.

A few of the participants said they wished their professional associations were more vocal about issues facing nurse managers. While a professional association may not have the legal mandate to intervene, posing questions to the chief hospital administrator and the board may in itself serve as an impetus to change. In light of nurse managers' feelings of voicelessness, professional associations need to consider how they might intervene at the organizational level.

One senior nursing administrator stated that she and her assistant had their positions terminated, supposedly due to organizational restructuring, shortly after speaking out against a decision taken by their organization. She noted that surviving nurse managers were hesitant to voice their concerns following this "restructuring." For nurses such as these, legislation against "whistle blowing" is meaningless. They have learned that an organization can distance the dismissal decision from the nurse manager's actions by claiming to be restructuring.

Further, a few participants witnessed the damaging effects of a senior administrator's smear campaign against a nurse manager. Boards of directors and professional associations need to be vigilant when a hospital's nurse manager turnover rate is higher than the norm for the region. They could do exit interviews of nurse managers when turnover rates are particularly high. Professional associations and senior nurse administrators of other hospitals should support nurse managers who have had their positions terminated or who are the victims of smear campaigns.

The findings of this study have implications for nursing research. Studies of nursing work life have focused on direct-care nurses. The present findings demonstrate that nurse managers are sometimes employed to go against their own values. Feelings of voicelessness, lack of budgetary control, having to sacrifice individual rights for organizational needs, and inability to change unjust administrative or human-resource practices result in nurse managers going against their own values and risking self-alienation. There is a need for more research on ethical decision-making in nursing management as well as on quality of work life among nurse managers.

Studies of nursing work life have typically focused on constructs such as job satisfaction, stress, and burnout and the prediction of absenteeism, organizational commitment, and turnover. It is possible that ethical conflict, as a construct related to values and self-concept, has a strong influence on the retention of nurses either by causing job dissatisfaction, stress, and burnout or by directly affecting turnover and commitment to the organization. Thus, research on nursing work life that includes ethical conflict as a variable could add to our knowledge about the factors that influence the retention of both nurse managers and direct-care nurses.

The present study is limited in that it describes the experiences of 15 nurse managers working in a hospital setting in one Canadian province. Future research could examine ethical conflict as experienced by nurse managers working in other settings and in other provinces. Quantitative research on the prevalence and intensity of ethical conflict among nurse managers would strengthen the findings of this study.

If they are to provide quality nursing care, hospitals will have to recruit and retain nurse leaders who have the vision, talent, and skills to develop nursing. For this to occur, nurse managers and hospitals need to understand each other's values and perspectives. Future research could evaluate the effectiveness of workshops that bring together nurse managers, direct-care nurses, administrators, and board members in order for them to share their perspectives. These workshops could be combined with organizational reforms such as decision-making processes that are more visible and structured in a way that allows all parties a voice and ensures that their opinions are respected.

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Ethical Orientation, Functional Linguistics, and the Codes of Ethics of the Canadian Nurses Association and the Canadian Medical Association

Thomas Hadjistavropoulos, David C. Malloy, Patrick Douaud, and William E. Smythe

Les textes traitant de déontologie donnent à penser que les structures grammaticales et linguistiques ainsi que les théories qui fondent les orientations éthiques véhiculées par les codes de déontologie influencent la manière dont ces derniers sont reçus par ceux qu'ils lient. Certaines structures grammaticales et linguistiques, par exemple, ont tendance à être directives et bloquantes tandis que d'autres seront stimulantes. Les analyses et les comparaisons des orientations éthiques et des structures grammaticales et linguistiques font ressortir des différences considérables entre le code de déontologie de l'Association des infirmières et des infirmiers du Canada (AIIC) et celui de l'Association médicale canadienne (AMC) quant à ces deux aspects. Ainsi, le code de l'AIIC comporte proportionnellement davantage de déclarations fournissant une analyse raisonnée du comportement éthique, alors que celui de l'AMC a tendance à être plus dogmatique. En revanche, l'analyse de la grammaire fonctionnelle semble indiquer que l'un et l'autre transmettent leur discours sur un ton dont la force ne valorise pas la capacité du destinataire à s'engager dans la voie de la prise de décision discrétionnaire. Néanmoins, le code des infirmières et des infirmiers laisse supposer une relation de collaboration avec le client, tandis qu'on sous-entend dans celui des médecins que le patient est le bénéficiaire de l'érudition de ces derniers. Les auteurs débattent des implications de ces résultats.

The literature on codes of ethics suggests that grammatical and linguistic structures as well as the theoretical ethical orientation conveyed in codes of ethics have implications for the manner in which such codes are received by those bound by them. Certain grammatical and linguistic structures, for example, tend to have an authoritarian and disempowering impact while others can be empowering. The authors analyze and compare the codes of ethics of the Canadian Nurses Association (CNA) and the Canadian Medical Association (CMA) in terms of their ethical orientation and grammatical/linguistic structures. The results suggest that the two codes differ substantially along these two dimensions. The CNA code contains proportionally more statements that provide a rationale

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Thomas Hadjistavropoulos, PhD, is CIHR Investigator and Professor, Department of Psychology, University of Regina, Saskatchewan, Canada. David C. Malloy, PhD, is Professor and Assistant Dean, Faculty of Graduate Studies and Research, University of Regina. Patrick Douaud, PhD, is Associate Professor, Faculty of Education, University of Regina. William E. Smythe, PhD, is Associate Professor and Head, Department of Psychology, University of Regina.

for ethical behaviour; the statements of the CMA code tend to be more dogmatic. Functional grammar analysis suggests that both codes convey a strong deontological tone that does not enhance the addressee's ability to engage in discretionary decision-making. The nurses' code nonetheless implies a collaborative relationship with the client, whereas the medical code implies that the patient is the recipient of medical wisdom. The implications of these findings are discussed.

Ethics codes, in an applied context such as health care, are intended to establish a set of standards as a framework for the regulation and enhancement of ethical behaviour. The code of ethics of an organization or profession outlines the practices that are acceptable and unacceptable (Kenny, 1996; Railborn & Payne, 1990). Dean (1992) contends that "codes are meant to translate the more formal philosophical theories of ethics into a set of guidelines that can be applied to the day-to-day decision making" (p. 285).

The historical impetus for the development of ethics codes in nursing was concern over experimentation on human beings during World War II, which led to the *Declaration of Universal Human Rights* in 1948 and an increased focus for health professions on ethical concerns (Kerr, 1991). The International Council of Nurses developed a code of ethics in 1953. The Canadian Nurses Association (CNA) adopted this code but then developed its own document in 1980. Balcom (1994) points out that the first code of ethics for nurses was developed out of need. Specifically, although nurses had been taught to promote the well-being of clients, the public, and families, this obligation was being overlooked. Moreover, according to Balcom, nurses were often told by physicians to follow orders without question, with little consideration being given to the nurses' personal values.

As a result of disagreements with the wording of the 1980 code of ethics, the CNA established an ad hoc committee to revise it. The revision was completed in 1985 following a lengthy consultative process (MacPhail, 1991). Moreover, the CNA has recognized the need to review its code every 5 years, not only because of medical and technological advances but also because of increasing awareness about ethical concerns (Balcom, 1994). The latest version was published in 1997 (Canadian Nurses Association [CNA], 1997a).

The CNA code of ethics is intended to provide guidance in decision-making through a set of values, to serve as a means of self-evaluation, to serve as a basis for peer review, to inform prospective nurses of expectations in the field, and to inform other health-care professionals as well as the general public of the ethical expectations of the nursing profession (CNA, 1997b). The CNA is also explicit regarding what the code is *not* intended to be. Specifically, it is not intended as a tool for prioritizing nursing values nor as a guide for decision-making in every circumstance that the practising nurse may face.

The Canadian Medical Association (CMA) adopted its first code of ethics in 1868 (Williams, 1994). The code was revised in 1936–37 and again in 1969–70. The most recent version (Canadian Medical Association [CMA], 1996) was prepared following an extensive review, during the course of which the Committee on Ethics attempted to determine the code that would be most appropriate for the medical profession. The Committee did not wish to reduce the code to a set of legal requirements. It took the position that the code should include both a statement of values and principles and a set of guidelines for physician behaviour (Joseph, 1995; Sawyer & Williams, 1996). Following consultation with a variety of CMA committees, councils, and provincial and territorial divisions, the revised code was adopted by the CMA General Council in 1996. Sawyer and Williams identify four goals of the code: (1) improved quality of the physician-patient relationship, (2) improved physician behaviour and guidance in decision-making, (3) improvements in health, and (4) improvements in professional and interprofessional collegiality.

While the extent to which Canadian nurses and physicians use their respective codes in practice is unknown, the empirical evidence from other professions is mixed. For example, Brief, Dukerich, Brown, and Brett (1996) conclude that codes of corporate conduct do not reduce the likelihood of fraudulent financial reporting. McCabe, Trevino, and Butterfield (1996), in contrast, found that the existence of a corporate code of ethics was associated with significantly lower levels of self-reported unethical behaviour in the workplace. Nurses and physicians have at least some familiarity with their respective codes of ethics. While it is unlikely that they consult their code each and every time they are faced with an ethical dilemma, their familiarity with the document is likely to influence the manner in which they approach ethical decision-making.

Given all the functions of codes of ethics, it is of the utmost importance that they be effective means of moderating behaviour rather than merely means of expressing organizational platitudes (Cassell, Jonson, & Smith, 1997). The question becomes, then: What are the most effective components of ethical codes, in terms of both content and design, in achieving optimal ethical behaviour?

Some linguistic and grammatical structures convey content in an authoritarian fashion while others are empowering (Farrell & Farrell, 1998). Similarly, one code of ethics might provide dicta while another might include an empowering rationale for ethical behaviour. The purpose of our research was to systematically analyze two of Canada's dominant health-care codes of ethics, those of the CNA and the CMA, in terms of their ethical content and grammatical/linguistic structure, in order to examine the implicit meanings conveyed in the two documents.

Ethical Theory

Teleology and deontology are the two mainstream theoretical perspectives that explain and prescribe ethical conduct. The former refers to an ethical perspective in which the ends or consequences of one's actions are paramount. The latter focuses on the means of action (e.g., principles, laws, policies, procedures, and codes) rather than on the outcome.

Teleology encompasses a variety of ends-oriented approaches to ethical conduct. At one extreme, the *individual*'s pleasures are paramount and action is geared towards their fulfilment (e.g., Epicureanism). The utilitarians, who view the maximization of happiness for *all sentient beings* as the desired end, occupy the other end of the teleological continuum (Mill, 1833/1985). Utilitarianism can be divided into act and rule orientations. In act-utilitarianism, action that results in the greatest good for the greatest number of people is preferred (MacIntyre, 1966). Many authors (e.g., Williams, 1998) comment that in its pursuit of what is best for the majority, act-utilitarianism may overlook the individual or the minority (Raphael, 1981). To address this perceived shortcoming, a hybrid model was developed that incorporates *a respect for process* in the pursuit of the greatest good for the greatest number. Rule-utilitarianism favours action that results in the desired end through adherence to established rules of conduct; while the end is still paramount, the decision-maker must adhere to certain standards of behaviour.

Deontology focuses not on the ends or consequences of an action but on the means employed in acting. Specifically, deontology is geared towards one's a priori duty to abide by religious, social contract, or rational precepts (Brody, 1983). The dominant form of deontology is based upon the work of Kant (1785/2001), who proposed the categorical imperative as the one universal rule of moral conduct, which can be stated succinctly as: "Act only on that maxim whereby thou canst at the same time will that it should become a universal law" (p. 178). From this perspective, therefore, the consequences of one's action are secondary to one's primary ethical duty. Moreover, there can be no exceptions to one's duty (e.g., "Never tell a lie").

Though much of the traditional debate in ethical theory has focused on teleology and deontology, a third perspective is relevant in the health-care context. This third perspective is called the ethics of "care" (Gilligan, 1982; Noddings, 1984). According to this perspective, the evaluation of ethical conduct is not based on the decision-maker's ability to determine outcome nor on the duty to follow universal and objective principles. Instead, ethical conduct is a function of the decision-maker's relationships with others and a commitment to the avoidance of harm — factors that are, one could argue, among the implicit axioms of the health-care professions. The ethics of care attempts to move away from the objectification and abstraction of ethical conduct that characterize the teleological and deontological approaches and towards a subjective and concrete concern with intimate human relations. This care orientation is frequently contrasted with the "justice" orientation of traditional ethical theory and practice (Gilligan). These three disparate approaches (teleology, deontology, and care) form the basic guidelines for our day-to-day ethical conduct. They also constitute the theoretical basis of our organizational and professional health-care codes of ethics. Thus, they are the central foci of our analysis.

Codes of Ethics, Ethical Orientation, and Grammatical Structures

Grammatical analysis of the content of ethical codes can be informative (Farrell & Farrell, 1998). This means of uncovering overt and covert meanings and intentions has had a respectable history since the pioneering structuralist work of Saussure (1916/68) and Meillet (1938) at the beginning of the 20th century. Stylistics and sociolinguistics have both contributed to this kind of analysis. More relevant for our purposes is the grammatical analysis movement based on functional linguistics, an approach that originated with the so-called London School of Linguistics (e.g., Halliday, 1994; Malinowski, 1935). The field of functional linguistics is concerned with the psychosocial function of language and applies the resources of grammatical analysis to the study of discourse in the context of its occurrence and application. This approach represents an internationally respected methodology of textual analysis. For our study, we selected two broad linguistic categories on the basis of content, syntax, and lexico-semantics, because these, far more than phonology (sounds) or morphology (word forms), are expressive of underlying intentions and assumptions.

The literature on the social functions of language supports the assumptions that the surface form of language is expressive of underlying motives and that it generates subtle impacts on the listener or reader (see Holtgraves, 2002). A command, for example, is more unequivocally expressed in the imperative but, in an appropriate context, can also be explicitly intended through the use of an indicative statement that affects the listener in a different way. For example, the statement "Nurses do X" issues a command in a way that leaves the addressee little room for discretionary decision-making.

While the *intent* of codes of ethics is implicitly accepted and theoretically well documented in the applied ethics literature, their *content* is less well understood and explored. Although the literature on discourse analysis contains many examples of functional analysis of text (e.g., Halliday, 1994; Oktar, 2001), to the best of our knowledge there is only one study (Farrell & Farrell, 1998) that has examined codes of ethics from this perspective. Previous examples of functional grammar analysis include examinations of newspaper texts (e.g., Oktar) and academic mission statements (e.g., Connell & Galasinski, 1998).

Two recent studies examined codes from the perspective of linguistic and ethical content (Farrell & Farrell, 1998; Malloy & Fennell, 1998). Farrell and Farrell investigated the impact of various grammatical structures (i.e., relational clauses, passive voice, grammatical metaphors, and use of modalities such as "can" and "must") on the manner in which ethical behaviour is communicated. They conclude that the language of the Australian codes that they studied constructs an authoritarian writer/reader relationship through overuse of grammatical structures such as relational clauses and passive voice. Farrell and Farrell also demonstrate that such grammatical structures communicate a sense of powerlessness, since they establish a strong authoritarian tone that does not permit the addressee to engage in discretionary decision-making.

Codes of ethics can also be assessed on the basis of ethical theory. Malloy and Fennell (1998) approached the content of codes from this perspective. In their study of codes of ethics related to tourism, they examined the extent to which ethical statements were teleological or deontological. They found that the codes tended to be deontological in nature and did not provide a teleological rationale for code adherence. Thus, the findings of both Farrell and Farrell (1998) and Malloy and Fennell suggest that some codes of ethics are written in a manner that is unlikely to empower those who are faced with difficult ethical dilemmas.

The purpose of the present study was to analyze the ethical and linguistic content of the codes of ethics of the CMA and the CNA. We sought to determine whether differences exist between the grammatical and theoretical orientations of the two documents and to analyze the implicit messages being communicated by them.

Method

Analysis of Ethical Orientation

The first phase of the research involved a content analysis of the ethical orientation of the CMA (CMA, 1996) and CNA (CNA, 1997a) codes of ethics. Every ethical statement (*n* = 129) in each code was identified as based upon a teleological, deontological, or caring ethical orientation. For our purposes, a *statement* consists of one or more clauses that form a coherent and complete conceptual unit. A statement may coincide with a sentence insofar as it is distinct from surrounding sentences in terms of semantic completeness; or a sentence may be composed of several statements linked by conjunctions such as *and* or *but*. The preambles to the codes were not included in our analysis because they were not considered constitutive of the codes as such.

The following working definitions were used for the purposes of our analysis:

- A statement is *teleological* if it points to some intended outcome of behaviour. This type of statement appeals to consequence (i.e., one should do X because it will result in Y). Consider, for example, the sixth standard listed under the CNA code's principle of *Accountability:* "Nurses, whether engaged in clinical practice, administration, research or education, provide timely and accurate feedback to other nurses about their practice, so as to support safe and competent care and contribute to ongoing learning." In this standard, the explicit teleological consequences for "timely and accurate feedback" are "to support safe competent care and contribute to ongoing learning."
- A statement is *deontological* if it appeals to the duty or obligation of the agent to act in a particular manner without providing a rationale for doing so. Such a statement appeals not to consequence but to duty as a function of professional membership (i.e., one should do X because he or she is a member of our profession). Consider, for example, the second standard of the CMA code: "Treat all patients with respect; do not exploit them for personal advantage." In this standard, no consequence for adherence is provided; it is an assumed duty to respect and not exploit. For this standard to be teleological, the outcome of respect and non-exploitive behaviour would have to be provided. A code could state, for example: *"In*

order to enhance the trusting relationship between the patient and the physician, treat all patients with respect; do not exploit them for personal advantage."

- A statement reflects a *caring ethical orientation* if it implies an interpersonal relationship that is not based on formal policy (i.e., one should do X because it appeals to one's sense of emotional commitment to another person). Consider, for example, the 18th standard of the CMA code: "Ascertain wherever possible and recognize your patient's wishes about the initiation, continuation or cessation of life-sustaining treatment."

After classifying each statement in the two codes, we tested the reliability of the analysis. Specifically, we assessed interrater agreement (found to be 88%) by having a second judge independently classify a randomly selected subsample of approximately one quarter of the statements.

Linguistic/Grammatical Analysis

Each of the 129 statements (taken together) of the CMA and CNA codes was subjected, by a linguistics expert (Patrick Douaud), to an analysis bearing on seven sub-categories of syntax and lexicosemantics (passive construction, relational process, mode, nominalization, modality, lexical choice, and lexical avoidance). These categories were selected because they are common in codes of ethics. Moreover, several (e.g., passive construction, nominalization) imply a reduction in the addressee's power to make independent decisions and have been used in previous linguistic/grammatical analyses of codes of ethics (Farrell & Farrell, 1998). They differ in this way from other grammatical forms (e.g., tense) that do not vary either within or between codes.

In other words, not all linguistic/grammatical categories are equally exemplified in specialized discourse: passive constructions are used frequently in the directives of authoritarian governments; the relational process is common in publicity slogans; mode varies widely according to intent; nominalization is paramount in academic writing; modality — similarly to mode, but at the level of phrase or clause — expresses emotional nuances; and, finally, lexical choice and lexical avoidance indicate specific trains of thought and political correctness (Halliday, 1994; Kroskrity, 2000). For the purpose of this study we chose grammatical categories on the basis of: (a) distribution, as they are commonly found in non-literary written discourse (Fawcett & Young, 1988); and (b) common sense, as a cursory linguistic examination at the ethical codes under study quickly revealed that the selected categories were all present to varying degrees. The functions of these categories are as follows:

- *Passive constructions* depersonalize the action and remove the focus from the participants (e.g., "appropriate care is provided until alternative care arrangements are in place" [CNA principle of *Choice*; Standard 5]). The passive voice allows for flexibility of clause structure but may omit the participant from the clause, thus having a negative impact on interpersonal function (Farrell & Farrell, 1998).
- The *relational process* uses verbs that imply inevitability (e.g., is, are) and therefore leaves no room for options (e.g., "Recognize that community, society and the environment are important factors in the health of individual patients" [CMA Standard 29]; "self-regulation of the profession is a privilege" [CMA Standard 35]). The central meaning of the relational process is that "something is" (Halliday, 1994).
- As a syntactic device, *mode* allows the verb to express facts, commands, and wishes. Our focus was the *indicative* (e.g., "Nurses foster well-being" [CNA principle of *Health and Well Being*; Standard 6]) and the *imperative* (e.g., "Use health care resources prudently" [CMA Standard 32]). The former implies fact, the latter authority (Thompson, 1996). We chose to focus on these two modes because other modes (e.g., the *interrogative,* which is used to question) are not often used in ethics codes. The classification of the *mode* involves a different level of analysis from the identification of *relational processes*. For example, a statement can be defined both as indicative and as involving a relational process.
- *Nominalization* refers to the process by which a noun or noun phrase is formed from another syntactic category without clearly identifying a subject or agent (e.g., "the development, implementation, and ongoing review of policies" [CNA principle of *Fairness*; Standard 5]). This process depersonalizes the participants and blurs the line between their various roles (e.g., Thompson, 1996).
- *Modality* (Halliday, 1994) refers to the verbal expression of nuances that allow for judgement and opinion (such as the words *can, will, shall, should, could, may*) (e.g., "there should be no fee for such treatment" [CMA Standard 11]).
- *Lexical choice* (e.g., MacKay & Konishi, 1994) can be used to challenge widely held assumptions (e.g., *rebellion* vs. *resistance* in Canadian aboriginal history, or, in the present context, *client* vs.

patient). Our inclusion of lexical choice was motivated by the striking difference between the two codes in their use of the terms *client* and *patient*.

