

*Guest Editorial and Discourse*

**Relating the “Is-Ought Problem”  
to Nursing Inquiry**

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**Overview of Past and Current Contributions**

The publication of this *CJNR* focus issue on Ethics, Values, and Decision-Making provides an opportunity to review past and current trends in this area of nursing inquiry. I discuss these trends with regard to an under-articulated philosophical problem in the relation between empirical and normative research: the “is-ought problem.”

*CJNR* has been publishing focus issues since 1994. In 1997 an issue was devoted to Values and Decision-Making. This included two research articles, one on the development of a scale for measuring decision-making control preferences, the other an analytical comparison of two frameworks for investigating patients’ treatment preferences.

In 2002 the focus theme was expanded to Ethics, Values, and Decision-Making. The number of excellent submissions was so great that the editors decided to extend the focus over two issues, with six comprehensive articles under Ethics and Values and six under Decision-Making. The first instalment included two qualitative research reports, three analytical discussions of specific issues (incongruities between the nurse-patient relationship and the scientific paradigm, clinician beliefs and values underlying untreated pain, and a feminist framework for understanding hope), and a grammatical/linguistic analysis of the Canadian Nurses Association’s past and current codes of ethics. The second published four qualitative research reports and two analytical discussions; the latter examined surrogate decision-making and equipoise in clinical nursing research.

To date, the authors submitting to *CJNR* and the work accepted by the Journal reveal three trends: (1) an extension of the values and decision-making theme to explicitly include ethics, (2) the publication of a larger number of papers, and (3) articles that include analytical discussions as well as empirical reports — the latter have become exclusively qualitative.

It is now 10 years since the publication of the first focus issue on Values and Decision-Making. What is on the menu this time around? This issue of the Journal presents six major contributions: three qualitative research reports, a theoretically driven integrative analysis of a body of published qualitative studies, and two analytical discussions.

Judith MacDonnell explores the relevance of power relations for nursing ethical inquiry through a case study of community nurses in Ontario. She uses a qualitative design based on a feminist bioethics framework to examine public health nursing policy regarding research with diversely situated sexual minorities. Brenda Beagan and Carolyn Ells report on their analysis of qualitative interviews with 20 nurses regarding their moral experience of everyday work. The study examines nurses' professional values and how well they are able to enact them in their work. Ignasi Clemente presents findings identified through an innovative conversation analysis of ethnographic data. The article reports on clinicians' practices of partial disclosure of information to adolescents with cancer in Barcelona.

Anne Simmonds and Elizabeth Peter examine a series of published qualitative research reports on intrapartum nursing and midwifery using Margaret Urban Walker's expressive-collaborative model of morality. Walker's model is favoured for its focus on everyday practices and knowledge, as distinguished from the "theoretical-judicial" models that dominate clinical ethical discourse.

Judy Rashotte and Louise Jensen present an analytical discussion that explores the relationship of ethics to validity in hermeneutic phenomenological inquiry. They specifically examine how to engage in ethical questioning in hermeneutics. Finally, Mary Ellen Macdonald and Mary Ann Murray conduct a historical and theoretical analysis of the clinical use of the word *appropriate*. Referencing rhetorical theory, they argue that the word is used to "smuggle" values into clinical encounters, which serves to marginalize patients and compromise relationships.

Thus the scope of this collection of work is remarkably broad, from everyday concerns to policy, from the context of cancer to intrapartum nursing to sexual diversity, from North America to Spain. A wide diversity of theoretical frameworks is used, including hermeneutics, feminist inquiry, rhetorical theory, and an expressive-collaborative model of morality, as well as diverse qualitative research methodologies. It is striking that, since the publication of an article on the measurement of decision-making control preferences in 1997, no quantitative studies have been published in *CJNR* focus issues in this domain of inquiry. This may be attributable to the growing recognition of qualitative research methodologies in nursing inquiry as well as their strong suitability for

examining phenomena that are highly experiential and/or processual, common features of questions in ethics, values, and decision-making.

### Examining the Underlying Is-Ought Problem

The examinations of ethics, values, and decision-making described above scarcely entail normative analyses (e.g., investigations of the moral norms that are required for particular domains of nursing practice), although some of the analytical discussions touch on normative considerations. This domain of inquiry involves a complex philosophical problem that requires more explicit consideration: the is-ought problem.

