A NARRATIVE APPROACH TO EMPIRICAL NURSING ETHICS RESEARCH: UNCOVERING THE EVERYDAY MORAL KNOWLEDGE OF NURSES[1]

UMA ABORDAGEM NARRATIVA PARA A PESQUISA ÉTICA EMPÍRICA DE ENFERMAGEM: DESVELANDO O CONHECIMENTO MORAL COTIDIANO DE ENFERMEIRAS

UN ABORDAJE NARRATIVO PARA LA INVESTIGACIÓN ÉTICA EMPÍRICA DE ENFERMERÍA: REVELANDO EL CONOCIMIENTO MORAL COTIDIANO DE LAS ENFERMERAS

Elizabeth Peter[2], Kirsten Martin[3]

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[2] Registered Nursing, PhD. Associate Professor & Associate Dean, Academic Programs Lawrence S. Bloomberg, Faculty of Nursing. Member, Joint Centre for Bioethics in University of Toronto. Ontario, Canada.

[3] Registered Nursing, MBA. Project Manager, Planning & Development in the St. Michael's Hospital in Toronto. Ontario, Canada.

KEYWORDS: Methods. Ethics. Feminism. Nursing.

ABSTRACT: In this paper we explore the use of Margaret Urban Walker's metaethical perspective, particularly the use of narratives, to inform the development of a research approach to uncover the everyday moral knowledge of nurses. A method based on Walker's work makes it possible to analyze the power dimensions inherent in nurses' moral experience, to ground a narrative approach to nursing ethics with a robust moral epistemology, and to differentiate different types of narratives. A number of analytic questions, which have their basis in Walker's work, are presented and are used to analyze a practice narrative written to illustrate how narratives can be used to draw out the moral knowledge of nurses within the context of their actual work.

PALAVRAS-CHAVE: Métodos. Ética. Feminismo. Enfermagem.

RESUMO: Neste artigo nós exploramos o uso da perspectiva metafísica de Margaret Urban Walker, particularmente o uso de narrativas, para informar o desenvolvimento de uma abordagem de pesquisa para revelar o conhecimento moral cotidiano de enfermeiras. Um método baseado no trabalho de Walker torna possível analisar as dimensões de poder intrínsecas na experiência moral das enfermeiras, fundamentar a abordagem narrativa à ética da enfermagem com uma moral epistemológica robusta e distinguir diferentes tipos de narrativas. Um número de questões analíticas que tem suas bases no trabalho Walker, são apresentadas e utilizadas para analisar a prática narrativa e ilustrar como as narrativas podem ser usadas para delinear o conhecimento moral de enfermeiras dentro do contexto de seu trabalho real.

PALABRAS CLAVE: Métodos. Ética. Feminismo. Enfermería.

RESUMEN: En el presente artículo exploramos el uso de la perspectiva metafísica de Margaret Urban Walter, particularmente el uso de narrativas, para informar sobre el desarrollo de un abordaje de investigación que revela el conocimiento moral cotidiano de las enfermeras. Un método basado en el trabajo de Walter permite analizar las dimensiones de poder inherentes en la experiencia moral de las enfermeras, así como fundamentar con una moral epistemológica robusta, el abordaje narrativo ético de la enfermería, y distinguir los diferentes tipos de narrativas. Un número de cuestiones analíticas basadas en el trabajo de Walker son aquí presentadas y empleadas para analizar la práctica narrativa e ilustrar cómo las narrativas pueden ser usadas para delinear el conocimiento moral de las enfermeras dentro del contexto de su trabajo real.

Elizabeth Peter
Address: 155 College Street
Toronto, Ontario M5T 1P8 - Canada
Email: elizabeth.peter@utoronto.ca
MartinKi@smh.toronto.on.ca

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INTRODUCTION

Over the past several decades, there has been both an increase in empirical research in nursing ethics and an increasing recognition of the need for empirical research in bioethics.[1-2] Empirical ethics research in nursing has shifted emphasis from moral development and moral reasoning to the articulation of moral concerns experienced by nurses at work. In keeping with this change, methods also moved from the use of instruments and hypothetical dilemmas to ethnographies and narrative analyses. Specific theories framed the research during these periods. Cognitive psychology following Piaget and Kohlberg informed research in moral development, while traditional principle-based bioethical theory informed research in moral reasoning.