- *Lexical avoidance* refers to the universal practice of replacing words that are deemed embarrassing or taboo with euphemistic words or phrases. Common examples in modern English are the use of *passing on* instead of *dying* and *terminate* instead of *kill*. This category was chosen for the present analysis because of the sensitive nature of words related to death and dying in health-care contexts.

Results and Discussion

Ethical Orientation

Our analysis of the ethical orientation of the CMA and CNA codes suggests substantial differences between the two (see Table 1). The CMA code exemplifies a dominant theme of deontology insofar as 49 of the statements (instances-to-statements ratio = .94) relate to the physician's obligation to abide by his or her duty to the patient and/or profession. Of the remaining statements, two (instances-to-statements ratio = .04) relate to a teleological rationale and one (instances-to-statements ratio = .02) focuses on caring. The CNA code demonstrates a much broader scope in terms of its ethical orientation. Of the 77 statements analyzed, 53 (instances-to-statements ratio = .69) are deontological, 10 (instances-to-statements ratio = .13) are teleological, and 14 (instances-to-statements ratio = .18) reflect the ethics of care.

The finding that deontological theory provides the basis for the majority of statements in both the CMA and CNA codes is not surprising, because their implicit and explicit deontological rationale for ethical conduct is rule-adherence (i.e., duty). This finding suggests that both physicians and nurses belong to professions in which individuals are expected to abide by a code of ethics as a function of their professional duty. While this sense of duty is strongly communicated in both codes, there do exist some interesting differences. The CMA provides the reader little latitude in terms of the rationale for ethical conduct, as 94% of statements are duty-bound. The reader is provided with some further rationale in only 4% of the remaining ethical statements, such as "Engage in lifelong learning to maintain and improve your professional knowledge, skills, and attitudes" (Standard 5). Thus, the focus is on the means, as opposed to the ends, of one's conduct (viz., Do your duty). The outcome of or rationale for one's action is either presumed to be implicitly known by the physician or of secondary importance to duty.

Though the majority of statements in the CNA code are deontological, the teleological and caring perspectives are strongly represented. This wider scope suggests that Canadian nurses are more concerned than physicians about understanding the effect that their behaviour will have on clients' health and on their relationship with their clients. The CNA appears to be interested in employing the code of ethics as an educational tool as opposed to merely as a professional dictum.

Grammatical Structure

Grammatical categories and sub-categories tend to overlap to some extent. However, it is possible to do a rather precise analysis of the differences in tone and intent between nurses' and physicians' codes of ethics, thanks to the narrow range of the categories employed and the clear, step-by-step format characteristic of these codes.

The results of our linguistic analysis are summarized in Table 1. Passive constructions are used in 20% of the CNA code's 77 statements

Table 1 *Instances-to-Statements Ratios Based on Ethical Orientation and Functional Grammar Analyses of the CNA and CMA Codes of Ethics*

	CNA (77 Statements)	CMA (52 Statements)
Ethical Orientation Analysis		
Deontological statements	.69	.94
Teleological statements	.13	.04
Ethics of care	.18	.02
Functional Grammar Analysis		
Passive constructions	.20	.17
Relational process	.31	.17
Nominalization	.82	.65
Indicative mode	used throughout	.04 (one instance)
Imperative mode	not used	used throughout
Use of modalities:		
can	.01	.02
would	.03	.02
must	.01	0
might	.01	0
should	.01	.02
will	.14	.04

and 17% of the CMA code's 52 statements. Thus, both codes show the depersonalizing tendency common in official documents that strive for detachment and objectivity. However, use of relational process (verbs implying inevitability) is much more pronounced in the CNA code (24 instances; instances-to-statements ratio = .31) than in the CMA code (9 instances; instances-to-statements ratio = .17). This points to a more categorical tone for nurses and a more guarded tone for physicians — members of a profession that is considered to represent the highest authority with respect to health-care decisions.

The divergent use of mode is striking, with the indicative being employed throughout the CNA code (e.g., "Nurses seek," "nurses provide") and the imperative throughout the CMA code (e.g., "Consider," "Recognize"). Thus, the CNA code presents its statements in a way that implies fact, whereas the CMA code is written in an imperative, authoritarian fashion. Despite this difference, the manner in which the indicative is used in the nurses' code is rather disempowering as it leaves little room for options. More specifically, the statements in the CNA code often take the form "Nurses do X," which does not allow much room for choice or discretion.

The frequent use of nominalization (63 instances, or an instances-to-statements ratio of .82, for nurses, compared with 34 instances, or an instances-to-statements ratio of .65, for physicians), with its accompanying depersonalizing effect, reinforces the impact of passive constructions. Examples of nominalization include "Where disclosure is warranted" (CNA principle of *Confidentiality*, Standard 3) and "When the maintenance of confidentiality would result" (CMA Standard 22).

Passing now from the analysis of syntax to that of lexico-semantics, we discover that the use of modalities (i.e., verbal expressions of judgement and opinion) shows a similar pattern. Whereas the two codes contain comparable numbers of expressions of mild obligation (namely *would* and *should*), the CNA code contains many more expressions of higher-level obligation: 11 instances of *will* (instances-to-statements ratio = .14) and 1 instance of *must* (instances-to-statements ratio of .01); the corresponding instances in the CMA code are 2 (.04) and 0.

As noted, the most striking feature in terms of lexical choice is the systematic use of *client* in the CNA code and *patient* in the CMA code. The former suggests a two-way interaction, with clients actively involved in their care and nurses providing guidance; the latter suggests a one-way interaction, with the patient playing a passive role and the physician taking over care of the individual's health. While it might be suggested that the specific connotations of the two terms have been attenuated to some extent in practice, it is nonetheless noteworthy that the codes themselves contrast so sharply in this respect.

Lexical avoidance in this context involves the word *death*, a source of considerable unease in Western culture, especially in the medical field where death is sometimes equated with failure. Predictably, the CMA code exhibits a remarkable degree of lexical avoidance, not mentioning *death* even once; the closest it comes to the topic is in Standard 3: "when cure is no longer possible..." In the CNA code, in contrast, *death* is mentioned twice: "process of dying" and "peaceful death" (both under the principle of *Health and Well Being*). Nurses typically spend long hours in close contact with the sick, are trained to assist the sick in all circumstances, and come to accept the inevitability of death as part of their routine. Physicians may be somewhat more remote in their interactions with patients. Although the two codes are equally binding, we can perhaps read into the CMA code a tone of authority towards patients, while the CNA code could be seen as encouraging nurses to work collaboratively with their clients. In terms of the ethics of justice and care, the CMA code is more congruent with the former and the CNA code with the latter.

Conclusions and Future Directions

Although the relatively higher proportion of teleological statements in the CNA code provides the addressee with a rationale for ethical behaviour and thus enhances empowerment, the functional grammar analysis suggests that both codes are written such that the addressee is offered few opportunities for discretionary decision-making. Moreover, both codes reveal many instances of impersonal constructions (e.g., passive voice). While use of the imperative and the indicative (which, at least in these codes, are authoritarian constructions expressing commands, wishes, and facts) may be inevitable in codes of conduct, the authoritarian impact of such constructions can be moderated in a variety of ways — for example, through the use of conditional statements (if X, then Y), phrasing that implies an effort to accomplish an end (e.g., "Nurses strive to do X" as opposed to "Nurses do X"), and words that imply a choice or exception (e.g., avoid, or, normally, but, however). Choice allows decision-makers to consider special circumstances. There are few such instances in these codes. For example, the conditional mode is used only three times in the physicians' code and twice in the nurses'. Moreover, we found few additional attempts to moderate the authoritarian impact of statements in the CMA code (e.g., Standard 13, "Make every reasonable effort to...") and in the CNA code (e.g., principle of *Choice*, Standard 1: "Nurses *seek to involve* clients"). In the case of the nurses' code, three of five such instances are associated with the principle of *Choice*.

Nonetheless, we found numerous concrete examples of such moderating statements in another professional code of ethics, namely that of the Canadian Psychological Association (2000). We present a few of these here with the relevant constructions italicized: "Personal behaviour becomes a concern of the discipline only *if* it...undermines public trust in the discipline as a whole or *if* it raises questions about the psychologist's ability to carry out appropriately his/her responsibilities as a psychologist" (p. 6); "This responsibility is *almost* always greater than their responsibility to those indirectly involved" (p. 8); "*Strive* to use language that conveys respect for the dignity of persons *as much as possible* in all written and oral communication" (p. 9).

Given that ethical dilemmas can rarely be resolved in a categorically right or wrong way, it is important that decision-makers be empowered to consider special circumstances when faced with such dilemmas. Although the preamble to the CNA code indicates that nurses should consider the specific circumstances of each ethical dilemma (and that nurses may disagree about the relative weight of the various ethical principles), the grammatical structures employed throughout the document do not always convey this message effectively. The results of our functional grammar analysis lead to the conclusion that the CNA code is written in a fashion that implies team work and a collaborative relation with clients/patients, and that the CMA code, in contrast, views the patient as a passive recipient of medical wisdom.

Our analytic approach has several practical implications. By making explicit elements that are hidden in code structure, one can foster a more thorough understanding of a code's impact and coherence. The CMA code, for instance, could be enriched with the addition of teleological statements that complement its deontological emphasis, through the provision of a rationale for ethical behaviour. It could also be enriched through the use of more care-oriented expressions of mutual help such as those found in the CNA code. Similarly, our analysis points to the need for greater attention to grammatical structures and their implications, as well as to lexical choice; with respect to the latter, the CNA's use of the term *client* instead of *patient* is particularly felicitous at a time when the notion of interactional passivity is increasingly unwelcome. The debate on use of the terms *client* and *patient* in health care is analogous, in some respects, to the debate on use of the terms *participant* and *subject* in human research (Danzinger, 1990). While *patient* and *subject* have a more specific meaning, they also connote passivity; *client* and *participant* are more wide-ranging, less precise terms but convey a sense of active involvement or engagement. Although these connotations can to some extent be attenuated in professional practice, they cannot be fully eliminated, as they are ultimately a function of broader linguistic practices. The information presented here can serve as a reminder that, under careful analysis, the elaborated text reflects on the author of the code and the intended audience as well as its assumptions.

It should be noted that the two codes of ethics are designed to offer guidance, as stated in both preambles. Moreover, according to the preamble to the CNA code, the document is intended to be educational. Modifications to the writing style (e.g., to allow room for carefully thought out, flexible decision-making) and content (e.g., the provision of an educational, teleological rationale for ethical behaviour) would serve to enhance these noble goals.

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Correspondence can be directed to Thomas Hadjistavropoulos, Department of Psychology, or David C. Malloy, Faculty of Graduate Studies and Research, University of Regina, Regina, Saskatchewan S4S 0A2 Canada. E-mail: Thomas.Hadjistavropoulos@uregina.ca or David.Malloy@uregina.ca

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Nursing as Science: A Critical Question

Denise L. Hawthorne and Nancy J. Yurkovich

La profession infirmière est une activité humaine profonde et généralement influencée par deux éléments – la relation entre le patient et l'infirmière, et le paradigme scientifique. Toutefois, les incongruités qui se manifestent entre ces deux éléments sont souvent minimisées. La relation patient-infirmière fait appel à l'identification, la proximité et le lien, alors que la science exige une distance, un détachement et une différentiation dans le but de répondre aux exigences de l'objectivité. La relation patient-infirmière est à la fois profonde et non tangible, alors que la science traite uniquement ce qui est observable et mesurable. Les auteures explorent ces dynamiques et les incongruités qu'elles comportent. Elles examinent les exigences qu'impose la science à la relation patient-infirmière et, inversement, la place de la relation patient-infirmière dans le cheminement de la profession infirmière en tant que science. Ces questions sont d'une grande importance pour l'avancement de la profession et sa pratique.

Nursing is a profound human activity generally influenced by two dynamics — the relationship between patient and nurse and the scientific paradigm. Often overlooked, however, are the incongruities that arise between these two dynamics. The patient-nurse relationship encompasses sameness, closeness, and connection, whereas science requires distance, detachment, and differentiation to fulfil the demands of objectivity. The patient-nurse relationship is both profound and intangible, whereas science attends only to that which can be observed and measured. The authors explore these dynamics and the incongruities between them. They consider the demands made by science on the patient-nurse relationship and, conversely, the place of the patient-nurse relationship in the development of nursing as science. These issues are critical to the advancement and practice of nursing.

To most nursing leaders the patient-nurse relationship is the essence of nursing (Boykin & Schoenhofer, 2001; Parse, 1998). Human relations encompasses an understanding of the human condition, the meaning and purpose of life's journey — and the realization that this journey through health and illness is made not alone but with another. The scientific paradigm is also an essential component of nursing, contributing as nursing science does to the development of both theory and practice. It provides nursing with structure and order, sharpens its vision in

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Denise L. Hawthorne, RN, BSN, MA, is an instructor in General Nursing, Faculty of Health Sciences, Douglas College (a partner with the Collaborative Nursing Program in British Columbia – CNPBC), New Westminster, British Columbia, Canada. Nancy J. Yurkovich, BSN, is a member of the Community Advisory Council of Rotary Hospice House, Richmond, British Columbia.

the advancement of its body of knowledge, and provides evidence to guide and support the complexity of its practice. There are, however, incongruities between the two dynamics, and as nursing *becomes* a science these impact the patient-nurse relationship and consequently nursing itself. The patient-nurse relationship encompasses sameness, closeness, and connection, whereas science requires distance, detachment, and differentiation to fulfil the demands of objectivity. Nursing leaders respond to the many voices raised in nursing concerning these incongruities by shifting the focus from a paradigm of empirical science to one of human science (Parse, 1998; Rogers, 1994) and by creating an entity called *caring* (Leininger, 1991; Roach, 2002; Watson, 2002). However, attempts to address concerns using these methods have failed. We contend that the requisites of science impact the patient-nurse relationship and, as nursing becomes a science, are the most critical to the future of nursing. The purpose of this paper is to consider the impact of the requisites of science on the patient-nurse relationship and ultimately on nursing.

Nursing: A Profound Human Activity

Nursing is, according to Benner and Wrubel (1989), Taylor (1992a), Watson (2002), and many others, a profound human activity. The meaning of nursing is embodied by the patient and the nurse and unfolds when they meet in the clinical encounter, a place where life's dramas are played out. The patient and the nurse connect and help each other, one on a journey through illness, the other on a journey of sharing the human gifts of strength and comfort. The patient looks to the nurse for solace, refuge, and comfort, while the nurse has the ability to understand the patient's loneliness, fear, and pain. Faith in the meaning of this deeply human experience brings joy, nourishment, and enrichment to both patient and nurse. This experience transcends time, place, and the physical world (Watson, 2002). It is a place of privilege for the nurse.

Major Dynamics in Nursing

Nursing is generally influenced by two major dynamics, the relationship between patient and nurse and the paradigm of science (DuGas, Esson, & Ronaldson, 1999). Scientists such as Jevons (1973) and Perlman (1995) assert that the values of relationship and the values of science are in conflict. Nursing is aware of this conflict and finds it challenging. Such conflict creates tension between the attempt to preserve the human dimension and the pursuit of science. Nursing leaders acknowledged this problem over 20 years ago (Leininger, 1981; Parse, 1981; Watson, 1981).

The Patient-Nurse Relationship

It has been well documented (e.g., Boykin & Schoenhofer, 2001; Parse, 1998) that the relationship between two human beings, patient and nurse, is central to nursing. Parse (1998) describes the patient-nurse relationship as a loving "true presence" (p. 71), while Vassallo (2001) considers it a "priceless source of comfort" (p. 27). Watson (1999) shares this view and refers to it as a human-to-human "transpersonal caring" relationship (p. 115). It is in the reflective aspect of this relationship that patient and nurse are inextricably bound together by their humanness (Taylor, 1992a) and their common humanity (Roach, 2002; Watson, 2002) and are immersed in the condition of being fully human (Watson, 1999). As a human being, each knows the other and each has an inherent capacity for connection and human expression. The experience of relationship unfolds in a unique and often unpredictable manner (Buber, 1966). Although intangible, human expression in the human experience is unconfined, has infinite possibility.

As Rawlinson (1982) aptly states, the human experience of illness defines a person's existence for a period of time. Illness generally challenges one's sense of worth and reason for being; the person may feel vulnerable, afraid, and alone and may even experience a crisis of hope and faith. In illness, one feels disconnected and less able to reach out to another and yet relies on another, the nurse, for support. The nurse reaffirms sameness and reconnects the other to the human family. Patient and nurse are involved in what it means to be human, sharing life's triumphs and tragedies together. Sharing a common humanity brings a profound sense of oneness, strength, and peace to both patient and nurse. The patient-nurse relationship has the potential to sustain hope in the most difficult situations, when the only means of refuge may be to transcend time, space, and the physical world. Though often defying description, the profound nature of the patient-nurse relationship is evident in the experiences of both patient and nurse. For example, one patient, Mark, experienced it in the following way:

> Mysteriously and powerfully, when I look deeply enough into you, I find me, and when you dare to hear my fear in the recess of your heart, you recognize it as your secret, which you thought no one else knew. And at that unexpected wholeness that is more than each of us, but common to all — that moment of unity — is the atom of God. (Nepo, 1997, p. 138)

Nurses describe similar experiences when in relationship with a patient. One nurse, Gino (1985), shares her experience:

> It was the one place I could be totally me. The place I could be as smart, as kind, as giving, and as real as I was capable of being. My patients and I had an understanding past words; we needed each other; we healed each other; and neither of us judged the other. There was no mask, no preference; we were just human beings. (p. 30)

The Paradigm of Science

Within relationship, contemporary nursing reflects the enduring contribution of science to humanity. The scientific paradigm gives structure to nursing. It gives a rational, logical, and objective focus to problems (Kuhn, 1970) and is directed towards solving those problems. Science requires a particular way of thinking, which, in turn, requires a specific way of relating. It explains phenomena through a process of logical reasoning (DuGas et al., 1999), which allows for predictability and certainty that are observable and measurable. To meet these criteria, a particular relationship of distance, detachment, and differentiation is necessary in a subject-object distinction between scientist and phenomena, between observer and observed, and between expert and object of study (Jevons, 1973; Perlman, 1995). According to the social scientist Woolgar (1988), maximum distance is achieved when the object is made different. Therefore, it is important for nursing to heed Perlman's caution that "although science is a dynamic search for understanding objects, it does not extend to human relationship" (p. 116).

Nursing draws on many sciences — natural, biomedical, empirical, social, and technical — to produce an extensive body of knowledge that continuously impacts and informs the development of nursing. In combination, these sciences broaden the base of knowledge, providing evidence to guide and support its complex practice. Science, on the whole, serves nursing well as it searches for meaning and purpose.

Science and Nursing

It has long been recognized that it is imperative for nursing to develop a science of its own, unique to nursing — a nursing science. The development of science as a resource in nursing is proving to be valuable in contributing to a deeper understanding of phenomena unique to nursing. However, assertions that science is more than a resource, that it forms the foundation of nursing, are now prominent in nursing discourse (Parse, 1999; Peplau, 1991; Rogers, 1994; Watson, 2002). For many, in fact, the practice of nursing has become a practice of science. The distinction between nursing science and nursing as science is not often addressed in the nursing literature. However, we suggest that there is a profound difference between the two.