The Scottish philosopher David Hume (1739/1978) points out in his *Treatise of Human Nature* that prescriptive (i.e., *ought*) inferences are frequently, and mistakenly, drawn from descriptive (i.e., *is*) statements or facts. For example, one may conclude that one should use corporal punishment as a means of disciplining one’s children because one’s own parents did so and most other people do so. The person is relying on what *is* the case (i.e., most people *do* strike their children as a means of controlling their behaviour) to judge what *ought* to be the case (i.e., people *should* strike their children as a means of controlling their behaviour).

Hume points out that this is a mistaken inference because the relations or affirmations expressed by *ought* or *ought not* are different from descriptions of empirical observations. An *ought* statement implies an ethical duty or obligation, whereas an *is* statement presents an empirical fact. The two are not substantively related. An *is* relation does not logically entail an *ought* obligation. To give another example, a study of nurses’ perspectives on severely disabled survivors of critical care could demonstrate that nurses regard these lives as highly compromised, suggesting that life-sustaining therapies may be excessively harmful. This observation does not morally imply that these lives should be ended.

Whereas *is* statements attempt to truthfully convey empirical facts, *ought* statements articulate ethical prescriptions. How, then, are *ought* statements to be formulated? Philosophers predominantly hold that *ought* statements need to be rooted in a moral philosophical framework (e.g., deontology, utilitarianism) and/or moral norms. For example, a specific norm such as the doctrine of informed consent is based on the moral value of respect for individual self-determination. The fact that the exercise of informed consent is time-consuming or even upsetting for patients, families, and clinicians does not disqualify the moral basis for seeking informed consent.

Facts do not necessarily involve moral relations. We need ongoing articulation of fundamental moral values, norms, principles, and/or

frameworks to continually inform the specification of particular ethical duties. Although early moral philosophical work affirmed the importance of respect for autonomy, further work has specified conditions and limits to this autonomy while affirming other moral values such as the sanctity of life. It is therefore widely acknowledged that an expressed desire to commit suicide involves different ethical responses from a refusal by a person of “sound mind” to accept medical therapy.

The is-ought problem raises an important question in nursing inquiry: How should empirical research relate to normative ethics research in nursing? The answer to this question can help to orient future discourse between these forms of inquiry.

A diversity of is-ought relations seems plausible for nursing. First, empirical data can inform ethical norms. For example, it is widely held that the benefits of treatments should outweigh the harms. Empirical data can help to determine the benefits and harms of specific treatments, strengthening the truth value of risk/benefit assertions. On the other hand, although empirical research may show how a treatment affects people, it cannot determine which effects are most morally significant. A study can demonstrate that mechanical ventilation for persons with a degenerative neuromuscular disorder can prolong life while documenting the accompanying pleasures and displeasures. However, the relative moral importance of longevity, suffering, or pleasure cannot be established exclusively through empirical research (although eliciting the opinions of the affected persons can be helpful). A cost/benefit analysis of a treatment will have to appeal to moral norms regarding the defensible value of each good and harm associated with the treatment. If all parents of children with end-stage heart disease reported that they would readily give up their own heart to save their child’s life, this empirical fact would not render such a practice ethically permissible. Moral philosophical analyses and norms relating to the value of life as an end in itself (and not a means to an end) limit the forms of personal “sacrifice” that would be morally defensible.

Second, empirical research may challenge the premises of existing ethical norms. For example, surrogate decision-making models commonly require family members to choose the treatment that the patient would have chosen if he/she could do so (i.e., the substituted judgement standard). Empirical research may demonstrate significant problems with this norm in practice. It may be difficult for the family member to truly take the patient’s perspective, project past discussions with the patient to this specific clinical situation, and dissociate one’s own wishes for the patient (i.e., one’s child, parent, spouse, or sibling) from what the patient would have wanted. Such empirical data would demonstrate the impracticability of an ideal form of surrogate decision-making, calling for

further specification of the norm — presenting a possibility for empirical and normative research to reciprocally inform each other.

Third, some empirical data may not be relevant to the content of ethical norms yet highlight problems related to the operationalization of a norm. For example, a study can demonstrate that persons facing particularly difficult situations, such as life-threatening illness, are incapable of managing the information required for them to make an informed decision about their care. Data can indicate that a person so desperately hopes for a positive outcome that he or she amplifies the likelihood of a favourable outcome and minimizes that of unfavourable outcomes. Informed consent is premised on a calculative form of reasoning that may at times be compromised. Clinicians are faced with the ethical imperative of ensuring informed consent while also attending to the patient with compassion regarding their limitations in managing such personally dire information. Such data can highlight the need to further develop the processual (i.e., “how to”) aspects of the norms in question.