It is a starting assumption of this paper, that a metaethical perspective has not rigorously informed the methods used in empirical bioethical inquiry, including the study of the ethics of nursing work. Metaethics takes into account the language, methods, logical structure, and reasoning used to justify moral decisions and knowledge. The metaethics behind the dominant view of moral philosophy through most of the 20th century views moral knowledge as a timeless and contextless set of impersonal truths that can be expressed as rationalistic and individualistic action guides.[3] A further inadequacy can be traced to the ontological assumptions inherent in much of traditional bioethical theories that portray persons as autonomous, independent, and rational as opposed to a view of persons as both, rational and emotional, interdependent, and deeply situated in sociopolitical contexts. The latter view makes possible an appreciation of the differentiated political and social spaces inhabited by nurses, patients, and other healthcare providers.

In contrast, feminist moral philosopher, Margaret Urban Walker[3-4] offers a metaethical perspective that challenges the very understanding of morality itself. The central point of Walker's challenge to the common understanding of morality is that morality is not formal, theoretical knowledge, but "a socially embodied medium of mutual understandings and negotiation between people over their responsibility for things open to human care and response".[3:9] Divisions of labour establish how moral responsibilities are to be shared by people, define the scope of their agency, affirm who they are and what they care about, and designate who has the authority to judge. These moral responsibilities are comprehended and sustained through narrative understandings that constitute peoples' sense of relationships, moral identity and moral values. Walker's understanding of morality reflects nurses' moral experience and offers a language robust enough to articulate these experiences and critique the moral understandings of which their experiences are part. Walker's metaethical approach offers a language, method, and logical structure that can reveal and articulate the moral world of nursing.

In this paper we explore the use of Walker's[3,4] metathical perspective, particularly the use of narratives, to inform the development of a research approach to uncover the everyday moral knowledge of nurses. We begin by describing how narrative approaches have been used in nursing ethics and then outline the potential contribution of Walker's approach. We then present a number of questions that can be used to guide the analysis of narratives. These are then used to analyze a practice narrative written by Author 2 to illustrate how narratives can be used to draw out the moral knowledge of nurses within the context of their actual work.

NARRATIVE APPROACHES

Narrative approaches in nursing ethics have existed for some time. Benner, perhaps the most notable, speaks of "articulating major areas of socially embedded knowledge and notions of the good in nursing practice".[5:138] through phenomenologically grounded empirical research using narratives. She suggests that expert nurses have the capacity to recognize the good or "the ought" in their practice. Knowledge of the good can be revealed through narratives that describe the everyday ethical comportment of expert nurses. Some of the goods Benner[6] identifies from her research include the themes of healing, being present, fostering care and connection, facing death and suffering, and learning the skill of involvement.

Narratives have also been used to compare nurses' and physicians' experiences in situations in which they did not know what was the right thing to do[7] and to capture stories from nurses using an ethnographic approach to study the everyday work on an oncology ward.[8] Others such as Lindsay and Graham,[9] who examined an ethical dilemma concerning a patient's health insurance, and Abma,[10] who analyzed a case study in palliative care, have used nurses' practice narratives drawing on the

postmodern relational approach to narrative ethics developed by Gadow.[11]

While these studies have merit in that they begin to uncover the narrative nature of moral understanding in nursing, there are three reasons that introducing Walker's[3-4] work to narrative-based empirical research in nursing ethics could be of benefit. First, Walker's approach is feminist which permits an analysis of the power dimensions inherent in nurses' moral experiences. The volume of studies revealing the moral distress of nurses attests to the frequency of constrained moral agency in nurses that can only be sufficiently addressed using a method that can capture the political character of nurses' ethical concerns.