Science as Resource

Benner and Wrubel (1989), Dunlop (1994), and Rose (1997) are among those who proclaim the benefits of science as resource. Within the physical dimension, science advances nursing and its practice by providing theoretical and conceptual frameworks to guide and direct its research and complex practice. Science structures nursing curricula. However, while science sharpens the vision of nursing and offers certain possibilities, it has the potential to limit the scope of nursing practice and the notion of patient and nurse as human beings. We contend that science as resource serves nursing well. It is science as foundation that has the greatest implications for nursing.

Science as Foundation

While science as resource benefits nursing, science as foundation places particular demands on nursing and has the potential to distort the patient-nurse relationship. Nursing as science confers a particular way of relating, a template for thought, and therefore does not reflect the reality of nursing. The incongruities between the values of science and the values of human relationship — the sameness, closeness, and connection of relationship versus the distance, detachment, and differentiation of science — are creating a dilemma for nursing. Nursing as relationship between patient and nurse is antithetical to nursing as science: when nursing becomes a science, the potential for the patient-nurse relationship to be distorted is ever present. Instead of being part of a relationship in which each partner recognizes the humanness of the other, the nurse is different from the patient and remains distant and detached. Instead of a relationship between patient and nurse that exists because they are human, relationship is often used as a means of solving problems. Table 1 illustrates the nature of the patient-nurse relationship with science as resource for nursing and science as foundation of nursing.

The nursing literature provides ample evidence that most scholars share the view that nursing is a science. However, many authorities dismiss the dominant perspective — the traditional, empirical paradigm — as a philosophical stance for nursing and support the shift to

Table 1 *The Patient-Nurse Relationship and Science*

Science as Resource	Science as Foundation
Intangible, infinite, inherent	Predictable, observable, measurable
Being human	Solving problems
Closeness	Distance
Connection	Detachment
Sameness as human beings	Differentiation between patient and nurse

the postmodern perspective. Among the most influential authorities in this area of nursing scholarship are Rogers, Parse, and Watson. They suggest that nursing is a practice grounded in human science and offer theories on human becoming and caring.

Human Science and Caring

Most nursing scholars, in an attempt to resolve the incongruities and to preserve the human dimension in nursing, have, for quite some time, been shifting to human science and the construction of a new conception of the patient-nurse relationship as *caring.* Nurse theorists such as Leininger (1981) and Watson (1981) have developed a concept of the patient-nurse relationship as *a science of caring* through a process of logical reasoning. Within this framework, the most profound explanations of the relationship between patient and nurse are based on operational definitions and behavioural designations such as constructs, frameworks, and factors — all scientific parameters — to meet the requisites of the scientific paradigm. The goal of caring, according to Halldorsdottir (1997), Stockdale and Warelow (2000), Watson (1997), and others, is to serve as a bridge between two dynamics, the patient nurse-relationship and the scientific paradigm.

The shift to a paradigm of human science, with its reaffirmation of caring as a way of preserving the human dimension in nursing, is a noble effort in that it puts the focus on the humanness and wholeness of the patient. However, when the relationship between patient and nurse is portrayed as science, conflict results, and the incongruities are difficult to ignore. It is a widely held view that this conflict is resolved through a delicate balance between attachment and distance (Halldorsdottir, 1997), closeness and distance (Gattuso & Bevan, 2000), and engagement and detachment (Henderson, 2001). However, caring as science must adhere to the requisites of science, whereby both patient and nurse act predictably (Crowe, 2000), alienated from one another, unfulfilled, and deprived of the opportunity to find meaning in life through their common humanity.

On close examination, claims that human science is somehow different from empirical science and that caring reduces objectivity and restores the human dimension to the patient-nurse relationship (Boykin & Schoenhofer, 2001) do not hold true. For example, although recent discourse in nursing acknowledges the humanness of the patient, it tends to dismiss the humanness of the nurse (Henderson, 2001; Taylor, 1992b). On the one hand, Parse (1998) and Watson (1999) suggest that patient and nurse relate human to human, in "authentic presence" (p. 150). On the other hand, in numerous accounts the nurse is viewed as distant, detached, and different from the patient. For example, Cody (2002) and Thorne et al. (1998) affirm the need for distance between patient and nurse. Benner and Wrubel (1989) and Peplau (1991) indicate that the nurse, aloof and detached, stands outside the relationship in order to maintain objectivity.

Differentiation between patient and nurse is widely acclaimed and perhaps of most concern. Gadow's (1990) work highlights important differences between patient and nurse but does not describe their similarities. In general, there is little discussion of the similarities between patient and nurse, although current theories assume that as human beings they are more similar than different. This is in sharp contrast to the contentions of Parse (1996) and Peplau (1991), who suggest that patient and nurse are strangers. One is left with the perception that the patient-nurse relationship is a difficult one that takes time (Stockdale & Warelow, 2000) and energy to develop. It is evident in the nursing literature, including introductory texts on the fundamentals of the profession, that the nurse is the expert and the patient is deficient. Descriptions of patients as "the deaf" (Sheehan, 2000), "the dying" (Kuebler & Heidrich, 2001), "the ill" (Bishop & Scudder, 2001), and "the marginal" (Hill, 1990) are prevalent. References to patient and nurse as subject and object (Watson, 1985) and as observer and observed (Peplau) have prompted further descriptors such as the caregiver and the cared for (Phillips, 1993), the helper and the helped (Woodward, 1998), and the nurse and the nursed (Boykin & Schoenhofer, 2001).

Concerns about the impact that nursing as science can have on the patient-nurse relationship continue to be raised. For example, Cody (2002) asserts that caring is insufficient to explain the patient-nurse relationship, Hawthorne and Yurkovich (1995) believe that science denigrates caring and distorts the patient-nurse relationship, and Fletcher

(2000), from her experience as a patient, reports a lack of presence on the part of nurses and notes that nurses have "lost concern for the patient" (p. 1083). These views are in sharp contrast to the reality that patient and nurse have an inherent capacity to be in a relationship.

These and many other concerns provide evidence that attempts to resolve the dilemma created by an overemphasis on science have failed. Regardless of how the case is made for human science, science is still science and the requisites of differentiation, distance, and detachment in the patient-nurse relationship still apply. Phenomena of the human dimension of the relationship, such as human experience and human expression, cannot be explained through a process of reasoning; generally, they are not predictable, nor can they be observed and measured as required by science. According to the poet William Blake (1790–1830), science is insufficient to explain human experience in its wholeness. Science imposes a "reign of quantity" upon immeasurable life (Raine, 1979, p. 35).

Conclusion

Because nursing is influenced by two major dynamics, relationship and science, incongruities are ever present. Each dynamic is essential to nursing and can coexist without distorting the other. However, this is not the reality for nursing. Despite the fact that concerns are raised about the incongruities, nursing considers science as foundation an extremely important goal, and, according to Smith (2000, p. 29) and others, one that should be actively pursued.

The pursuit of science as foundation poses an apparently irresolvable dilemma for nursing, perhaps in part because the profound distinction between nursing science and nursing as science is often overlooked. As resource, science serves nursing well. However, as foundation science is overemphasized in nursing and consequently affects the way in which nurses relate to patients. The requisites of distance, detachment, and differentiation between patient and nurse are in sharp contrast to the notion of relationship and the humanness, connectedness, and being and becoming that are espoused in the prominent theories of the patient-nurse relationship.

This dilemma is critical for nursing and its practice. We contend that attempts by nursing leaders to resolve the dilemma have failed, for a number of reasons. Efforts appear to be focused on addressing the incongruities between relationship and science, instead of the incongruities that are inherent in the notion of science as foundation. Efforts are focused on connecting two dynamics, relationship and science, rather than on connecting patient and nurse. Confounding the problem is the perception that a solution can be found within the scientific realm and that shifting from one paradigm to another will ultimately ease the tension in nursing.

This tension is evident in the debate among nursing leaders about which paradigm is most appropriate and best reflects the reality of nursing. Discontent is evident, as seen in the many calls to redefine (Watson, 2002) and transform (Boykin & Schoenhofer, 2001; Parse, 1999) nursing, to reconstruct caring (Marks-Maran & Rose, 1997), and to revitalize the spiritual dimension of nursing (Watson, 2002). In recent work, Watson (2002) proposes a new paradigm, drawing from the noetic sciences to support the expectation that her "intentional transpersonal caring theory" (p. 14) will address transcendence and the human dimension that others do not.

We assert that searching *within* science will not reveal the answer but that searching *outside* science will reveal a new and fresh perspective and, with it, new possibilities. We suggest that while science sharpens the vision of nursing and offers certain possibilities for the future, it nevertheless limits the scope of nursing practice and the notion of patient and nurse as human beings. We encourage nursing leaders and nurses to collectively reflect on their pursuit of science as foundation of nursing and to critically examine the impact that the requisites of science have on nursing as a profound human activity. It is a formidable task but one that is critical to the future direction of nursing.

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Unrelieved Pain: An Ethical and Epistemological Analysis of Distrust in Patients

Elizabeth Peter and Judy Watt-Watson

La douleur non soulagée est un problème clinique grave auquel la bioéthique a accordé peu d'attention. Les auteurs de cet article affirment qu'elle est due au scepticisme à l'égard des patients, qui met en évidence un manquement tant éthique qu'épistémologique de la part des infirmières et infirmiers de même que des médecins. Ils proposent une analyse bâtie sur des concepts issus de précédents travaux portant sur l'articulation de la confiance en matière de soins infirmiers et débattent, en particulier, du manque de confiance des cliniciens dans l'expérience subjective des patients, de leur méfiance à l'égard de ceux qui appartiennent à des groupes marginalisés et relativement peu puissants ainsi que de leur refus de croire à la douleur et à la souffrance des patients ou de se laisser atteindre par celles-ci. Des croyances et des valeurs profondément ancrées dans notre société influencent au quotidien les décisions prises pour soulager la douleur. Les auteurs de cet article abordent la nécessité d'en prendre conscience et d'en faire l'examen critique.

Unrelieved pain is a serious clinical problem that has received little attention in bioethics. This paper contends that unrelieved pain is the result of distrust in patients that reveals both an ethical and epistemological failure on behalf of nurses and physicians. The analysis is conceptually framed in previous work on the articulation of trust in nursing. Specifically, an argument is made that clinicians do not trust patients' subjective experiences, distrust patients from marginalized and relatively less powerful groups, and resist entrusting themselves or becoming vulnerable to patients' pain and suffering. The authors discuss the need for awareness and critical examination of deeply entrenched societal beliefs and values that influence everyday decision-making in pain management.

Many patients experience moderate to severe unrelieved pain despite advances in treatment options. Inadequate pain relief as a result of both the under-prescribing and under-administration of analgesics has been documented repeatedly for almost 30 years, from Marks and Sachar's (1973) seminal work to current research (Watt-Watson, Garfinkel, Gallop, Stevens, & Streiner, 2000). Analgesia often is not prescribed or administered in spite of patients' reports of pain (Close, 1990; Donovan,

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Elizabeth Peter, RN, PhD, is Assistant Professor, Faculty of Nursing, and Member of the Joint Centre for Bioethics, University of Toronto, Ontario, Canada. Judy Watt-Watson, RN, PhD, is Associate Professor, Faculty of Nursing, and Member of the Advisory Committee, Centre for the Study of Pain, University of Toronto.

Dillon, & McGuire, 1987; Marks & Sachar; Watt-Watson & Graydon, 1995; Watt-Watson et al., 2000). Surprisingly little attention has been given in the bioethics literature to the phenomenon of unrelieved pain. Exceptions include work by Rich (1997, 2000) and Hunter (2000), who frame this issue as the failure of clinicians to fulfil their moral duty to relieve suffering, and Greipp (1992), who has developed an ethical model for the under-medication of pain based on the codes of ethics of the International Council of Nurses (1977) and the American Nurses Association (1985). In this paper, we further this work by arguing that unrelieved pain is at least partly a consequence of a lack of trust in patients that reflects both an ethical and an epistemological failure on the part of clinicians. In the words of Scarry (1985), "To have pain is to have certainty; to hear about pain is to have doubt" (p. 13).

Theoretically, this paper is located within Peter and Morgan's (2001) and Peter's (2002) articulation of trust as a normative and epistemological concept or phenomenon in nursing. This work draws extensively on Baier's (1985, 1986, 1994) use of the notion of trust in feminist ethics. First we delineate various meanings of trust, highlighting the significance of reciprocal trust. Then we illustrate that unrelieved pain is associated with several interrelated aspects of trust involving clinicians — namely, their failure to trust in patients' subjective experiences, their distrust in patients from marginalized and relatively less powerful groups, and their reluctance to entrust themselves, or become vulnerable, to patients' suffering. Finally we put forth some suggestions that reflect the need for awareness and critical examination of deeply entrenched societal beliefs and values that influence everyday decision-making in pain management. To simplify this very complex issue, we limit the scope of the paper to unrelieved pain in adult patients who are mentally competent and not drug addicted. In addition, because poor pain management is a problem common to medicine and nursing, we generally refer to physicians and nurses collectively as clinicians.

Trust and Reciprocal Trust: Distinguishing the Meanings

Trust has been examined extensively as a concept or phenomenon in nursing (Hupcey, Penrod, Morse, & Mitcham, 2001; Johns, 1996; Meize-Grochowski, 1984; Morse, 1991; Thorne & Robinson, 1988), medicine (Illingworth, 2002; Mechanic & Meyer, 2000; Pearson & Raeke, 2000; Thom & Campbell, 1997), and other health disciplines (Semmes, 1991; Thorstensen, 2000). Much of this scholarship has focused on the development of trust in the clinician. Other work has explored the notion of reciprocal or bilateral trust, in which the importance of clinician trust in the patient is highlighted (Arnason, 1994; Katz, 1984; Lynn-McHale & Deatrick, 2000; Nelson, 1996; Thom & Campbell; Thorstensen; Thorne & Robinson; Wilson, Morse, & Penrod, 1998). Ultimately, trust in the patient is of ethical significance because it demonstrates a sharing of power and respect for the patient's knowledge and virtue. Such trust can also foster the development of clinician-patient relationships — an aspect of practice that has been described as ethically fundamental to both nursing and medicine (Bishop & Scudder, 1999; Pellegrino, 1995).

The notion of trust has been described as lacking in conceptual clarity (Hupcey et al., 2001). To clarify the meaning of trust, particularly reciprocal trust, or clinician trust in the patient, we delineate four interrelated types of trust.

The first type of trust emphasizes the act of trusting. The act of trusting entails relying on others to be dutiful, caring, and good, resulting in the dependency and vulnerability of the truster. The vulnerability of the truster is the result of the trustee's power to inflict harm on the truster (Baier, 1985, 1986, 1994). Baier (1986) states that "trust alters power positions" (p. 240), referring to the loss of power experienced by the truster and the gain in power experienced by the trustee when a relationship of trust is initiated. She also explains that trust is not necessarily good, as one can be exploited or harmed while trusting another. Acknowledging the truster's vulnerability to harm brings to light the need to morally evaluate relationships of trust (Peter & Morgan, 2001).

Entrusting oneself to patients could entail different actions. It could mean trusting patients not to harm us either physically or emotionally. It could, however, also involve making oneself vulnerable to them in some way — perhaps to rely on a patient to carry out a treatment as directed in one's absence. In this paper we will develop the idea of resistance, on the part of clinicians, to give themselves over — or to entrust themselves — to the pain and suffering of their patients. In this form of entrustment, the clinician's surrendering to the patient's experience entails a diminishing of personal control and susceptibility to the "infectiousness" of pain and its impact.

The second type of trust implies a judgement whereby persons are evaluated in terms of the goodness of their will or moral character. Character traits associated with trustworthiness include discretion, patience, honesty, reliability, tact, and resilience (Baier, 1994). The health literature on trust places much emphasis on honesty (Bok, 1978; Morse 1991; Teasdale & Kent, 1995; Thom & Campbell, 1997). In bioethics, honesty, or veracity, is often held to be a central obligation or virtue (Beauchamp & Childress, 2001; Yeo & Mitchell, 1996). Honesty is an essential dimension in the "network of trust relationships." Without honesty, we would not be able to rely on information provided by others or on the sincerity of personal interactions (Peter & Morgan, 2001). As Bok states: "Trust in some degree of veracity functions as a foundation of relations among human beings; when this trust shatters or wears away, institutions collapse" (p. 31). In this paper we will show that a belief in patients' trustworthiness, particularly their honesty, is fundamental to the clinician's evaluation of their reported pain.

The third type of trust is epistemic in nature. It can entail the evaluation of competence, whereby individuals are trusted or distrusted on the basis of the knowledge and specific competencies they do or do not possess (Baier, 1986). This type of trust is commonplace in terms of ascertaining a clinician's competence. Empirical research indicates that clinician competence is necessary for the development of patient trust (Mechanic & Meyer, 2000; Semmes, 1991; Thom & Campbell, 1997). Competence is critical in professions like nursing and medicine where individuals are trusted to provide a service that requires a broad range of knowledge and skills. Nursing and medical knowledge itself is subject to much scrutiny as to its soundness or trustworthiness, particularly since the advent of evidence-based practice (Peter, 2002).

Epistemic trust is also central to clinicians' trust in their patients. Arnason (1994) and Katz (1984) focus on mutual trust and cooperation between patient and clinician with respect to decision-making. They argue that cooperation is possible only when both parties engage in authentic dialogue. In order to preserve the patient's autonomy, the clinician must honour the patient's values. According to Bergum (1994), each person gives unique meaning to his or her health concerns, and thus the clinician must work with the patient to develop mutual understanding: "The kind of knowledge needed for ethical care must be constructed in the relationship between professional and patient, who strive together to understand what meaning the disease has within the experience of the individual patient" (p. 72). The salient words are *together, mutual,* and *constructed.* Neither perspective is privileged. The two parties — patient and clinician — work together to develop a shared knowledge and understanding. The participation of both parties is essential.

Similarly, Katz (1984), Nelson (1996), Peter (2002), and Thorstensen (2000) stress the importance of a clinician's trust in the patient's judgement, knowledge, and experience. This kind of trust encourages power-sharing and helps to diminish the epistemic privilege of health professionals. Katz discusses the often unacknowledged vulnerability of clinicians: "Physicians first must learn to trust themselves to face up to and acknowledge the tragic limitations of their own professional knowledge" (p. 102). The empirical findings of Semmes (1991) and Thorne and Robinson (1988) also support the role of reciprocal trust in facilitating mutually beneficial clinician-patient relationships. Their findings indicate that many patients have developed an expertise in managing their health problems that merits respect.

The fourth type of trust is that described by Baier (1986), who refers to a "network of trust" and "climates of trust" (p. 258), thereby situating intimate and dyadic relationships of trust within a broader, community context. Peter and Morgan (2001) develop this idea further, exploring its relevance for nursing ethics. They argue that it is important to recognize that the care nurses offer is possible only because they practise within a broader system, or network of trust, that provides them with the means — technological, epistemological, and so on — to provide this care. Nurses and other clinicians work within elaborate health-care systems with multiple individuals, groups, and organizations. This network of relationships includes other professional groups, governments, unions, schools, granting agencies, businesses, professional regulatory bodies, hospitals, and community agencies. Nurses, in turn, participate in the network of trust by providing assistance, knowledge, respect, guidance, and psychological and physical security. Ultimately, the network can act as either a facilitator of or a barrier to care, depending on the trustworthiness of the system.

Situating dyadic relationships of trust within a network also fosters an appreciation for the political context in which clinicians work. Power imbalances, financial constraints, and organizational and government policies can greatly influence a clinician's ability to establish trusting relationships with patients. Cultural beliefs and biases also enter into determinations of who and what can be trusted. In fact, entire groups of individuals are trusted or distrusted on the basis of societal beliefs about their characteristics.

Distrust and Unrelieved Pain

We argue in this section that distrust in patients' reports of pain manifests in three distinct ways, reflecting the complexity of and interrelationships among various notions of trust. First, clinicians are likely to trust the objective aspects of clinical knowledge more than patients' subjective experiences and self-reports, revealing an epistemic stance that lacks trust in the vagueness of the subjective. Second, distrust of patients' complaints of pain is compounded when patients belong to marginalized or relatively less powerful groups such as women or members of visible minorities. These groups may be distrusted because they are perceived to be epistemically unreliable and/or dishonest. Third, although both of these manifestations of distrust reveal an inability on the part of clinicians to act on reports of pain, the reluctance of clinicians to entrust themselves to patients is most profoundly demonstrated in their resistance to becoming vulnerable to patients' pain and suffering. They shield themselves behind cultural misconceptions about the danger of opioids and over-estimations of their own knowledge and abilities.