Fourth, empirical data can help to identify the need for new ethical norms, by identifying moral dilemmas that were not previously recognized. For example, as success rates continue to improve in living-related organ transplantation (e.g., parent-to-child kidney transplantation), and as the demand for organs continues to exceed the supply, some persons are seeking to donate their organs to persons they do not know (“altruistic” organ donation). Is it permissible to allow a person to donate to a “stranger” an organ that he/she or a family member may need in the future? The donor and the recipient would enter into a weakly understood relational dynamic while maintaining confidential identities, providing the recipient with an opportunity to improve his/her quality of life and the donor to derive satisfaction from an altruistic act.

### **Explicitly Addressing the Is-Ought Problem in Nursing Inquiry**

The examples of is-ought relations discussed above should not be regarded as exhaustive. Many other relations can exist. The aim of this discussion is to illustrate the diverse forms of relationships that can be drawn between empirical data and ethical norms. The complex nature of the is-ought problem calls for explicit attention to empirical-normative relations in nursing inquiry, especially in the domain of ethics, values, and decision-making. Specifically, empirical research in this domain should be designed to directly address the normative implications of the findings. Such important issues should not be relegated to brief “future considerations” statements at the end of a Discussion section.

The articles published in this issue of the *Journal* do address this concern at one level or another. This is most explicitly evident in the

contribution by Simmonds and Peter, who use Walker's expressive-colaborative model of morality to examine the research literature on intrapartum nursing and midwifery.

I conclude this discourse with a couple of illustrations of how my collaborators and I have addressed the problem in our own research. We recently published the findings of a qualitative study of the moral experience of families with children living at home using assisted ventilation (Carnevale, Alexander, Davis, Rennick, & Troini, 2006). As we presented early analyses of our data, reporting the extraordinary distresses associated with these families' daily lives, we noted that our clinician audiences inferred that these were clearly "wrongful lives" — that we should rethink the position we were putting these children and families in and consider earlier withdrawal of life-sustaining therapies. An *ought* was directly inferred from our early empirical findings, using our data to inform risk/benefit assessments. This struck us as problematic, as we were not drawing the same conclusions from our research. It then became apparent that we were understating the forms of enrichment that these children and their families were deriving daily from their lives together. Our own "cost/benefit analysis" was much more complex. Furthermore, it was also evident that many of the so-called costs or burdens associated with the situation were, in principle, preventable. These included systematic discrimination against the child and family by community members, schools, and health professionals, as well as social and physical barriers in everyday life.

Our analysis showed that a patient-centred cost/benefit analysis failed to address the full range of morally relevant considerations. The study revealed that this population called for the examination of other moral matters, such as justice and social responsibility towards the provision of health and social services, questions about what form of life is morally worthwhile, and how to reconcile the patient's interests with those of other family members. Anticipating these complex issues, we planned a series of normative analyses to follow our empirical investigation, incorporating these into the study budget. In one paper we specifically examine the treatment decision-making implications of our data for this population (Cranley Glass & Carnevale, 2006). In another we review the methodological ethical challenges in collecting observational data with children and families, critically examining ethical norms for participant-observation research in pediatrics (Carnevale, Macdonald, Bluebond-Langner, & McKeever, in press). In a study currently underway (Principal Investigator: Bilkis Vissandjee), we are using qualitative methods to investigate the ethical issues involved in nursing across linguistic differences. Early in the study, we conducted an analysis of nursing norms to determine how nurses *ought* to be nursing in the context of linguistic barri-

ers. This normative analysis provides a framework for interpreting nurses’ accounts (i.e., the *is* of how they construe what is ethically meaningful and how they manage these issues).

The articles presented in the pages that follow make an important contribution to our understanding of ethics, values, and decision-making in nursing and in related clinical and theoretical domains. They make significant empirical, theoretical, and analytical contributions. I call for future inquiry in this domain to more explicitly examine the relationship between empirical research and normative analysis. This will help to ensure that the ethical implications of empirical data are soundly interpreted and that normative inquiry is systematically informed, challenged, and enriched by empirical examinations of the operationalization of ethical norms.

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