Second, Walker brings forward a robust moral epistemology that can inform a rigorous narrative approach to nursing ethics research by explaining the interpersonal nature of moral justification. Walker[3-4] terms the process of moral justification in moral-social orders as an "interpretative moral ethnography", a process through which moral arrangements can be made transparent so that it can become clear who bears responsibility for what things and what agreements, implicit or explicit, are available to distribute and evaluate these responsibilities. This type of analysis of moral accountability makes it possible to examine how differently situated people experience their responsibilities and how the costs of these responsibilities are shared or not shared. It also permits an analysis of the moral habitability of a given moral-social order or environment. Environments can be considered habitable if they are found to cultivate recognition, cooperation and the sharing of societal goods and benefit as opposed to those that foster oppression, suffering, deception and violence.

Third, Walker[3] differentiates different type of narratives, delineating three kinds--narratives of identity, relationship and value. A narrative of relationship is one about the expectations, foundations, types of trust, and the potential for future continuation within a relationship. A narrative of moral identity illustrates a person's consistent history of values that can be uncovered by what a person cares for, responds to, and takes responsibility for. The final type, the narrative of moral values, involves a history of values or moral concepts that are acquired, modified, or replaced both by individuals and sometimes within communities or groups who share common moral understandings. These types of narratives are not mutually exclusive, but can be intertwined within a specific narrative.

Walker's moral epistemology

Walker has called her approach to ethics the "expressive-collaborative" model of morality, in contrast to the "theoretical-juridical" model that "prescribes the representation of morality as a compact, propositionally codifiable, impersonally action-guiding code within an agent".[3:7] Moral practices and agency from the expressive-collaborative model exist in context and cannot be extracted from other social roles and practices. Walker uses the idea of narrative as a way to shift perspectives in bioethics from thinking about morality as theory applied to cases, the "theoretical-juridical" model, to thinking about morality as a medium of ever evolving acknowledgement and negotiation among people in, or in search of, a common and morally habitable world. Moral thinking and understanding are narratively structured such that a story is considered by Walker to be the fundamental form of representation for moral problems. In these narratives, it is important to know who the parties are, how they understand themselves and each other, what history of trust, expectation and agreements exists, what the terms of relationship are, and what social or institutional factors shape their options. It is also necessary to know how they got to a situation that requires moral attention because this shows something about the kinds of attention and responses that are being considered.[3-4]

The process of narrative analysis

To facilitate the process of narrative analysis using Walker's approach we have developed a number of guiding questions. Given the breadth and depth of Walker's work it is beyond the scope of this paper to present all possible questions that could be raised. Thus, we list the most salient ones below.

1) What are the moral concerns? How are they described?

2) What type(s) of narrative(s) is being presented-one of relationship, identity or value?

3) How do people understand their responsibilities? Or, who gets to do what to whom and who is supposed to do what for whom?

4) How is accountability determined? How and by whom were responsibilities assigned? What history of trust, expectation and agreement in relationships exist? Were responsibilities deflected?

5) What are the voiced problems? Are moral understandings intelligible/coherent to those enacting them? What problems do they describe?

6) How morally habitable are the moral-social orders in which persons live and work? Do they foster recognition, cooperation, and the shared benefit of many goods? Or, do they engender oppression, suffering, deception, and violence?

7) How are people socially situated? How do social or institutional factors shape their options?

The narrative

Author 2 was asked to describe a situation in her practice in which she experienced an ethical concern, either a dilemma or simply a problem. The situation was to be written up in an informal, narrative style but with as many details as possible, excluding names and identifying institutions. She was also asked to include a thorough description of the situation or event, why this was an issue of her, the persons involved, actions taken or not taken, consequences, and reasons why she did what she did. Below is the narrative she wrote:

As an oncology nurse I worked in the outpatient radiation clinics of a large urban teaching hospital. Partnered with a physician, Dr. A, I provided care and education to patients receiving treatment for lung cancer and related metastasis. On many occasions, we would see these patients on a palliative basis and give radiation to control pain caused by the location and bulk of their disease. On one day in particular I was left questioning whether the care we provide causes more harm than good, and if we are really providing patient-centered care.