Distrust in the Subjective

Pain is private, subjective, and multidimensional. Melzack and Dennis (1978) point out that noxious stimuli enter a nervous system that has already been activated by past experience, culture, anticipation, and emotions. Cognitive processes act selectively on sensory input and motivation to influence the transmission of pain. Hence the degree and quality of one's pain are determined by cultural and personal factors such as previous pain experiences, the perceived cause and consequences of pain, and one's feelings about and responses to pain (Melzack & Wall, 1965, 1996). The plasticity of the nervous system, which contributes to the individuality of the pain response, is being increasingly recognized. Pain, therefore, is a highly variable and personal experience, not merely a noxious stimulus.

No objective tests exist to validate a person's pain. In this sense, pain differs from other symptoms such as fever and dyspnea. Furthermore, patient self-reports of pain and clinician ratings differ (Camp & O'Sullivan, 1987; Grossman, Sheidler, Swedeen, Mucenski, & Piantadosi, 1991; Iafrati, 1986; Teske, Daut, & Cleeland, 1983; Zalon, 1993). Rich (1997, 2000) contends that scientific objectivity is accorded greater value than patients' subjective experiences. In the absence of a definitive test, pain can be difficult to assess. While nurses have identified "asking the patient" as the most frequent means of determining pain intensity, fewer than 50% regard it as the most influential factor in pain assessment (Ferrell, McCaffery, & Grant, 1991). Patient behaviours such as movement and verbal expression are the most frequent means of assessing pain and determining analgesic intervention. This is unfortunate, because patients frequently do not express pain or their need for help. Also, their pain may be minimal if they do not move (Watt-Watson, Stevens, Streiner, Garfinkel, & Gallop, 2001).

In addition, clinicians tend to focus on diagnosing and treating disease, not on relieving symptoms. Thus the relief of pain is of minor importance. Scarry (1985) makes this case poignantly: "Physicians do not trust (hence, hear) the human voice...they in effect perceive the voice of the patient as an 'unreliable narrator' of bodily events, a voice which must be bypassed as quickly as possible so that they can get around and behind it to the physical events themselves. But if the only external sign of the felt-experience of pain (for which there is no alteration in blood count, no shadow on the X ray, no pattern on the CAT scan) is the patient's verbal report (however itself inadequate), then to bypass the voice is to bypass the bodily event, to bypass the patient, to bypass the person in pain. Thus the reality of a patient's X-rayable cancer may be believed-in but the accompanying pain disbelieved and the pain medication underprescribed" (p. 6–7). As Kirmayer (1988) argues, the disease revealed by the tests is more real and more important than the distress of the patient.

Trust in the observable, objective, and quantifiable as opposed to the personal, subjective, and qualitative in clinical care reflects ancient biases in Western culture. Lloyd (1984) explains that binary oppositions developed in the ancient world by the Pythagoreans linger on in our ideas about reason and knowledge. The clear and determinate continue to be associated with what is superior and male, the vague and indeterminate with what is inferior and female. This insight reveals an historically constructed bias that is evident today in our evaluation of what constitutes reliable clinical and scientific knowledge. From a positivistic perspective, objective diagnostic tests, such as blood counts, provide the clearest, most determinate results possible. Therefore, trusting them seems to be most rational.

Because medicine's primary goal is to cure disease, it would be easy to claim that distrust of patient subjectivity is a problem in medicine only. Nursing places an emphasis on attending to the subjectivity of patients, as expressed in its interest in quality of life, caring, and treating the patient as a person, and its valuing of the nurse-patient relationship. Yet the inadequate assessment and under-medication of pain is a serious problem in nursing (Close, 1990; Madjar, 1999; Watt-Watson & Graydon, 1995; Watt-Watson et al., 2000).

According to Kelly (1998), nursing students and new graduates must reconcile the ideals they learn in the academy with the ideals they learn in the hospital setting. In striving to meet the demands of their work and to become valued team members, recent graduates compromise their standards of care. The nurses who participated in Kelly's research placed more value on speed and task accomplishment than on caring interactions with patients. Kelly's findings are consistent with Fagerhaugh and Strauss's (1977) classic political perspective on institutional pain management. These authors explain that pain work is peripheral to the staff's legal and organizational responsibilities, resulting in a lack of genuine accountability for the care of patients who are in pain. Staff are accountable for medical tasks, not psychosocial ones, thus reflecting the underlying acute-care model. We hypothesize that novice nurses become re-socialized in the workplace such that their epistemological stance shifts from a focus on subjectivity to a focus on the objectivity characteristic of the medical/acute-care model, leading to a diminished response to patients' subjective experience of pain.

Distrust in the Marginalized and the Relatively Less Powerful

Researchers have found that clinicians do not believe patients when they report pain. Women, the elderly, and members of ethnic minorities are the patients most likely to be disbelieved. The reasons for the disbelief are unclear; however, we surmise that the disbelief reflects the second and third types of trust we have outlined above: patients are viewed as lacking in virtue, particularly honesty, or are deemed to be unreliable knowers.

In a recent study, Watt-Watson et al. (2001) explored this lack of trust in patient reports. Their findings suggest that some nurses have their own benchmark for the level of pain that is acceptable and, possibly, when and how pain is to be expressed. In that study, nurses administered only 47% of the average analgesic dose prescribed for patients with moderate to severe pain. In the final hierarchical regression model of the relationship between pain knowledge and analgesics administered, nurses' belief that patients overstate their pain contributed to 4% of the variance. In other studies, people with chronic non-malignant pain have reported that when others do not believe they have pain, they are blamed for their pain and/or the authenticity of their pain is challenged (Seers & Friedli, 1996; Walker, Holloway, & Sofaer, 1999).

Patients from marginalized groups are the most vulnerable. Evidence since the 1980s indicates that the pain management of these people differs from the norm. For example, it has been found that female patients receive fewer post-operative analgesics than male patients (Calderone, 1990; Faherty & Grier, 1984; McDonald, 1994), that older adult patients receive fewer analgesics than younger adult patients (Duggleby & Lander, 1994; Melzack, Abbott, Zackon, Mulder, & Davis, 1987; Winefield, Katsikitis, Hart, & Rounsefell, 1990), and that patients from racial minorities receive less opioid analgesia post-operatively than Caucasian patients (McDonald). Bernabei et al. (1998) report similar data in a study with 13,625 cancer patients aged 65 or older living in a nursing home. Older patients, members of racial minorities, the cognitively less able, and women are the groups most likely to experience unrelieved pain and minimal or no analgesic administration. Todd, Samaroo, and Hoffman (1993) found that Hispanics with long-bone fractures were twice as likely as non-Hispanic whites to receive no pain medication in emergency departments, although Choi, Yate, Coats, Kalinda, and Paul (2000) found no racial differences in the amount of analgesia given in emergency departments.

Feminist theorists contend that certain groups, such as women, the aged, and people of colour, may be viewed by society as less trustworthy than others, both epistemically and morally (Code, 1991; Sherwin, 1998; Young, 1990). Young's analysis is especially helpful in that it acknowledges that such negative judgements may be unintentional: "Judgments of beauty or ugliness, attraction or aversion, cleverness or stupidity, competence or ineptness, and so on are made unconsciously in interactive contexts and in generalized media culture, and these judgments often mark, stereotype, devalue, or degrade some groups" (p. 133). These types of pejorative and somewhat automatic judgements may underlie clinicians' distrust in the reports of some patients.

Avoidance of Vulnerability

The avoidance of vulnerability relates directly to the first type of trust we have described — the entrusting of oneself to another. Specifically, we argue that clinicians avoid entering into patients' experiences of pain in order to protect themselves from vulnerability. Although pain may be a private experience, it is possible for one person to experience vicariously, through close intersubjectivity, the pain of another. Madjar's (1999) phenomenological study of nurses working in burn care illustrates exquisitely how nurses avoid becoming vulnerable by distancing themselves from their patients. She describes defences that nurses use to protect themselves from becoming overwhelmed by their patients' pain, such as qualifying, defining, explaining, or denying pain such that it becomes invisible or not real; nurses learn to construct pain as inevitable, temporary, sometimes beneficial, and of no great concern. Like Scarry (1985), Madjar concludes that patients in pain are ultimately distanced to the extent of being objectified. Nurses become detached and self-focused, concentrating on their technical performance as opposed to the relief of suffering.

Similarly, Maeve (1998) explored the experiences of nurses caring for patients who were suffering and dying. They tempered their involvement with their patients by avoiding intense relationships, by separating themselves physically from their patients, and by using humour. In this way they were able to distinguish their own lives from those of their patients. These nurses acknowledged that their patients' plights might well be their own in the future, but by tempering their involvement they were able to shield themselves from the suffering of others. Maeve's work, like that of Madjar (1999), illustrates well how the avoidance of full engagement with patients can be self-protective for nurses. Regularly entrusting oneself, in an intersubjective sense, to the pain and/or suffering of another may prove ultimately to be unbearable.

The over-estimation of clinical knowledge and fear of opioids also serve to protect clinicians from vulnerability. Watt-Watson et al. (2001) found that most nurses in their study rated their pain knowledge and management competence as excellent, despite moderate knowledge scores and minimal or no recent pain-related service (the sources of their pain information are not known). Clarke et al. (1996) found that hospital orientation programs offered the least information about pain; nurses reported learning more from informal sources, such as personal experience and colleagues, than from formal education. In addition, we live in a culture that fears opioids. There are misconceptions regarding the dosages that are effective and exaggerated fears of addiction, hastening death, and legal reprisal (Madjar, 1999; Rich, 1997, 2000). These misconceptions and fears help clinicians to rationalize their lack of involvement in patients' pain and serve to protect them from the accompanying vulnerability of entrustment.

Conclusions and Recommendations

We have explored various meanings of the concept of trust in patients in order to better understand the phenomenon of unrelieved pain. The concept of trust can entail entrusting oneself to another, or entering into another's experiences, and it can connote evaluating the moral character/goodness of another. Trust can also be epistemic in nature — confidence in certain forms of knowledge and competence. It can also go beyond dyadic trust relationships to encompass a network of trust relationships (Peter & Morgan, 2001). We have examined several types of clinician distrust in patients that result in inadequate pain relief. A lack of trust in patient subjectivity reveals an epistemic bias that privileges objectivity in a positivistic sense. Unfortunately, the outcome of this epistemological failure is a moral failure: disrespect for patients' bodily experiences and knowledge and, in the end, unnecessary pain and suffering. We have explained that patients' complaints of pain are often not believed, particularly if voiced by members of marginalized or relatively less powerful groups. We hypothesize that this distrust might have a basis in clinicians' judgements concerning patient dishonesty and ignorance. These judgements, too, demonstrate disrespect. Finally, we have described how clinicians shield themselves from patients' pain by distancing themselves in order to resist entrustment.

It would be wrong, however, to hold individual clinicians entirely accountable for these moral and epistemological failings, for such failings have deep cultural and historical roots. They originate in the broader network of trust relationships. Therefore, the focus of change must also go beyond the individual. Broader, societal awareness and reflection are needed. For example, examining the neutrality of scientific knowledge may appear to be purely academic, but this belief in neutrality has ramifications for the delivery of care. Minimally, nursing and medical educators need to be mindful of the ethical implications of wholeheartedly trusting in positivistic science. To distrust the subjective when relieving pain is, often, to disparage the most significant clinical evidence available. It is also important that future and practising clinicians address unconscious racism, ageism, and sexism. In addition, clinicians should be rewarded and held accountable for more than the acute-care needs of their patients; subjective and interpersonal needs should also be valued.

Treating this issue as a systemic one may help to underscore its pervasiveness and may be a less threatening way of confronting it than focusing on the blameworthiness of specific individuals. Research findings regarding the lack of pain relief among the marginalized and relatively less powerful provide grounds for discussion as well as evidence of the everydayness of this issue. Furthermore, clinicians need to be supported in their work such that the moral significance of their own vulnerability and suffering is acknowledged. We realize that this suggestion is highly idealistic. However, clinicians may become depleted through continual exposure to pain and suffering. Finally, we recommend that both clinicians and the public be educated. In an effort to enhance clinicians' understanding of pain theories, assessment, and appropriate management, organizations such as the US Agency for Heath Care Policy and Research, the Canadian Pain Society, and the American Pain Society have published position statements and guidelines for optimal practice. Almost all acute and cancer pain can be relieved, and many patients with chronic non-cancer pain can also be helped (Watt-Watson, Clark, Finley, & Watson, 1999). While fears of regulatory scrutiny related to opioids are valid, admonitions against drug use do not always differentiate between illegal abuse and therapeutic use. With time, clinicians can become more knowledgeable and feel less vulnerable in prescribing and administering appropriate analgesia, particularly opioids. Patients, too, should become more knowledgeable about pain management and learn to expect more from clinicians. Rich (2000) describes patients misguidedly trusting physicians and nurses to not allow them to suffer unnecessarily. Ironically, however, patients ought to trust clinicians less.

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Hope and Feminist Care Ethics: What Is the Connection?

Christy Simpson

Encourager l'espoir des patients est considéré comme un devoir pour les fournisseurs de soins de santé, infirmières et infirmiers compris. Aussi a-t-on proposé différents types d'intervention permettant de répondre à cette obligation. Toutefois, on a consacré moins de temps à examiner ce devoir sous ses aspects moraux et à déterminer un cadre déontologique adéquat pour procéder à cet examen. Étant donné l'importance de l'espoir dans la vie des patients et celle de leurs relations avec les fournisseurs de soins de santé, l'auteure soutient qu'en la matière une approche fondée sur l'éthique féministe est ce qui convient le mieux. L'auteure s'inspire en particulier de l'éthique prônée par Joan Tronto et aborde les quatre aspects qu'elle décrit pour leur lien avec le rôle de l'espoir dans ce domaine. Enfin, l'auteure montre dans cet article qu'il est possible pour les fournisseurs de soins de santé de se soucier de l'espoir, et de l'entretenir. Puis à partir de ce cadre, l'auteure traite de l'orientation future des recherches en sciences infirmières.

Health-care providers — including nurses — are considered to have an obligation to foster hope in their patients. Various interventions for fulfilling this obligation have been suggested. Comparatively little time, however, has been devoted to examining the moral aspects of this duty and to situating this investigation within an appropriate ethical framework. Given the significance of hope in patients' lives, and the significance of their relationships with health-care providers, the author contends that a feminist care ethics approach is best suited for this investigation. In particular, the author draws upon Joan Tronto's ethic of care and discusses the 4 aspects of care she describes as they relate to the role of hope in health care. Ultimately, this paper shows that it is possible for health-care providers to care about and for hope. Based on this framework, future directions for nursing research are discussed.

Introduction

The notion of hope takes on special importance in the health-care context, as pain, uncertainty, and fear frequently accompany illness and injury. Patients look to their health-care providers not only for cures or treatments, but also as sources of comfort. Indeed, nurses have consistently been cited as enablers or supporters of hope by patients across both the age spectrum and the illness continuum (Farran, Herth, & Popovich, 1995, p. 106). Further, it is claimed in the nursing and medical literature that health-care providers have an obligation to promote, instil, and foster hope in their patients (see, e.g., Dufault & Martocchio,

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Christy Simpson, PhD, is Clinical Ethics Coordinator, Department of Bioethics, Dalhousie University, Halifax, Nova Scotia, Canada.

1985; Kodish, Singer, & Siegler, 1997). A number of health-care interventions for nurturing hope have been described (see, e.g., Herth, 2000; Penrod & Morse, 1997; Roberts, Johnson, & Keely, 1999).

By quickly moving from duty to action, however, we may have skipped over some important ethical terrain. It is worth taking a step back to examine this terrain. I submit that there is more to consider than merely whether a patient is hopeful and the interventions that might be employed to instil hope. In particular, the moral framework most appropriate for analyzing the duty to promote and instil hope must be determined, so that the ethical aspects and issues of attending to patients' hopes can be identified and addressed. I argue that a feminist care ethics framework is most appropriate for this task. I explore the ways in which this framework focuses our attention on relationships of care as they pertain to patients' hopes, and the ways in which it lends itself to future research.

Focusing on Hope

The role that hope plays in the lives of patients and health-care providers should not be ignored or underestimated: hope makes a difference in how people live their lives. Studies suggest, for example, that hope promotes healing (Cousins, 1989; Gottschalk, 1985; Udelman & Udelman, 1985, 1991), facilitates coping (Elliott, Witty, Herrick, & Hoffman, 1991; Herth, 1989), and enhances quality of life (Staats, 1991). Further, a connection has been found between loss of hope and depression and suicide (Abramson et al., 2000; Beck, Steer, Kovacs, & Garrison, 1985; Brown & Harris, 1978). Thus, the significance of hope to people's lives must not be ignored.

Further, one's relationships with others — including health-care providers — can have a great impact on one's ability to have and sustain hope (e.g., Farran et al., 1995; Wong-Wylie & Jevne, 1997). This point is illustrated in a comment by Bonnie Sherr Klein, a woman who is recovering from a stroke and learning how to talk by covering her tracheostomy tube, in which she recalls an incident some 2 months after her stroke:

> The speech therapist said that I would never regain normal speech. I could try, and she could help, but we were doomed to failure. The damage had been done, and we had to be "realistic" in our expectations. She was cool and brisk, as if she had just stopped off at the hospital on the way to doing something really important, like preparing to give a dinner party.

> I was devastated. How could I be me if I couldn't speak? Who the hell did she think she was? Who taught her it was her job to make me "realistic," to dash my so-called false hopes? (Klein, 1998, p. 146)

The speech therapist's dismissal of her efforts as "doomed to failure" does not convey a sense of caring about, or even acknowledgement of, Bonnie's hopes and fears with respect to her recovery. It is clear that, because of her dependence on the speech therapist for support, Bonnie resents the way in which her hope is challenged — and potentially destroyed — by this person. Given the nature of the relationship between patients and health-care providers — with the patient having less power, less control, and less information about his or her condition (Sherwin, 1992) — patients are dependent upon and vulnerable to what health-care providers say and do in terms of both their ability to hope and what they can hope for. Therefore, exploring the moral dimensions of this relationship with respect to hope seems particularly important. A recurring theme emerges from stories like Bonnie's, about hope being supported or destroyed by a health-care provider: patients want health-care providers to acknowledge and address their suffering, problems, victories, defeats, and recovery in a caring manner.

Given the significance of hope in people's lives and the significance of people's need for support, *how* should health-care providers fulfil their moral duty to attend to the emotion of hope in their relationships with patients? From a philosophical perspective, the first step is to choose an ethical framework for situating the analysis and/or providing a basis for the assessment of moral decisions. I shall now explore the suitability of the traditional or standard ethical approaches for addressing these aspects of hope in health care.

Choosing an Ethical Framework

One could consider using the standard or traditional ethical theories for this investigation. Indeed, any of a variety of ethical theories and approaches, such as Kantianism or consequentialism, could be used in identifying and addressing problematic assumptions or practices with respect to hope in health care. However, not all ethical theories are equally suited to the same types of moral work. What this investigation requires is a normative framework that is able to sort through and deal with the ethics of relationships. In particular, the framework must be able to provide insight into how best to structure, conduct, and evaluate relationships between unequal partners. As Sherwin (1999) argues, some ethical theories may have more appeal than others in a particular case, because "each sort of theory helps to make clear certain dimensions of the subject that may be inaccessible when using other approaches" (pp. 202–203).

Traditional ethical discussions, if they do address the question of hope in health care, tend to focus on the dilemma of telling the truth versus preserving a patient's hope and the difficulty of dealing with patients who have "false" hopes (see, e.g., Brody, 1981; Kodish & Post, 1995; Ruddick, 1999). And yet in Bonnie's case there is much more that can and should be said about the patient's hope of regaining her ability to speak. To limit the analysis to whether this hope is false and should be destroyed is to ignore a number of other ethical features of the situation. For example, it is not clear what the grounds for judging hope are, whether Bonnie's hopes do need to be changed, and even whether the therapist's own hopes (or lack thereof) for Bonnie's recovery need to examined. One might also critique both the therapist's approach to destroying hope and the manner in which she tries to make Bonnie hope for something realistic. There is little doubt that the relationship between Bonnie and the therapist is damaged by the way in which this discussion about hope occurs.

One of the difficulties with using the standard ethical approaches to examine hope is the paradigm that underlies theories like deontology and consequentialism, despite their differences. This paradigm assumes that the best moral decisions are those that are made from a disinterested and disengaged point of view, on the basis of certain universal or codifiable principles (for more discussion, see Walker, 1998). In addition, these theories have tended to abstract away from the particularities of each individual, to identify a generic feature of all individuals, such that one can determine who is worthy of consideration when making moral decisions.

The upshot of this paradigm for circumscribing the moral terrain is that traditional theories, in focusing on what determines whether a person deserves moral consideration, are not able to "make clear" the different relationships and contexts within which people live and work. By assuming that individuals are equal and that "each counts for one" (as claimed by basic utilitarian theory), these theories tend to overlook the ways in which people are interdependent and how such interdependence should be factored into our moral decisions. Thus, while the standard approaches to ethics do help to "make clear" certain features of the moral terrain (such as the consequences of actions), we will need a framework based on a different paradigm. In other words, investigation of the role of hope in health care requires a moral theory that is designed for exploring relationships and interdependencies.

What is needed, then, is an ethical theory whose starting point is the relationships between persons who occupy different roles or positions. Care ethics recognizes the particularity of individuals as well as the relationships of care between individuals. It creates a space within which our emotions, as part of our moral life, can be attended to. This framework can also help us to see how our moral decisions both affect and are affected by our emotions and our connections to others, whether personal or professional. Care ethics requires us to look at the ways in which patients and health-care providers interact — primarily not out of concern for rights, autonomy, or truth-telling (although these can play a role in patient care as well as patient hope), but out of concern for the ways in which care is given and received.

Using a Feminist Care Ethics Framework

While all theories of care ethics examine relationships of care, the most appropriate for an analysis of hope in health care is feminist care ethics. The advantage of a feminist care ethics over other care ethics theories is the opportunity it offers to specifically address power imbalances in caring relationships. Many feminists ask who has what power, who has particular resources and who does not, and who makes decisions and for what reasons. These questions encourage us to consider the various relationships within which people are embedded, and the choices they are sometimes forced to make as a result of these relationships. The questions raised by a feminist perspective are directly relevant to the role of hope in health care, especially in combination with a care perspective. Since health-care providers have, on balance, more power than patients, we need to ensure that we do not increase the power imbalance by taking something away from patients. In the case under discussion, what should not be taken away is patients' ability to discover and sustain hope. From the perspective of feminist care ethics, one can also consider the ways in which, for example, cutbacks and policy decisions affect the ability of health professionals to provide care, including their ability to meet patients' hope needs.

In *Moral Boundaries: A Political Argument for an Ethic of Care*, Joan Tronto (1993) makes a sustained critique of the traditional care ethics debate and highlights the political context within which both this debate and caring activities occur. She is careful to attend to the ways in which power relations affect our understanding of what care is, what the practices of care are and should be, and who is and should be providing care. The result is a well-developed and well-defended feminist theory of care ethics. By breaking care or caring activities down into four aspects, and noting the contextual elements that affect each aspect, Tronto's approach represents an advancement over other care ethics theories, for two reasons: (1) it is explicit about the importance of recognizing and understanding the other person's needs and responding appropriately (this is discussed below), and (2) its political basis enables Tronto to address criticisms of other care ethics theories for paying insufficient attention to the social and economic contexts in which caring relationships exist (see Carse & Nelson, 1996; Houston, 1993). In other words, Tronto's ethic of care will help an investigation into hope and its role in health care to reveal and comment on the ways in which current forms of care distort and trivialize expressions of hope, and may lead to improved caring about and for this emotion.

But what does it mean to "care" and to "care about patients and their ability to hope"? How should health-care providers go about offering this kind of care? Tronto's four aspects of care are: caring about, taking care of, care-giving, and care-receiving (1993, pp. 106–108, 127–136). Each of these distinct yet interrelated facets of care is relevant for understanding the ethical issues connected with hope and the role of hope in the lives of patients and health-care providers. I will now review these four aspects of care, paying particular attention to how each one highlights different features of hope that are relevant for its appropriate (ethical) acknowledgement and its role in health care. Due to space constraints, this analysis will focus on patients and their hopes as recipients of health care.

Caring About

Caring about is recognizing that a need for care exists and that something should be done to meet this need. Yet whose needs are being recognized, and what these needs are taken to be, can be shaped in various ways — for example, by the society in which we live and by our position/role in that society. With respect to determining a patient's hope needs, the health-care provider may not know what the patient's values and goals are nor what resources are available to support the patient's hopes (which can, in turn, affect what is hoped for).

This aspect of care therefore requires attentiveness on the part of those who are in a position to offer care. In other words, the health-care provider has a moral responsibility to consider what needs others might have and to acknowledge those needs. As Bonnie's experience illustrates, if the need for hope and the need for the patient to have his or her hopes respectfully addressed are not taken seriously by the health-care provider, much emotional damage can be done to the patient and, in turn, the relationship between the patient and the health-care provider can be affected. Determining what should be done with respect to the "hope needs" of patients ought to be guided by the other three aspects of care.

Taking Care Of

In *taking care of*, the individual who has determined that there is a need takes responsibility for meeting this need: by deciding that something can be done, considering the various options, and choosing to act. By extension, then, *taking care of* requires that care-givers accept the implications of their decisions about which action(s) to pursue given any apparent constraints or limitations. *Taking care of* boils down to finding an appropriate way to provide care such as by bringing together whatever resources are necessary to make care happen. Proper attention to the needs of others will give some guidance as to what types of actions may be best and can thereby inform this aspect of care. *Taking care of* that fails to consider various treatment alternatives or various assumptions about care can result in an inappropriate action for meeting a patient's hope needs.

This last point is illustrated by a study of American oncologists' understanding of and discussions about hope. The oncologists based their hopefulness "primarily in the biomedical dimensions of their work. Caring is conveyed through the treatment process, through offering therapeutic options and holding out hope for the development of new treatments on the cutting edge of medicine and technology" (Good, Good, Schaffer, & Lind, 1990, p. 74). While medical intervention may well be necessary, this form of care will not necessarily meet all of the hope needs of patients and may even distort both oncologists' and patients' perceptions of such needs. Toombs (1995) argues that this form of care tends to treat "the psychological, spiritual, social, and cultural aspects of illness" as "peripheral" (p. 12). Indeed, if oncologist-patient discussions are limited to the hope for a cure, then patients' hopes in terms of quality of life or day-to-day coping with cancer will be left unattended or even overlooked. In other words, *taking care of* entails a re-evaluation of care practices in order to identify those that may unduly limit patient hopes and effectively ignore a patient's values — especially if these values differ from those of the health-care provider.

Care-Giving

The third aspect of care, *care-giving*, involves "the direct meeting of needs for care" (Tronto, 1993, p. 107). This is perhaps the most obvious part of care, as it is the "doing" of care. Tronto notes that it frequently entails physical work and typically requires contact with the care recipient. In other words, care is primarily a face-to-face activity and involves both the recipient and the provider. However, as Ruddick (1998) points out, the physical demands of care-giving should not overshadow the emotional needs of the patient: "Most recipients of care are only partially 'dependent' and are often becoming less so; most of their 'needs,' even those [that are] clearly physical, cannot be separated from more elusive emotional requirements...respect, affection, and cheer [and hope]" (p. 11).

This aspect of care extends care-givers' responsibility to ensuring that care is competently provided. Competence here means the ability and skills to provide care according to need — such as the ability and skills to acknowledge the significance of a patient's hope. With respect to hope, for example, competent care recognizes the vulnerability that is often associated with hope and responds to it by ensuring that discussions with patients about the possibility for hope take this vulnerability into account. It may influence when and how information is shared with patients and extends to day-to-day conversations with patients. This is not to suggest that patients should be lied to in order to preserve their hope, but attention ought to be paid to not only what information should be divulged in a discussion with a patient but also the discussion itself. In Bonnie's case, hope care ignores this feature of hope and therefore is not competently given. Telling Bonnie that efforts to regain her ability to speak are doomed to failure does little to address her hope needs. In addition, the therapist gives Bonnie the impression that she is on her way to somewhere more important, which clearly adds to Bonnie's sense that neither she nor her hope to regain her speech are worthy of consideration.

Care-Receiving

Care-receiving, Tronto's fourth aspect, is the involvement of the person whose need for care has been identified. Only by including the care recipient can it be determined whether the need has been accurately framed and whether the actions taken are appropriate (Tronto, 1993, p. 108). The moral responsibility Tronto ascribes to this aspect of care is responsiveness on the part of care-receivers. Although Tronto does not fully explain this, responsiveness is understood to cut across the other three aspects of care; in other words, care-receiving should not be limited to or thought of solely as the end-point of care (everything has been done; now let's see how the person responds). Care-receiving should be integral to defining and redefining needs and to choosing appropriate actions, and it can occur concurrently with care-giving. The care-giver must be aware of and attend to the care-receiver's responses to each aspect of care. Tronto establishes a "feedback loop" of responsiveness (care-receivers) and attentiveness (care-givers) as a part of what makes "good" care.

The importance of feedback from patients is illustrated by the debate on how best to deal with "false" hopes. To assume that a patient's hope should be changed because it is not likely to be met is to miss much of the point about how to care for patients. As Bonnie's story suggests, actually fulfilling a hope may not be what is most important to the patient. What may be most important is for others — including health-care providers — to actually hear what the patient's hopes and fears are and try to understand what the experience of illness or injury is like. Stephen Schmidt, a person with Crohn's disease, writes in an open letter to health-care providers:

> When you come into my room...support my hope that tomorrow there may be new medicines[,] that today you care deeply[,] that you will do your best. When you come into my hospital room, promise me presence[,] promise me a healing partnership. (Schmidt, 1996)

Since all aspects of care, from identifying needs, to acting on them, to evaluating the response, are subject to scrutiny using Tronto's theory, better judgements should be made about how to provide ethically appropriate and defensible care with respect to hope.

Conclusion

I have used an excerpt from Bonnie's story to illustrate the importance of hope in health care and to support the claim that feminist care ethics is the approach best suited to determining how to morally respond to and acknowledge the significance of hope in people's lives. However, not all of Bonnie's interactions with her health-care providers had a negative effect on her ability to hope. If what I have said about the possibility for care to meet the hope needs of patients is correct, the following account by Bonnie suggests a model of good caring that attends to hope in moral ways:

> I still couldn't breathe, eat, pee, sit up, or dance, but surely these would come soon. Meanwhile the nurses did practically everything for me. There was skin care, back care, mouth care, bedpans, massage,

> bed baths… The best time was Rick's shift... He'd tell me about his day and what he was doing and what he was going to do next: not profound talk, just talk. (Klein, 1998, p. 117)

Although Bonnie received many forms of care, it is the care that she received from Rick — his conversations with her — that she recalls as the most significant. Rick's care provides a space for Bonnie to identify and articulate her hopes for her recovery. By treating her as a person capable of thinking and of engaging with others (even if in a limited way), Rick fosters in Bonnie a sense of self and what she wants for her life. This example shows that it is possible to care for others in a way that allows for, and even encourages, the development and expression of hope.

Still, determining that Tronto's ethic of care provides a suitable framework for this investigation into hope is only the first step in determining how to attend in moral ways to hope needs. Much more research is needed into current health-care practices with respect to hope. As the above examples demonstrate, frequently hope is not properly considered in interactions with patients and is unduly limited in terms of what count as legitimate reasons for hope. But, as Rick's care of Bonnie suggests, there is reason to *hope* that health-care providers will find ways to morally attend to this emotion as part of the care they offer to patients.

Future Directions for Nursing Research

Since nurses are responsible for the day-to-day care of patients and often have more contact with patients than other health-care providers, they are well positioned to address the hopes and hope needs of patients. Nurses have many opportunities to discover what patients hope for and are well equipped to encourage patients whose hope has been challenged. And yet, given the workload of many nurses and the increasing demands on their time, is it possible for nurses to fulfil their duty to promote hope and their other duties as well? More theoretical and ethical investigation is required to determine whether the duty to promote hope conflicts with or complements other professional duties. Two key questions to address are: Where does, or should, hope fit into the code of ethics for nurses and other health-care providers? Can Tronto's four aspects of care help nurses to identify and resolve the tensions among their various responsibilities? A longitudinal study of how practices of care change over time, in relation to acknowledging and addressing patient hope, would be a valuable tool for monitoring the effects of cutbacks and restructuring.

More research is also required to determine whether current healthcare practices destroy patient hope unnecessarily and whether they should be modified to better address hope. For example, patient surveys or interviews about nursing practices that fall under each of Tronto's four aspects of care might reveal the ways in which patients' hope needs are or are not being met. Also, tracking of the care that patients receive could provide insight into the ways in which hope is or is not attended to over the course of a patient's experience. We might then be in a position to address questions such as the following: Is hope attended to over time with a given patient? Is hope addressed only when there is crisis or a sudden change in a patient's health status? Is hope discussed in the terminal phases of a patient's life?

The nursing literature describes a variety of interventions for increasing or instilling hope in selected patient populations. These interventions, however, require more research as to their efficacy and suitability (Farran et al., 1995; Penrod & Morse, 1997). Although Holt (2001) found that the factors cited by patients and families as supportive of hope were for the most part congruent with nursing interventions cited in the literature, more in-situ research on these interventions is required. Herth (2000) recently evaluated a theory-driven nursing intervention program to enhance hope among persons experiencing a first recurrence of cancer. The findings suggest that nursing interventions can foster hope but that further research is needed on how to tailor the intervention(s) to specific patients. As well, some interventions may be more effective at certain times over the course of a patient's illness or recovery. Research into this issue, and into the development of systematic means of measuring the effectiveness of such interventions, might ultimately help nurses to provide care that is more responsive to patients' hope needs.

Also worthy of investigation are nurses' attitudes and beliefs regarding hope and how these relate to and influence their interactions with patients. Whether or not nurses themselves have hope, and what their hopes are, might affect their ability to provide hope care. Given the above-described interconnections between care-givers and care-receivers, this aspect of hope care should not be ignored; in other words, the focus on patient hope should not obscure the hope needs of nurses. The question of whether nurses have hope and are able to develop and sustain hope in their professional practice is vital to broadening the analysis of hope and the ethics of care. Research questions specifically addressing the hopes of nurses might include: How do nurses define hope? What are nurses' key sources of hope/hopelessness? How do nurses deal with situations in which patients' hopes differ from their own? Does nursing care differ for patients who have hope and those who do not? Simmons, Nelson, and Neal (2001) have done some preliminary work in this direction by comparing the positive and negative work attitudes of home-care and hospital nurses; they found hope to be one of the attitudes that related to job satisfaction and to the need for decreased role ambiguity.

Ultimately, the findings of future research could serve to substantially enhance our ability to create and maintain caring relationships that will better identify and respond to the hope needs of patients, nurses, and other health-care providers.

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Author's Note

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Comments or queries concerning this paper may be directed to Christy Simpson, Clinical Ethics Coordinator, Department of Bioethics, Dalhousie University, 5849 University Avenue, Halifax, Nova Scotia B3H 3J5 Canada. Telephone: 902-494-3801. Fax: 902-494-3865. E-mail: christy.simpson@dal.ca

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Economism, Efficiency, and the Moral Ecology of Good Nursing Practice

Sara M. Weiss, Ruth E. Malone, Joseph R. Merighi, and Patricia Benner

La rhétorique du marché concurrentiel qui domine les discussions en matière de politiques de santé aujourd'hui identifie les produits et les services médicaux comme des commodités destinées à être consommées par le public, qui les achète ou ne les achète pas, selon le prix. Les systèmes de soins sont révisés et les hôpitaux restructurés sous l'angle de l'accroissement de l'efficacité et de la productivité. À partir des expériences des infirmières cliniciennes œuvrant aux États-Unis, cet article démontre comment l'application de la notion d'économisme à la profession peut gravement porter atteinte à l'écologie d'une pratique infirmière saine et rend difficile le maintien de normes de soins minimales. De plus, elle limite sérieusement les gestes de compassion qui doivent être posés lorsque les gens vivent la maladie, la perte et la mort. Des préoccupations portant sur la responsabilité morale et les oppositions entre objectifs institutionnels et objectifs infirmiers sont émises. La présence d'une méfiance de plus en plus grande face aux systèmes de santé de la part des praticiens, des patients et des familles suggère que le temps est venu de se pencher attentivement sur la question de l'écologie morale dans le domaine des soins infirmiers.

The free-market rhetoric dominating health-policy discussions today frames health-care goods and services as commodities that consumers will or will not buy at a given price. Health-care systems are being redesigned and hospitals restructured with a view to increased efficiency and productivity. Drawing on the experiences of clinical nurses in the United States, this paper shows how the application of economism to nursing may severely disrupt the ecology of good practice, leading to difficulties in meeting minimal standards of nursing care and severely constraining the acts of compassion called for by the human experiences of illness, loss, and death. Concerns about moral responsibility and conflicts between institutional and nursing goals are described. Increasing mistrust of health-care systems on the part of practitioners, patients, and families suggests that it is time to attend closely to the moral ecology of caring practices.

Sara M. Weiss, RN, PhD, is Research Scientist, Institute on Aging, San Francisco, California, USA, and Assistant Clinical Professor, Department of Physiological Nursing, University of California, San Francisco. Ruth E. Malone, RN, PhD, is Acting Associate Professor, Department of Social and Behavioral Sciences, School of Nursing, and Institute for Health Policy Studies, University of California, San Francisco. Joseph R. Merighi, MSW, PhD, is Assistant Professor, College of Social Work, San José State University, San José, California. Patricia Benner, RN, PhD, FAAN, is Professor, Department of Social and Behavioral Sciences, School of Nursing, University of California, San Francisco.

> *A lot of issues that are simply monetary for a lot of people around us, above us, below us, are completely ethical and moral for us. I find that particular situation is the most difficult situation for me as a professional, and it's getting worse and worse.*
>
> – Registered nurse practising in the United States

Over the past two decades, proponents of free-market competitive models of health care have argued with unwarranted optimism that such models are the answer to accelerating health-care costs in the United States (Ellwood & Enthoven, 1995; Enthoven, 1981, 1988). These models have been the subject of considerable criticism based on the conflicts of interest they can cause for physicians, the way in which they have changed the locus of clinical decision-making, and the economic threat that market-based institutions pose to safety-net services for the uninsured (Kassirer, 1995, 1996; Malone, 1999; McKenzie & Bilofsky, 1994; Mechanic, 1996; Relman, 1992; Smith & Lipsky, 1992; Socolar, Sager, & Hiam, 1992). Even in countries with excellent public health-care systems, such as Canada, ideological pressures for privatization and competition raise similar concerns. The discussion of competitive, market-based models has focused on the relationship between physicians and patients or between physicians and payers, as though these were the only actors. Yet clinical nurses occupy a unique place in the health-care system. As has been noted elsewhere (Andre, 1998), they hold a central and morally difficult position insofar as they act as interpreters between patient, family, physician, and system; bear a largely unacknowledged responsibility for critical, moment-to-moment decision-making; and spend more time than other health-care providers in direct contact with patients — yet have little structural power to alter the institutional conditions under which they practise.

Nursing as a practice carries both practical and symbolic meanings, embedded in an ethic of caring for vulnerable, commonly ill or injured, others (Benner, 1994a, 1994d, 1997; Benner, Tanner, & Chesla, 1996; Benner & Wrubel, 1989). To become educated and socialized into any practice is to develop the skills, knowledge, and character traits suitable for that practice. However, caring professions such as nursing, medicine, and social work are socially organized: institutional structures and spaces support them and facilitate their passage to successive generations of practitioners (Malone, in press). A practice embodies more than technology and science, more than individual knowledge and technique. Practitioners adopt styles and patterns of relating and attending to those they serve. Social institutions play an important part in the quality of caring practices, in that good public institutions and good citizenship are mutually supportive:

> The relationship between compassion and social institutions is and should be a two-way street: compassionate individuals construct institutions that embody what they imagine; and institutions, in turn, influence the development of compassion in individuals. As both Rousseau and Tocqueville show, empathy and the judgment of similar possibilities are profoundly influenced by the ways in which institutions situate people in relation to one another… Similarly, institutions teach citizens definite conceptions of basic goods, responsibility, and appropriate concern, which will inform any compassion that they learn. Finally, institutions can either promote or discourage, and can shape in various ways, the emotions that impede appropriate compassion: shame, envy, and disgust. (Nussbaum, 2001, p. 405)

Here, Nussbaum outlines the shape of a moral ecology, calling attention to the way in which institutions structure moral action. Moral activity, in turn, shapes institutions. Caring practices develop not in a vacuum but within specific institutional settings. Nursing takes place almost entirely within institutions: hospitals, home-care agencies, public health departments, and schools. How these institutions are structured, and the organizational values they embrace as primary, directly affect the practice of nursing.

The Ecology of Practice

Aristotle (1985) made a distinction between production and practice. The making of things can be reduced to narrow, rational technique, whereas practice is relational and entails a responsibility to do right by others. A practice has goods that are internal to it; these notions of good are socially embedded in the teaching and expectations of practitioners (Dunne, 1997; MacIntyre, 1981). In this view, individual practitioners are members rather than competitors seeking independent goals; they must be open to experiential learning and ongoing education and research. Experiential learning involves the recognition of failures and errors as well as insight and innovation. In forming habits, thoughts, and actions, the practitioner envisions and adopts the standards of good practice.

Experiential learning in a complex and rapidly changing practice is necessarily risky and expensive. It is irresponsible for practitioners to keep innovations or errors a secret from colleagues because, as members of a socially organized group, they hold joint responsibility for continually improving the practice (Rosner, Berker, Kark, Potash, & Bennett, 2000). The practitioner develops traits and skills that are characteristic of excellent practice in order to achieve the ends of the practice. Just as an athletic team trains in order to achieve mental and physical mastery of the sport and a coordinated response, so the practitioner develops the character and skills to be a good practitioner. To be a good practitioner is to embrace the structures and processes that embody the principles of good practice and that organize a community of practitioners around common goals. We suggest that the interaction between a practice and the institutions upon which it depends constitutes a moral ecology, and that critical examination of the ecology of nursing practice is essential to its survival. In this paper, we analyze data from qualitative research findings to show dimensions of the ecology of hospital nursing practice in the United States under conditions of increasing cost-containment.

By moral ecology, we mean the institutional influences that shape the social and moral working environment. Ecology, as a concept derived broadly from the environmental movement, asserts that an endangered plant or animal cannot be considered in isolation; it must be considered in terms of the ecosystem of which it is a part. Thus the concept of an ecology of nursing practice implies temporal and moral dimensions, in addition to the physical, institutional dimensions that are essential to good practice.

In an ecological approach, particular attention is paid to aspects of caring work that resist abstraction and commodification (Donnelly, 1995). Such an approach also considers the goal of *sustainability*, although how that is to be defined is a matter of ongoing ideological and theoretical debate (Norton, 1995). It seems reasonable to assume that as a society we have a basic interest in healing those who are sick or injured and in maintaining health, and thus should consider how to sustain the kinds of practices that support these aims. In a sustainable moral ecology of good nursing practice, or of any health-care practice, the etiquette and social norms of the institutions will be congruent with the ethics and ethical comportment of its members (Benner, 1994b; Day, 2001; Day & Benner, 2002).

Methods

This paper reports findings from the second phase of an interpretive phenomenological study of skill acquisition and clinical and ethical reasoning among nurses caring for critically ill patients in the United States (see Table 1). The first phase, Expertise in Nursing Practice, articulated the knowledge embedded in critical-care nursing practice, the exercise of clinical judgement, and the acquisition of skills (Benner et al., 1996). The second phase, Teaching Critical Thinking and Clinical and Ethical Reasoning, extended the first phase and coincided with dramatic changes taking place in the US health-care system and in critical-care nursing under the expansion of managed care and the market model during the mid-1990s (Benner, Hooper-Kyriakidis, & Stannard, 1999). The second phase updated the earlier findings and also included areas of critical care not covered in the first phase: burn intensive care, neurologic intensive care, emergency care, flight nursing, operating-room nursing, post-anesthesia care, and home care. In the second phase we interviewed 75 nurses from 20 hospitals and one home-care agency and observed a subsample of 31 nurses in their practice, documenting critical-care nursing at a time of extreme destabilization of health-care delivery.

Audiotaped interviews were conducted with nurses individually and in small groups. The participants were asked to share episodes in their practice in which they felt they had made a difference or learned from the experience. The observations of the subsample of nurses in their everyday practice were conducted by trained nurse ethnographers. Transcriptions of both the interviews and the nurse ethnographers' notes were analyzed with a view to exploring the context in which the episodes described in the interviews took place. The study was approved by the University of California at San Francisco Committee on Human Research and all nurse participants provided written consent prior to being interviewed or observed. To protect confidentiality, names and identifying information are omitted from this report. In both phases of the study, data collection and analysis were guided by the following aims:

> 1. To delineate the practical knowledge embedded in expert practice
> 2. To describe the nature of skill acquisition in critical-care nursing practice
> 3. To identify institutional impediments and resources for the development of expertise in nursing practice
> 4. To begin to identify educational strategies that encourage the development of expertise (Benner et al., 1996)
> 5. To articulate the nature of knowledge and interventions in critical care.
>
> (Benner et al., 1999, p. 6)

As well as confirming many of the findings of the first phase, the second phase revealed new means of acquiring and sustaining moral agency in the face of economic restructuring. The interview and observational data on skill acquisition and clinical and ethical reasoning included large segments on the disruptive effect of economic pressures and downsizing. By analyzing these segments using interpretive

Table 1 *Phase One and Phase Two*

	Dates	Hospitals	Home-care Agency	Nurses Interviewed	Nurses Observed*
Phase One Expertise in Nursing Practice	1988–92	8		130	48
Phase Two Teaching Critical Thinking and Clinical and Ethical Reasoning	1996–97	20	1	75	31

*Subsample of nurses interviewed.

approaches described elsewhere (see Benner, 1994c; Benner et al., 1996), we identified new themes capturing the effect of institutional changes on nursing. This paper presents an interpretive analysis of thematic data on disrupted nursing practice in the face of new economic pressures.

Findings

In the hospitals studied, system reorganization had been undertaken in response to perceived market pressures to be more competitive and minimize staffing costs. This had resulted in hiring freezes, staff cuts, and altered work expectations. The altered working conditions disrupted the continuity of specific nursing units. An Adult Critical Care Clinical Nurse Specialist (CNS) drew attention to the additional labour needed to compensate for the disruption:

> Interviewer: *What is the size of your staff?*
>
> CNS: *We have a lot of [vacancies]. We couldn't hire for so long…so we have per diems [nurses hired by the day], floats [nurses not regularly assigned to any one unit], new people. And they're great nurses! But we don't have that…core group of people that…all knew the standards, and so we're doing some standards revisions on the [leadership] committee right now… We're working on that, but it's also saying, "What's realistic today…in practice? Do you mount strips [the practice of incorporating EKG recordings into the patient chart at regular intervals]? How frequently?" I had the staff nurses calling other institutions in [the area] to*

> *find out… And saying, "Is this really possible to do any more?" Because it doubles [nurses caring for twice the number of patients they are customarily assigned] like crazy in here, and it's not regular staff. So we have to really look at what we're doing. When I started in critical care we checked capillary refill [examining how quickly and adequately capillaries refill after pressure is applied to the fingernail, a sign of the patient's perfusion] every 2 hours and wrote it down once a shift and PRN [as needed]. Do we really need to do that for every patient, and when does judgement, nursing judgement, come in? We have to give them a base to start from: "This is the minimum." But then, from there…nursing judgement has to come in.*

The core group to which the CNS refers is a community of caregivers who have shared understandings, standards, and visions of good practice. Such a community forms a socially embedded ethos and style of vigilance. The group recognizes blind spots and weaknesses as well as strengths, and cross-monitoring serves to strengthen, augment, and correct (Risser, Simon, Rice, & Salisbury, 1999). When the group is composed of per diem workers and floats, and when turnover is high, the community of vigilance and internal control is disrupted. Nurses working on the same unit are unfamiliar with one another's practice style, pace, and special abilities; thus, shared understandings must be replaced with written standards. The word *standards* as used here suggests a minimum level of safety. When standards are lowered to fit the reality of minimal staff resources, rather than being established on the basis of safety requirements and excellent practice, their meaning and social function are reversed.

There is a conflict here in that written standards are brought in to make up for the gaps in knowledge and continuity caused by the loss of the core group. When expectations are lowered to a minimum, nurses must rely on their "judgement" to decide whether additional measures are needed. This requirement for judgement comes just when there are fewer nurses and fewer institutional supports to ensure the kind of stable staffing and continuity that foster good judgement. The ecology of good nursing practice thus appears to be disrupted, as "flexible" staffing serves to minimize familiar and relational knowledge exchanges.

The institutional value systems under which nursing is practised must sustain some congruence with both cultural and practice values. This *moral* ecology of practice warrants close attention, because it is critical to the socialization of new practitioners. As unit stability diminishes, so too does the ability of practitioners to maintain reasonable standards:

> Nurse: *I've brought my standards down, too, a level. But there's a minimum, you know, a bottom that I won't go past. And it's very frustrating to witness.*
>
> Interviewer: *When you say "standards," what exactly are you talking about?*
>
> Nurse: *About the level of nursing care that's provided in terms of assessment, interventions, and even documentation... If a patient has a dressing on, then I expect the nurse to know or find out what's under that dressing... What happens now is [a nurse may say], "The docs didn't write an order to change anything," so they just leave it. And that can't be an excuse... In the past, nurses were always either saying [to physicians or to each other], "Well, that's the wrong dose," or "Hey, you haven't addressed [the fact] that this person is a diabetic and we haven't checked any sugars yet." [Now there are] oversights, many oversights.*

This nurse calls attention to the fact that cross-monitoring requires time, staff, and/or familiarity among practitioners. Contrary to constricted views of nursing practice as merely carrying out the orders of physicians, nurses do recall, check, question, and verify the treatment decisions of physicians and other nurses. However, staff instability and the need for increased efficiency make this kind of monitoring difficult to sustain, and nurses noted that there seemed to be little institutional recognition of its importance to their clinical roles.

In one small-group interview, the nurses said that the focus of nursing leadership meetings had shifted to organizational and system changes, to the extent that there was little discussion of clinical issues:

> First nurse: *Our focus is on team-building, incorporating PCAs [patient care assistants] and care assistants, and whatever else, but not about clinical care for years, a couple of years probably...*
>
> Second nurse: *...it was the first time we talked about anything clinical in...I don't know, a year and a half.*
>
> First nurse: *We've spent a lot of time learning about the health-care systems out there...about all services, all the different levels of care, all the different insurances, all the new review processes... Most of it we need to know, but it was all going to that, and how you can use your computer now that you've finally got one so that you can enter that you've given a review to the insurance company. I mean, all this time on that stuff and not at the bedside, and clinical care has suffered.*

System redesign often displaces direct clinical care and increases nurses' responsibility for supervising the non-licensed personnel who have stepped into bedside roles. However, it also creates new clinical education needs, as illustrated in the following discussion by an intensive-care unit (ICU) nurse about the move to place more critical patients on regular units:

> *With the whole managed care, they are asking [us] to make changes without any support. An example is on our acute floors. Now they take [patients with] dobutamine infusions, dopamine infusions [both are intravenous vasopressors to maintain blood pressure and cardiac output], and Pronestyl infusions [an anti-arrhythmic medication]. And it just happened, and they didn't change the staffing ratio, yet the patients have to be monitored more frequently. They [nurses on floor units] didn't get education. There's no educator. I mean, they didn't get a formal education [planned inservice]. It was all kind of thrown out there. And the patients are put on mechanical ventilation, a bi-pap format [a type of ventilation in which endotracheal intubation is not required] on the floor [regular unit]. They call me, "Can you come see this patient?" There's no planning, it's just "gotta push them out," and we're pushing patients out of the ICU because we need the bed, and then they are still critically ill.*

Not only is the core group of practitioners disrupted, but patient allocations are changed, so that nurses are responsible for more acutely ill patients and are expected to administer therapies for which they have received little or no training.

Compressed Time for Contact and Connection

Weber (1964) forecasted the problem of the relational and the moral being overlooked in the drive towards ever more efficient systems. The human functions of vigilance, engagement with others, and commitment to excellence may also be overlooked as means are separated from ends and efficiency is disassociated from efficacy. In the systems engineering approach, differences in temperament and skills are minimized and human beings are treated as standard units of labour rather than as unique resources for the teaching and advancement of good practice. Demoralization of the work group can occur when informal leadership patterns are disrupted, significant aspects of the work are overlooked in the redesign, and tasks considered essential for safety and relational work are omitted.

In a group interview, several operating room (OR) nurses discussed the impact of their hospital's efforts to reduce the "turnover time" between patients' entry into the OR suite from the pre-operative room and their departure for the recovery room:

> First nurse: *Turnover time isn't inherently bad. It's how that time gets used... They can't say that the turnover's over when the nursing hasn't been done. So turnover isn't an inherent evil. It's when they are saying, "Get rid of the nurses"...*
>
> Interviewer: *We can eliminate nursing?*
>
> Second nurse: *There's a movement underfoot...*

> First nurse: *...to eliminate that time.*
>
> Third nurse: *Nursing assessment time?*
>
> First nurse: *Nurses going to the pre-op room and pre-opping the patients and taking patients to the recovery room...there's a movement to get rid of them.*
>
> Third nurse: *And replace it with what? We just wait in our rooms and they just bring us a patient?*
>
> First nurse: *That's right.*
>
> Fourth nurse: *And we say goodbye to our patients at the OR door? We don't deliver them to the hands of another nurse to whom we give report?*
>
> First nurse: *That's right. The first time we see them is when they hit the OR door... That's why I say very strongly that they're trying to compress this nursing time.*
>
> Second nurse: *Because they don't see value in it.*
>
> First nurse: *That's right. This [administrative] person said right out to me, he said, "Well, I don't see any value in what you do. You need to be in the operating room itself, getting things ready." He feels that our patient contact is totally unnecessary and he's not happy with it.*

In the OR environment, where the processing of larger numbers of surgical cases per day was identified as the goal, the time during which the nurse meets, assesses, and transfers a patient from the pre-op room to the OR, and similarly to the post-anesthesia recovery unit (PACU) following surgery ("patient turnover time"), was being scrutinized for possible elimination. Yet this time, viewed as superfluous to the "real" work entailed in the actual surgical procedure, was regarded by nurses as essential to preserving the patient's humanity and security in a highly threatening, highly technological atmosphere. This move to speed up patient processing is at odds with the fact that the OR is at particular risk for errors in patient care (Risser et al., 1999, p. 237).

It is worth noting that nurses do not view this process in terms of industrial production — with the patient moving along a sort of surgical conveyor belt as the nurses stand ready to administer therapies to one patient after another. Rather, the patient is delivered "into the hands" of the next nurse, an image suggesting an awareness of the trust placed in nurses by patients and families and the nurses' responsibility to ensure the safe passage of the patient. This process of receiving and transferring the patient includes double-checking of location of surgery, any allergies, and other particulars, and reassuring patients and families that they are in capable and trustworthy hands. This kind of vigilance is impossible if the nurse sees the patients for the first time as they "hit the OR door." In complex organizations made up of strangers, attention to detail and double-checking are essential. Operating room nurses also speak of connecting with families, because it is difficult for family members to say goodbye and turn their vulnerable relative over to strangers. Likewise, in returning the patient from surgery, the nurse obtains crucial information about what has transpired during the procedure.

Nurses also consider the time with the alert patient and family members as vital for ensuring that the planned surgical procedure is the correct one as well as other details. Such last-minute double-checking is essential in a complex system, and the nurses were able to cite many examples where it was crucial to the patient's safety:

> First nurse: *It's a frequent occurrence that they want to just rush somebody in — the surgeon or the anesthesiologist. But I tell them, "Just because we're in a hurry, we don't skip nursing." And I make that point, that it is nursing we have to do... So, "I don't care if we are short on time. I don't care if you have to get out of here by 3 o'clock. We don't skip nursing... [There are] some things that I have to check, and it's important."*
>
> Second nurse: *It's a little different when you know the people and you can talk to them one on one. But when you get the message from above [from hospital administration] that you are of little value, it's very demoralizing. I mean, I value the people I work with and I love what I do, but it's so demoralizing to realize that you are still not really valued much at all.*

Time, in this view, is not merely the minutes it takes to perform a particular task multiplied by the number of times it must be performed. Rather, time provides a space for meaningful human interaction to occur. Two pediatric nurses drew attention to this fact when speaking about the importance of developing trust with parents of hospitalized children:

> First nurse: *Most of the time families want you to stay, whether you talk or not... If you're just standing there, they're very happy, if you're just there, watching and being with them...you don't even have to talk...you don't have to do anything.*
>
> Second nurse: *Because if you're hyper and uptight, that's a terrible thing to do to them; that gives them a bad message.*
>
> First nurse: *Sometimes you can sense if they want you to take care of the child and they don't want to...if they're so frustrated, overwhelmed, worried [that] they cannot deal with that child. You don't know that unless you stay there and spend some time in a relaxed atmosphere and get the feeling of what's happening in the family.*

Later in the same interview the second nurse added: "I like to quit moving when I get in there [the child's room]... I like to find a chair and sit down and just quit moving... I think it just changes the whole tone...the whole atmosphere, you know, of everybody."

Attending to the "tone" or "atmosphere," intentionally altering it from one of rushed tasks to one that is restful and conducive to healing, is at the heart of nursing's most cherished traditions (Nightingale, 1969). For pediatric nurses, whose practice epitomizes nursing's focus on the whole patient as part of a family and community, such time is especially critical, because they must tailor their practice to the patient's developmental needs and the family's coping resources. Pediatric nurses are concerned not only with the patient's medical problem, but also with preserving and supporting the family through the child's illness. They see therapeutic value in "just being there," bearing witness, offering solace, and attending to a situation in which families are at their most distressed and vulnerable.

People are rarely more vulnerable than during recovery from anesthesia following surgery. At this time patients need both expert management of their physiological needs, such as ensuring that they have sufficient oxygenation, and close attention to their emotional needs, as post-operative patients frequently wake up feeling helpless and confused. When staffing in this setting is reduced to minimum levels, the nursing functions that have to do with physiological management have such priority that care of the patient's vulnerability and personhood, a central precept of nursing practice, may be neglected. Nurses in a PACU commented:

> First nurse: *Often times I find it very frustrating. We get so busy that sometimes it's the tasks we have to do to get the patient out of there. Sometimes they just want to hold my hand — that's all they want to do. "I want to hold your hand." I say, "You can have it for 5 minutes and then I have to run off to the next bed." That's what I find very frustrating, that a lot of the care that we can give [is] much more the physical aspect. We don't really have the time to give the spiritual and psychological and emotional care that they really want. Sometimes they just want a closeness to somebody.*
>
> Second nurse: *Right.*
>
> First nurse: *And the way health care is going to be restructured, if the powers that be have their way there will never be an opportunity for that, if they restructure the PACU in a way where other people that are untrained are taking care of our patients and we are supervising eight patients at a time. The patients will never benefit from our expert care. What will happen to us when we're old? Who's going to take care of us? Not people like us.*

"People like us" suggests an ethos of direct-care expertise that this nurse regards as threatened by cost-cutting efforts that move nurses away from the bedside and into roles as the supervisors of less-trained personnel. The distinction between practice and production is evident here. Technicians can be well trained to perform discrete technical tasks, but such narrow training and supervisory delegation of tasks does not take into account good clinical judgement guided by patient needs and vulnerabilities and changes in the patient's condition over time.

Efficiency is the driving force behind much of the health-care restructuring that has taken place. In this context, efficiency is defined in terms of producing more in less time and with fewer resources such as personnel and equipment. In effect, producing more actually means moving consumers (commodities) along a planned trajectory as rapidly and inexpensively as possible. Efficiency may be a worthy goal, but it is jeopardized when the pace of work is such that practitioners have no time to assess their patients in a meaningful way, weigh priorities, and share their knowledge with patients, families, and one another.

Being responsible for eight patients precludes the ability to follow changes in any one patient over time. Continuous monitoring of a patient's trajectory is replaced by snapshot judgements at particular points in time. To be effective, such a managerial approach to patient care has to include time for assessing patients, talking to patients, and conveying clinical assessments to other nurses.

If nursing care is the provision and monitoring of various technological fixes, and if efficient care is the provision and monitoring of more such technological fixes, whether pharmaceutical, mechanical, or other, for more "consumers" in less time, then what these nurses describe doing (or yearning to do) is not only inefficient but irrelevant. If, in contrast, nursing practice is embedded in human relationships of healing and caring, then what these nurses describe is essential to good practice. Single-minded pursuit of outcomes, without consideration of what nurses and patients are forced to become in the process, undermines the essential good in nursing and medicine (Taylor, 1997). Optimal conditions for healing and care within the family system are possible only when nurses, patients, and family members are treated as persons, not as commodities to be managed as rapidly and inexpensively as possible. The moral ecology of nursing is sustained by institutional structures that allow adequate time for nurses' relational work with patients, families, and colleagues in order to skilfully assess the patient's safety, physiological, and emotional needs and to intervene with appropriate timing and care.

Paradoxically, the industrial production model may lead to reduced efficiency, as nurses lack the time to evaluate and monitor their practice in a cohesive way. Two advanced-practice nurses expressed their frustration with an administrative leadership session they had attended:

> First nurse: *We are led by hospital administrators who have to be very concerned about the financial problems, so that's what's constantly being told to us over and over and over again about the constraints and the budget cuts and the this and the that, and it's hard. ...what we still want to be able to do is maintain quality care... I'm not saying there's no leadership, I'm not saying people don't care, but that's not really what we're hearing, is it?*
>
> Second nurse: *I've heard it from the administrator of our hospital, "Quality patient care is what we want," but it's just...that's said over there, but in terms of our nursing department...we didn't even talk about [patient care] goals... I mean, we didn't even have time to say, "What is our goal today and what are the priorities?"*

These nurses are describing an "Emperor's New Clothes" situation in which the administration's stated goals are at odds with the reality of the practice environment. When nurses are regarded as line workers, care becomes reduced to a piecemeal series of tasks, and the aims of care may be obscured or ill-defined, increasing the potential for misunderstandings, errors, and ethical conflicts between families, patients, payers, and staff.

Erosion of Trust Between Nurses and Patients

In situations where patients and families do not feel cared for, nurses must do additional work in order to overcome suspicion, resistance, and mistrust (Mechanic, 1996). Trust is jeopardized when temporal or structural constraints preclude relational work. A nurse whose husband had been hospitalized shared insight into some of the basic nursing requirements of patients and families:

> First nurse: *The attending [physician] came in and I said to him, "I'm not leaving. I'm not leaving till I know he's okay, then I'm going to go." He goes, "It's fine. It's fine." But really, you know, that's what patients want and family members want. They want to know that you care. If you don't care, they can't trust you. And that's it, you know.*
>
> Second nurse: *Well, you have to care about the patient but you also have to care about the members of the family. Because essentially they are an extension of the patient. They need the information, they need the reassurance, and they need the guidance. They need...to know that you care, that you are a caring person. That trust has to be built...*

> First nurse: *...and just let them know that we're watching and caring, yeah, because the minute you act like you don't care...*
>
> Third nurse: *...well, the thing is, you lose the trust.*

A healing atmosphere is one in which patients, families, and caregivers trust one another and recognize and commit to a common good. When caregivers are unable to establish trust, their work may become for them a matter of enforcing controls rather than nurturing and healing, resulting in a loss of their identity as healers. Central to the practice of nursing is the poorly articulated and poorly understood social function of meeting the other and bearing witness to his or her plight and concerns. It is in this relational arena that trust and safety thrive and patients are assured of not being reduced to a number.

When clinicians feel rushed and harried, their ability to engage with patients and families is impaired, resulting in a disruption of their self-identity as healers. They express moral outrage on behalf of their patients and themselves. This reflects not merely a concern with niceties but an assault on nurses' identity as caring practitioners. An OR nurse described the atmosphere that results from staff cutbacks:

> *The [operating] room's still bloody and dirty. And so, if nobody's there to clean up, then we're [nurses are] expected to grab a mop and mop the floor, and wash the walls and wash the bed. This is what happened to us last week. There was a patient who was very ill and it was a big messy room and...I had to grab a mop and start sweeping and mopping away. Our next patient was a young man who needed a double valve [replacement] and he was absolutely terrified. I met him in the pre-op area. His whole family was terrified. They were all just very emotionally uptight. And the anesthesiologist rolled this guy back to the room that's still covered with blood and parks him next to the two big trash cans with the big containers of blood and guts and trash and says, "Are you ready? Can we bring him in?" And he's right there in the door of the operating room and I'm swinging a mop. And, you know, to me it was the worst thing that I've seen happen to somebody in a long time, and I just — it's like the patient is not significant to them, I'm not significant to them, and all they want to do is roll as many bodies in and out of that room as they can. And that's terrible! That's terrible what that man went through. He was scared to death... I think that our profession is being eroded away by incidents like this and attitudes like this, and cutting way back on the staffing and trying to cut corners at all costs. You know, that to me is very upsetting because I feel my professional practice is being eroded as well.*

The ideal of patient as consumer that is foundational to free-market ideologies in health care breaks down under such circumstances (Malone, 1998). This patient, partially anesthetized for surgery to correct a life-threatening problem, is utterly vulnerable; he is not a consumer who can pick and choose among options. Likewise, the ideal of nurse as manager of a "service line" breaks down as her efforts to ensure a safe and humane atmosphere are disregarded. This example also illustrates the limitations of construing "medical errors" as discrete sentinel events or critical incidents. A breakdown in civility and lack of concern for the patient's integrity constitute bad practice that could have harmful effects on the patient's well-being. An ethos of civility and concern that *discloses* the patient's basic humanity creates social practices of "etiquette" that determine the proper ethical comportment in a particular situation (Day & Benner, 2002). In this case, etiquette, ethical comportment, and an ethics of civility and concern broke down, causing the nurse to become angry and disgusted (see Nussbaum, 2001). Such incidents are likely to be detected or disclosed only by practitioners whose intention is to do no harm and to show compassion, thus fulfilling their fiduciary responsibility to the patient (Sharpe & Faden, 1998).

Such a health-care environment devalues the humanity of both patient and nurse in favour of a system in which actual service is supplanted by the rapidity with which it can be delivered. Nurses are put in the awkward position of having to coach family members to be vigilant and to become involved in the care of their hospitalized loved ones because of staff shortages:

> *Because we are number one witnesses to just how the retrenchment has affected my institution, I am acutely aware that patients need someone with them to help them while they're in the hospital, whereas before I did not feel that way; I did not see the shortage of…nurses.*

This participant and others related instances of members of their own immediate family being hospitalized or too hastily discharged and needing their nursing skills and vigilance. A nurse described the advice she now gave to patients' family members:

> *I try and educate my families about how they need to stay with their family member to protect them. I don't quite say that, but I will say to the wife that's coming to visit the husband, "Are you staying the night tonight?" And she'll say, "Well, I'm not sure." I'll say, "I think you should stay. I would stay if I were you." …I would not think of leaving my own family member, even my husband.*

The moral ecology of nursing requires a trusting relationship so that patient and family vulnerabilities are identified and protected. Trust and the relationships necessary to build and maintain trustworthiness in health care are central to curing, healing, and palliative treatment. Caring practices such as bearing witness, developing trust, getting to know a patient, and being present point to the relational work that is central to the art of healing (Benner et al., 1999; Benner & Wrubel, 1989). Yet this is the very work that is most vulnerable to cost-cutting strategies; it does not fare well in proving its worth in instrumental ways. In the long run, however, it may be more economical to preserve those professional practices that sustain trust than to try to restore trust and good will once they have been supplanted by suspicion and doubt.

Loss of Identity: Patients and Nurses as Commodities

The managerial practice of making physicians and nurses accountable for patient populations rather than individual patients represents a major shift in the moral landscape (Shultz, 1999). For example, while nurses cite the positive effects of managed care for getting premature infants weaned from technological supports and sent home more quickly, earlier discharge for well babies is based upon an acceptance of the risk that some babies will end up being readmitted. The current emphasis on acceptable levels of complications within a patient population — versus a fiduciary concern for the individual and the family, whose losses may be considerable and irreversible — is a major shift in the ethos of practice. One group of nurses spoke about the early discharge of well babies:

> First nurse: *[There are problems with] sending babies home too fast.*
>
> Second nurse: *You know, they…go home at 12 hours or 24 hours, and they haven't — the milk isn't in, they haven't latched on, they don't know how to breastfeed, they come back in and the poor baby…*
>
> First nurse: *…they become dehydrated with hyperbilirubin…*
>
> Second nurse: *…hyperbilirubinemic and dehydrated…*
>
> Third nurse: *…and the mother feels completely inadequate.*
>
> First nurse: *It's devastating for the mother.*
>
> Third nurse: *She'll stop breastfeeding. It's a horrible experience. They feel failures as parents… You know, they have no one — they don't have extended families [to] teach them to breastfeed. By the time they get back [to the hospital] the baby is so dehydrated and so listless, because its bilirubin is so high, that breastfeeding is just not going to happen… And then the mother's milk supply dwindles, and it's — it's…oh, it's terrible, it's awful!*
>
> First nurse: *When you look at the overall number of well babies who go home…it's a small percentage that gets readmitted and so they're saying it's not economically feasible to hang on to everybody for 24 hours or 48 hours or whatever. And, I mean, that's true, it is a small number, but it's still the ones that slip through the cracks.*

Nurses acknowledge the fact that some patients and families benefit from streamlined care and early discharge. However, streamlining entails a shifting of costs to parents and family members, who may not be prepared to provide the level of care that is required. The moral boundaries of care and responsibility have been redrawn. The policy of standardized discharge practices is drawn up with "acceptable risks" for patient populations in mind. However, nurses do not see their work with individual babies in terms of "acceptable risks"; when babies are readmitted, nurses feel the moral burden of their failure to avert harm. Additionally, parental responsibility for medical monitoring is considerably greater and more daunting than the usual parental responsibility to protect and nurture. It is little wonder that many parents feel ill-prepared.

The moral ecology of responsible nursing practice is radically altered when insurance criteria for discharge take precedence over professional judgement and must be overridden or negotiated by professional arguments in favour of additional hospital services. Interestingly, the nurses identified the "well babies" and their parents as at greater risk from the ever shorter hospital stays than the babies in neonatal intensive care, whom the system recognizes as at risk. In the well-baby group, there is little or no indication of which well mothers and infants will have difficulty with breastfeeding, so there is no clinical basis for altering the insurance guidelines for early discharge. Sending infants and mothers home before the mother's milk comes in precludes the breastfeeding instruction formerly provided by nurses.

It will be years before the liability costs and the relative costs of readmission are weighed against the new early-discharge practices. But the costs must also be weighed against the question of whether any infant and mother should be discharged before safe feeding patterns have been established. The potential for harm caused by failed early feeding for a certain percentage of babies may be an acceptable economic risk but an unacceptable human risk.

The shift to a population-based model is accompanied by a shift towards institutional accountability to insurers and purchasers of insurance. This latter shift was evident in the pressure not to admit day-surgery patients to the ICU because increased complications, and thus costs, would mar the hospital's and the physician's record with payers. For example, one nurse was observed negotiating for an ICU bed for a pediatric patient who was in respiratory distress and would likely need continued ventilatory support. The decision was postponed as long as possible, the nurse explained, in order to avoid an "unnecessary" admission and elevated complication rates for the hospital and the physician. Ultimately, the patient was admitted to the ICU, but against the gradient serving to protect the performance statistics of the hospital and the physician group. The addition of this institutional and group focus to the existing family and patient focus creates a new layer of accountability and indicates a need to consider new models of accountability (Malone & Luft, 2002).

The ethos of saving money to increase profits in a for-profit system is very different from that of cutting costs to improve distributive justice. The Kantian ethic of treating people as ends in themselves, rather than as means to some other end, is violated when cost savings do not support improved services for more people but, rather, support increased profits for stockholders (Weisskopf, 1977). This ethos sacrifices clinicians' fiduciary trust with patients for "acceptable" levels of complications and risks within patient populations. At the individual level, complications add to suffering and even death; the risk is unacceptable (Shultz, 1999). In hospital environments that have been redesigned for the "efficient" provision of various "service lines," based on an industrial production model, the patient is viewed not as a consumer but as a commodity to be produced and traded. In this model, the least expensive patients are the most valued patients. Contrary to this ethic of processing patients (commodities) in order to maximize shareholders' profits, the moral ecology of nursing is contingent upon institutional values that situate the patient's and nurse's humanity at the centre.

Health Care in the Marketplace

Health-care restructuring is often justified on the grounds that it limits the overuse of expensive services. The claim is that health care, as a business, can be run more efficiently by trimming staff, reducing waste, and using other measures designed to minimize per-patient costs. Protection of patients from unscrupulous acts in a climate of cost-cutting relies heavily upon the patients themselves, as consumers who will shop elsewhere if services are unsatisfactory, and upon professional ethics and the ability of clinicians to uphold them. These means, however, are constrained by the interests of payers, insurers, and groups of physicians who share risks and profits. In such an environment it is difficult for patients and individual nurses and physicians to exert control over the style and quality of practice:

> First nurse: *[I] need to touch base with the fact that I'm a human being…it's not just hemostats and scalpels.*

> Second nurse: *As we get caught up in the busy day-to-day, short length of stay, people moving in and out, it's almost Greyhound. It's a Greyhound depot…the basics get lost.*

The rhetoric of this system redesign — that the changes promote better care at lower cost — is revealed as a fraud by the nurses' expression of frustration at their inability to provide what they regard as basic nursing care. In fact, such system redesign creates temporal and other barriers to the provision of safe care. The aim becomes not care but the rapid processing of people, compelling clinicians to struggle on a daily basis to convince themselves that they are doing good. Such circumstances undermine the basic moral ecology of good nursing practice. In situations of cost-driven urgency, nurses' concern for patients on a human level can actually become a problem insofar as it requires time and resources that are not forthcoming. Confronted with this situation, clinicians may resort to subverting the system in order to preserve fragments of their identity as healers, as suggested by a critical-care nurse:

> *I guess more or less for myself as a nurse, I basically have expectations…I make sure that patients are always kept cleaned up. I make sure they're okay. It's kind of hard [in ICU] because most of my patients are intubated so we don't have that rapport, but we do have the rapport with families… I was a patient myself for two and a half weeks, and it wasn't that bad but it changes everything, you know. Like sometimes you have patients call you every 5 minutes and you're, like, what does she have to call me every 5 minutes for? [embarrassed laugh] And then I realize that, being on bed rest for two and a half weeks, you have no concept of time, 24 hours just keep going for days and days and days… For me, I have to always straighten up my patients' sheets, or change them, make sure the patient's comfortable, because I was lying in bed for two and a half weeks and that bed can be really uncomfortable, where you get body aches and you're not even doing anything. And that's a big thing for me. I get upset when they're telling us to cut back on linen and [not to] change the sheets unless they're soiled. I mean, that bothers me a lot, but I still manage to do it. If I have to sneak them into [the] room I still do it.*

Care becomes something to be surreptitiously snatched, a covert activity. Human caring for those who are suffering becomes something for which clinicians no longer have time:

> First nurse: *I mean, [second nurse] and I help support each other that it's okay to stay in that role, you know, and that's good. "This is what this is all about," and "Yes, what I am identifying is important." What I have been doing is important even though nobody else — we feel like nobody else really is doing that or sees it [direct patient care and comfort measures] as important.*

> Second nurse: *How to keep the patient care as the priority through all of this other extraneous bombardment — things that just weren't there [before].*
>
> Third nurse: *I try to look at the very big picture, and I just remind myself from time to time that managed care is not only inadequate, it's probably a deliberate fraud in that it's an attempt to further privatize care under the guise of reform, and in that it specifically and deliberately ignores the uninsured. What I say to myself is...managed care is to national health what the Depression was to social security.*

Conclusion: A Moral Ecology of Care

In this study, critical-care nurses told stories about their practice that revealed strains in sustaining an ethic of good nursing in the face of the economic restructuring of health care in the United States. For example, despite increased patient acuity, downsizing has resulted in greater utilization of less-trained per diem and float nurses, requiring written standards to establish minimum safety requirements for a pool of inconsistent staff, in place of a team of nurses whose cohesiveness promoted nursing excellence. The press for efficiency has resulted in system restructuring that allows less time for nursing care and assumes an indifferent if not dismissive stance towards the relational practices in which nurses engage to ensure the security, well-being, and humanity of their patients. An institutional environment in which the trust of patients and families is compromised puts nurses in the awkward position of having to coach families to be vigilant. Redesigned systems that view nursing care through the lens of an industrial production model, wherein patients are treated as consumers at best and as commodities at worst, have compelled nurses to act surreptitiously to sustain caring practices that ensure patients and families a safe and humane passage.

As members of an institutionally based profession, nurses rely on institutional structures to support the caring functions that constitute good nursing practice. Besides the physical dimensions, the temporal and moral dimensions of institutions can increase or decrease the likelihood that a community of practitioners, organized around common goals, will adopt the standards and visions of good practice and pass them on to new generations of practitioners. This moral ecology, or the interaction between nurses and the institutional environments on which they rely, directly affects nursing practice and the well-being of patients and families. Discussions of organizational ethics should be broadened to address the issue of whether institutional resources and structures enhance or constrain patient care as they impact on nursing and medical practice.

Medicine and nursing are founded on a vision of healing and responsiveness to suffering. Aristotle was the first to see a distinction between the production of things and the practice of an art or science, which requires character, skill, responsiveness, and relationship. Survival of an institutionally based practice like nursing requires an ecology wherein caring and compassion are the raison d'être of the practice. In such an ecology, practitioners and patients have the time to integrate experience; pass on experiential learning to novice practitioners; develop creative ways of effecting change; sustain a sense of trust and connection on a human level; and grow and move forward in innovative, responsive ways (Benner et al., 1996, 1999). Alasdair MacIntyre has written on the value of institutionalizing practices so that their visions can be fulfilled:

> Lack of justice, lack of truthfulness, lack of courage, lack of relevant intellectual virtues — these corrupt traditions, just as they do those institutions and practices which derive their life from the traditions of which they are the contemporary embodiments. To recognize this is of course also to recognize the existence of an additional virtue, one whose importance is perhaps most obvious when it is least present, the virtue of having an adequate sense of the traditions to which one belongs or which confront one. This virtue is not to be confused with any form of conservative antiquarianism; I am not praising those who choose the conventional conservative role of *laudator temporis acti.* It is rather the case that an adequate sense of tradition manifests itself in a grasp of those future possibilities which the past has made available to the present. Living traditions, just because they continue a not-yet-completed narrative, confront a future whose determinate and determinable character, so far as it possesses any, derives from the past. (MacIntyre, 1981, p. 207)

What kinds of caring traditions do we as a society want to sustain for ourselves and our families? The experiences of these nurses warn us that the moral ecology of caring practice is in jeopardy. Both nursing and medicine, as living traditions and as professions, must shoulder part of the responsibility for curtailing the escalation in health-care costs. However, in order to do so while providing morally grounded care, they must act within systems and institutions that instantiate and support a healthy ecology of practice, not merely an assembly line of tasks.

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Authors' Note

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Correspondence may be directed to Sara M. Weiss, RN, PhD, Institute on Aging, 3330 Geary Boulevard, 2E, San Francisco, California 94118 USA. Telephone: 415-750-4180, ext. 192. Fax: 415-750-5341. E-mail: sweiss@ioaging.org

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Designer's Corner

Authentic Qualitative Research and the Quest for Methodological Rigour

Franco A. Carnevale

The nursing literature has witnessed a veritable explosion of qualitative research over the last two decades. Advocates of this trend would argue that it has clearly enriched our understanding of nursing phenomena, whereas sceptics might suggest that it has blurred the scientific foundations of our discipline. I would argue that both these positions have merit.

In this short paper, I would like to address two related points. First, I will briefly discuss the problematic relationship between qualitative research and scientific tradition. Second, I will argue for the utilization of distinct criteria for methodological rigour that should be systematically upheld in qualitative nursing research.

This discussion will call on nursing scholars to critically examine the values that underlie nursing research and knowledge development. This will particularly reflect upon contested conceptions of "reality" and "truth" and how nursing epistemology *ought* to be construed. Although such an analysis is pertinent for the largely qualitative research addressing ethics, values, and decision-making (the theme of this issue of the Journal), this paper is directed to the broader nursing research community — designed to challenge some current controversies regarding the foundations of qualitative research.

Franco A. Carnevale, RN, PhD, is Associate Professor, School of Nursing and Faculty of Medicine (Pediatrics), Adjunct Professor, Counselling Psychology, and Affiliate Member, Biomedical Ethics Unit, McGill University, Montreal, Quebec, Canada, and Head Nurse, Pediatric Intensive Care Unit, Montreal Children's Hospital.

Qualitative Research: Is It Science?

Qualitative researchers have adopted a diversity of stances on the relationship of their work to science. A dominant view is that such research provides a necessary foundation for any emerging field of inquiry where very little is known. A qualitative study can help ensure the canvassing of a domain of interest that guards against the imposition of a priori presuppositions, striving to identify the domain's most pertinent phenomena and the contexts within which they unfold.

This stance was formally articulated well in Dickoff and James's (1968) classic outline of the four principal levels of nursing inquiry (factor-searching, factor-relating, situation-relating, and situation-producing). This framework highlights the first two levels (factor-searching, factor-relating) as particularly suited for qualitative research.

Within this form of thinking, such work would give rise to "evidence-based" hypotheses that could in turn be examined more rigorously with quantitative methods. This outlook regards qualitative research as foundationally significant towards "good science." Many investigators extend this view and conduct studies that mix qualitative and quantitative methods within the same study, relying on the merits of each to ensure the most "truthful" representation of a domain.

A fundamentally opposed view would argue against such an epistemological and ontological hierarchical positioning of qualitative research. To understand this position, it can be helpful to distinguish the *techniques* of qualitative research from their corresponding *paradigms*.

Several qualitative research traditions have emerged: grounded theory, phenomenology, hermeneutics, ethnography, feminist, critical, post-structuralist, historiographical, ethnomethodology, postmodern, and narrative among many others. Each of these has elaborated distinctive methodological approaches to data collection and analysis. These would constitute the *techniques* of the specific tradition. However, such techniques are grounded on *paradigms* that articulate foundational assumptions about the field of inquiry and the process of inquiry itself. An authentic utilization of these techniques should be rooted within their respective paradigms.

More specifically, the quantitative research tradition can be said to be based on the paradigm of *positivism* (*postpositivism,* to be more precise). This presumes that "reality" exists and that it is apprehendable (albeit imperfectly). Further, "objectivity" serves as an ideal for such inquiry that strives to produce universalizable knowledge that is valid across time and context (Guba & Lincoln, 1994).

In contrast, the qualitative traditions draw upon relativistic paradigms wherein no single "reality" is recognized but, rather, a multiplicity of realities are claimed to exist, which in turn are all constructed by the perspective of the inquirer[1] (Guba & Lincoln, 1994) — a general outlook commonly referred to as *constructivism*. The various qualitative traditions, each drawing on its own particular view of the world, human life, and inquiry, will consequently give rise to distinctive constructions of knowledge. For example, the knowledge produced through ethnography is partly attributable to the techniques employed, such as participant observation, but this cannot be estranged from the fundamental basis of ethnography which regards *culture* as a primordial phenomenon that shapes all human experience.[2]

An authentic view of qualitative research would need to recognize the study's respective underlying paradigm. Consequently, attempts to blend such methods with (positivistic) quantitative approaches are highly problematic. A dominant view argues that the former are incommensurate with the latter — that is, the premises on which they rely are so fundamentally disparate as to be irreconcilable.[3]

Qualitative research in *nursing* is situated in a difficult position within this debate. On the one hand, nursing knowledge has important foundations in the predominantly (quantitative) positivistic health sciences. On the other hand, nursing has more recently drawn on the qualitative traditions of the "human sciences" (largely within sociology and anthropology) to develop innovative approaches to our understanding of complex human experiences.

We are currently in a situation wherein these two traditions, drawing on disparate conceptions of "human nature" and inquiry, have very limited cross-discourses. Consequently, neither can properly benefit from the "discoveries" of the other or meaningfully engage in challenging the claims of the other.

I will add to this a truly unique problem that qualitative research faces within nursing in particular. Nursing, unlike sociology or anthropology, is an *interventional discipline*. Nursing is supposed to employ research in order to effect healthy outcomes. This involves the utilization of research findings to develop nursing practice or inform the development of health policy. This *instrumental* commitment of nursing, even when interpreted in a most "constructivist" light, has implications for the types of inquiry that can be regarded as "good" nursing research.[4]

Towards a Recognition of "Good" Qualitative Nursing Research

In light of nursing's interventional commitments, some corresponding conditions should be applied towards our recognition of "good" qualitative nursing research. Two conditions seem particularly relevant.

First, such research should address an important nursing problem. A study can be well conducted, yielding highly interesting findings, yet if it does not address a pertinent issue in nursing it will not meet this first condition. For example, the investment strategies of middle-aged Canadian men would not commonly be regarded as an important nursing problem.

Second, qualitative nursing research should conform to some recognized criteria for methodological rigour. This assertion is highly contentious and merits some justification. It is commonly and persuasively argued within the qualitative traditions that no such universally agreed upon criteria exist. It is further argued that any attempts to "impose" such conditions would constrain the imaginative scope of the research, while covertly implanting a layer of positivism upon these distinct paradigms.

Indeed, proponents of these paradigms are particularly concerned about (commonly unarticulated) political phenomena that shape and limit such criteria, systematically determining the types of realities that can be understood. These arguments are particularly well defended by some exemplary "critical" work in the philosophy and history of science (Feyerabend, 1993; Kuhn, 1970).

Despite the merits of these arguments, nursing remains an interventional discipline. Consequently, nursing research will necessarily imply some claims on the "nature of reality," even if these claims are highly implicit. For example, a phenomenological study of grief among young women undergoing abortions might not explicitly claim that its findings correspond with the women's "real" grief — because in the end such accounts are inescapably shaped by the researcher's perspective.

However, a nursing researcher striving towards a reading of the work as favourably affecting the lives of these women, or women in similar contexts, would likely also assert that such accounts are not simply arbitrary or fictitious — that is, some correspondence between the findings and the informants' "real" experiences is sought. Towards that end, each researcher would necessarily employ some methodological rigour.

Such strategies or criteria could be regarded as necessarily idiosyncratic — researcher-defined — to guard against the threat of political or intellectual constraint that I mentioned earlier. However, this does make the process of examining, reviewing, and interpreting such work highly difficult, particularly with regard to implications for nursing practice or health-policy development.

It would seem more defensible to adopt a position of recommended criteria for methodological rigour — that is, selected criteria could be highlighted as conditions for judging the methodological merits of qualitative studies (for funding or publication). However, these would be recommended and not absolute (as within the quantitative tradition), because the qualitative traditions do not share one consensus on this matter. This would leave open the possibility for a researcher to propose alternative criteria for a specific study, with the expectation that a supporting argumentation is provided. However, studies could for the most part be examined in light of these recommended criteria.

Such criteria for qualitative research have already been proposed by several leaders in the field (Guba & Lincoln, 1981; Leininger, 1994; Sandelowski, 1986).[5] Anselm Strauss and his associates have also made important contributions in this area, by putting forth the most documented system for qualitative research data collection and analysis — grounded theory (Strauss 1987; Strauss & Corbin, 1990). All of these works have taken care to ensure that their recommended criteria remain faithful to the distinctive paradigms employed in qualitative research.

I will present an outline of such criteria that I recommend for judging qualitative research proposals or manuscripts. All qualitative studies would be expected to document their respective utilization of these criteria, and the work would be judged accordingly.

These criteria have been selected on the basis of their comprehensiveness as well as their mutual exclusiveness — that is, redundant criteria have been discarded or incorporated into others, while ensuring that the selection encompasses all of the most widely recognized criteria. Four criteria were selected as a result of this process: credibility, confirmability, saturation, and transferability.

Credibility

Credibility refers to the believability or truth value of a study — that is, the extent to which the researcher's account is faithful to the experiences of the informants. This implies strategies that foster proximity of the researcher to the informants while taking measures to guard against having the researcher inadvertently influence the manner in which the informants' experiences are recorded.

One strategy for fostering credibility is the use of triangulation — collecting multiple forms of data and searching for convergence among them. Another strategy is to seek the recognition of persons who understand the experience in question. For example, the researcher could present the preliminary findings to a panel of those who have had the experience themselves or to a panel of experts in the domain.

Confirmability

Confirmability refers to the assurance that data were collected and analyzed in a neutral manner, whereby the researcher's potential distortion of informant accounts is minimized. This can be fostered by obtaining verification of the recorded data and the researcher's interpretations from the informants themselves. This is also supported through an "audit trail" — the maintenance of detailed records of the data-collection and analysis process, whereby a reader could confirm that they would arrive at the same conclusions.

Saturation

Saturation refers to the thoroughness of the data collected. The researcher demonstrates that data were collected until redundancies emerged — that is, the phenomena under study have been examined to the extent that additional data would not significantly contribute to their understanding.

Transferability

Transferability refers to the extent to which the findings "fit" with the experiences of persons in similar contexts. This implies careful consideration in the design of a study to guard against the selection of a unique and idiosyncratic context that bears no resemblance to related settings that would be of concern to nursing. The researcher might also consider using multiple settings to help distinguish phenomena that are bound to a specific context. This can be verified by seeking comments from persons in similar contexts to determine whether the findings "speak to" their experiences.

In light of the highly contextual nature of qualitative research, it is likely that this criterion will not be readily defensible by an initial study. The transferability of a study may not be supported until studies of additional contexts demonstrate a "fit" with the earlier study.

Concluding Remarks

I have presented an argument that calls for the explicit use of criteria for fostering methodological rigour in qualitative nursing research while remaining faithful to the distinctive paradigms within this body of work — that is, while preserving the authenticity of the inquiry. My argument is grounded in the interventional commitments of the discipline. The promotion of such criteria can help strengthen the links connecting the findings of such studies to the development of nursing practice, health policy, and further research.

Notes

1. It should be noted, however, that qualitative research can also be conducted firmly within the positivistic tradition. For example, Charles Darwin's (1859/1968) landmark *The Origin of Species* employed qualitative methods (rich description, categorization, interpretation, hypothesizing, among others — no quantitative procedures were employed) while being clearly situated within the worldview of science.
2. I am referring here to an anthropological conception of ethnography, given that this research methodology originated within this discipline. Other disciplines (such as sociology) have developed approaches to ethnography that are not necessarily centred on culture.
3. This question of incommensurability raises a complex debate that is beyond the scope of this paper. For example, Martin Heidegger (1962) recognized a clear (commensurate) relationship between science and his conception of hermeneutics. However, this is fundamentally different from the form of hierarchy implied by Dickoff and James (1968).
4. It should be recognized, however, that *instrumentality* is essentially a positivistic phenomenon — one that presumes the world can be apprehended with a level of precision whereby predictive changes can be effected.
5. The work of Guba and Lincoln (1981) and Sandelowski (1986) is particularly interesting because these researchers directly contrast their criteria with corresponding criteria within quantitative research.

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CJNR, 2002, Vol. 34, No. 2, 129–130

CJNR Reviewer of the Year: Dr. Souraya Sidani for the Year 2001

In the March 2002 issue of the Journal, we announced the first ever *CJNR* "Reviewer of the Year" (Gagnon, 2002). This distinction is conferred annually on one reviewer from our pool of approximately two hundred, to draw attention to and celebrate the work done by *CJNR* reviewers as a whole. Our standards for reviews are high and include both quality criteria and timeliness (Gagnon, 2000). Each individual in our reviewer database is assessed on several indicators in a standardized fashion, enabling us to clearly identify those individuals who stand out among others in supporting the Journal's mission.

Again this year, I have the privilege of highlighting the work of one of our excellent reviewers. This year's recipient of the honour is Dr. Souraya Sidani, for her outstanding contributions during the year 2001. Dr. Sidani's reviews have been consistently thorough and detailed. She provides general comments and specific feedback. Her assessments of various aspects of manuscripts are defended with clarity, and suggestions for other approaches the author may wish to consider in re-working the manuscript are offered. References to potentially useful books and articles are often provided, as are explanations of concepts that may be incorrectly employed by the author. As for timeliness, I only wish I could be so timely — we have received each of her reviews this year in less than 21 days! In short, I would be happy to be an author receiving a review carried out by Dr. Sidani.

Dr. Sidani is an associate professor in the Faculty of Nursing at the University of Toronto. She received her PhD in Nursing from the University of Arizona, Tucson, in 1994. Her areas of expertise are quantitative research methods, intervention design and evaluation, and measurement. Dr. Sidani has been involved in projects evaluating various interventions such as the use of music to relieve dyspnea and anxiety in patients with COPD, an abilities-focused program of morning care to promote functioning in older adults with dementia, and organizational initiatives to enhance the quality of the nursing work environment; nursing-care delivery models and changes in nursing staffing patterns; the contribution of advanced-practice nurses (i.e., nurse practitioners and case managers) to patient and system outcomes; and the reliability, validity, and clinical utility of instruments measuring health-related phenomena such as fatigue in patients with cancer, feeding abilities in patients with cognitive impairment, and therapeutic self-care in patients with acute illness. Her publication topics relate to methodological issues such as comparison between repeated measures analysis of variance and individual regression, the application of the multitrait, multi-method logic in examining family relational data, and measuring intervention dose.

Our warmest congratulations to Dr. Sidani on being named Reviewer of the Year for all her efforts on behalf of the *CJNR*.

Anita J. Gagnon
Associate Editor

References

Gagnon, A. J. (2000). Editorial: The journey to publication and support for the peer-review process. *Canadian Journal of Nursing Research, 32*(1), 3–6.

Gagnon, A. J. (2002). CJNR's first "Reviewer of the Year": Dr. Judith Wuest for the year 2000. *Canadian Journal of Nursing Research, 33*(4), 185–186.

The *CJNR* Editorial Board has modified the Journal's publication schedule so that each volume will fall within the calendar year. The Journal will continue to be published on a quarterly basis. Beginning in 2003, issue no. 1 will be published in March, followed by issues 2, 3, and 4 in June, September, and December. Due to this change, we are able to grant an extension on several expired deadlines for calls for papers.

CJNR Special Issue: Completed Student Research Projects

December 2002 (vol. 34, no. 4)

The December 2002 issue of *CJNR* will highlight the work of the next generation of researchers. Papers describing completed research from either undergraduate or master's programs (i.e., excluding doctoral programs) are being sought. We are interested in reports of studies that have used one or more of a variety of methodologies to examine clinical or other areas of nursing meant to advance knowledge in the field. Manuscripts should be no more than 10 pages, double-spaced, 12-pitch type, including references, tables, and figures. Since all papers will be subject to an expedited peer-review process, a paper's chances of being accepted will be improved if it has been reviewed and edited by someone with authorship experience, and revisions made accordingly, prior to submission. Prizes of a one-year complimentary subscription to *CJNR* will be awarded to the students with the three strongest papers.

The *CJNR* Editorial Board realizes that many student projects have not received formal IRB approval. Nonetheless, every study must meet accepted standards of ethical conduct. A number of procedures must be followed to ensure the ethical integrity of the study with regard to the treatment of human subjects. Authors are asked to include in their manuscripts a paragraph outlining the procedures that were followed to ensure the ethical integrity of the study.

Submission Deadline: October 1, 2002

Addiction & Dependence

March 2003 (vol. 35, no. 1)

In nursing and in other disciplines, addiction, dependence, and addictive behaviours and their health consequences are of growing social concern. This issue will focus on all aspects of these phenomena as they intersect with nursing practice in all health-care settings. We are interested in addiction in all its forms (e.g., tobacco, drugs, alcohol), any behaviour that results in a physiological dependency (e.g., eating disorders), the effects on individual and family well-being across the lifespan, physical and mental health outcomes, and prevention and intervention. We are also interested in individual, parental/family, and social/environmental factors that place individuals at risk or that lessen the risk of these phenomena. We are particularly interested in the testing of interventions and the factors that contribute to an intervention's success. We plan to mainly publish research reports but will consider papers on theory development and testing. We welcome investigations that use either qualitative or quantitative data or a combination of the two.

Guest Editor: Dr. Pamela Ratner
Submission Deadline: ***extended to*** **October 15, 2002**

Culture & Gender

June 2003 (vol. 35, no. 2)

Culture and gender have been identified as important determinants of health. For this issue, we invite papers that examine the interaction of culture and gender with other health determinants, and the influence of culture and gender on the outcomes of nursing interventions. Manuscripts that describe research studies, present a systematic review, or provide a theoretical analysis will be considered. We are particularly interested in papers that focus on innovative interventions designed to mediate the influence of culture or gender on collective health action, individual behaviour change, social environments, health-service utilization, or health status. We welcome papers describing studies undertaken either in Canada or internationally.

Guest Editors: Dr. Nancy Edwards and Dr. Judy Mill
Submission Deadline: ***extended to*** **November 15, 2002**

Nursing Care Effectiveness

September 2003 (vol. 35, no. 3)

In the context of the changes that are currently taking place in health-care systems, it is imperative that the effectiveness of nursing care be systemically studied and highlighted in research reports. Additionally, it is critical that the policy implications of such research be specifically addressed. For this issue of the Journal, we invite papers that examine nursing care effectiveness in terms of health outcomes for individuals, families, groups, communities, or populations and from the perspective of the cost to clients and to health-care systems. We will consider manuscripts that describe research studies, present a systematic review, discuss the implications of nursing care effectiveness research on policy, present methodological issues, or provide analysis of theoretical and/or ethical issues.

Guest Editor: Dr. Sandra M. LeFort
Submission Deadline: ***extended to*** **January 15, 2003**

Gerontology

December 2003 (vol. 35, no. 4)

As populations age, all disciplines and public-service sectors are beginning to address the issues of ageing from their diverse perspectives. For this issue of *CJNR* we invite manuscripts that present research focused on enhancing the health and life of older populations through the creation and dissemination of knowledge relevant to gerontological nursing practice and the policy, health-services delivery, and practice issues germane to optimizing the health and lives of older people. We particularly welcome papers on innovative interventions and strategies for promoting health and well-being in later life.

Guest Editor: Dr. Carol L. McWilliam
Submission Deadline: April 15, 2003

Please send manuscripts to:
The Editor, *CJNR*
McGill University School of Nursing
3506 University Street
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Submission deadline: April 30, 2000
Publication date: December 2000

Abuse & Violence
Submission deadline: July 30, 2000
Publication date: March 2001

VOLUME 33

Economics of Nursing Care
Submission deadline: October 15, 2000
Publication date: June 2001

Home Care
Submission deadline: January 15, 2001
Publication date: September 2001

Women's Health
Submission deadline: April 15, 2001
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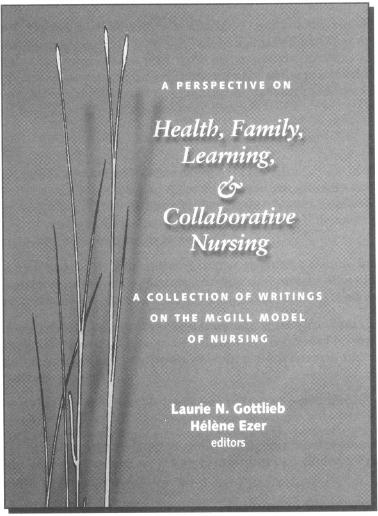

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The *CJNR* is a quarterly journal. Its primary mandate is to publish nursing research that develops basic knowledge for the discipline and examines the application of the knowledge in practice. It also accepts research related to education and history and welcomes methodological, theory, and review papers that advance nursing science. Letters or commentaries about published articles are encouraged.

Procedure: 1. Articles must be written in English. 2. Authors are requested *not* to put their name in the body of the text, which will be submitted for blind review. 3. Only unpublished manuscripts are accepted. 4. All research studies must have received IRB approval. 5. A written statement assigning copyright of the manuscript to the *CJNR* must accompany all submissions to the Journal. 6. Manuscripts should be submitted by e-mail to the Editor, c/o joanna.toti@mcgill.ca

Manuscripts

Manuscripts must be prepared in accordance with the Fifth Edition of the *Publication Manual of the American Psychological Association*. Research articles must follow APA style for presentation of the literature review, research questions and hypotheses, method, and discussion. All articles must adhere to APA guidelines for references, tables, and figures. Footnotes are to be avoided.

Title page: This should include author(s) name, degrees, position, information on financial assistance, acknowledgements, address, and present affiliation. This page should also include keywords as well as a suggested running head for the article.

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Text: The text should not exceed 20 double-spaced typed pages, including references, tables, and figures.

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Tables and figures: Tables and figures should appear only when absolutely necessary, up to a maximum of four. They must be self-explanatory and summarize relevant information without duplicating the content of the text. Each table must include a short title, omit abbreviations, and be typed on a separate page. Figures must be in camera-ready form. Tables and figures should be placed at the end of the paper, after the references.

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Modalités : 1. Les articles doivent être rédigés en anglais. 2. Pour garantir l'anonymat des auteurs pendant l'examen des articles, on demande à ceux-ci d'éviter d'indiquer leurs noms dans le corps du texte. 3. Seuls les manuscrits inédits seront acceptés. 4. Tous les projets de recherche doivent avoir reçu l'approbation d'un comité d'éthique. 5. Une déclaration de cession du droit d'auteur à la revue *CJNR* doit accompagner toutes les propositions d'article. 6. Les manuscrits doivent être soumis par courriel à la rédactrice en chef a/s: joanna.toti@mcgill.ca.

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