A palliative patient named Mrs. M came into the clinic, having traveled approximately 45 minutes by ambulance. Dr. A was notoriously late, consistently arriving 30 minutes to an hour late to begin seeing his patients; thus causing Mrs. M to be held in the waiting bay to be seen for an hour and a half after her booked clinic time. When we finally called Mrs. M into the clinic, I found a very frail woman in her fifties who was unresponsive to my verbal cues.

She suffered from advanced Stage 4 non-small cell lung cancer with metastasis to multiple parts of her body, including her liver and bone. She was accompanied by her husband who by his disheveled appearance and flat expression seemed emotionally and physically exhausted. I apologized to Mr. M for the wait, and he said that he was grateful that they had been able to get into the clinic at all. I could hear some desperation in his tone and chatted with him for some time to settle him into the clinic and introduce some of the process to him.

Mr. M spoke for his wife as she could not communicate verbally at this point in her illness. He stated that she looked like she was uncomfortable all the time now and he felt that she was in a great deal of pain since she was always diaphoretic and moaned a lot. It was obvious to me that it pained him to watch his wife deteriorate and he was looking for anything that could help control her pain. I thought that it was terribly sad for Mr. M to have to watch his wife suffer in this way, and that after 25 years together her passing would leave a terrible void in his life.

Dr. A entered the room and proceeded to do a full physical assessment on Mrs. M while she lay in the stretcher. He pressed on various bones and organs, all the while communicating only with Mr. M to fill in the gaps of his assessment. Mrs. M moaned a little when her ribs were touched, but overall remained unresponsive. I could not help but think how odd it was that she was not involved in anything that was happening to her, did not know where she was or what was going on.

Following the assessment, Dr. A and I returned to the clinic area to review Mrs. M's imaging again.

"That's a sad situation" I said, "It doesn't seem like she knows what's going on at this point and he looks beside himself with grief".

Dr. A murmured in response; he was lost in his thoughts as he looked at the films and picked up the phone to make a call down to the radiation area to inquire if there was a treatment spot open for today. Apparently, Dr. A had decided that radiation treatment for Mrs. M was justified, and he proceeded without addressing my previous comment. After confirming a spot for Mrs. M he put the receiver down and asked me to draft up the necessary paperwork. I felt a strong resistance to his treatment decision and inquired into his rationale for doing it.

– Are you really going to bring this woman in for treatment everyday?, I asked.

My assessment of the situation had been to see a woman who had very few days left to live and was being managed fairly well with narcotic medication at her current institution. I asked him to consider that the patient and her husband would have to make a 45 minute drive both ways from

an outside hospital everyday, for 10 days, which would be disruptive to her palliative management at this point. Besides that, it did not seem like an appropriate use of her few remaining days that might be more restful and better spent with loved ones around her. Mr. M was riddled with grief and could not make clear decisions, so it was up to us to help him clearly understand his options.

Dr. A explained that she was in a great deal of pain because of her metastasis and that she would greatly benefit from 10 consecutive days of radiation. In his opinion, the benefits of treatment outweighed the burden brought about by travel and disruption in her care.

I remarked that there is always a flair in bone pain before the patient feels any benefit from this treatment, and she did not have the life expectancy to fully achieve this benefit.

What is the ultimate goal of this treatment I wondered, to treat for the sake of treating? Or to truly do what is best for this woman and her husband?

Following our brief discussion, Dr. A returned to the patient's room and informed Mr. M that he had set up a treatment slot for today and that he strongly recommended a palliative daily course of radiation for Mrs. M. He stated that her pain would be greatly reduced and it would improve her current state. None of the concerns I had raised were mentioned during this discussion, and it bothered me that Dr. A sold the treatment with more benefit attached to it than I felt it deserved in this context. In particular, it seemed that Mr. M was clutching to any hope to delay his wife's illness and from his interjections. I could tell that he did not fully understand that this treatment was strictly palliative and would in no way prolong her life. Mr. M consented to treatment and Dr. A and I left the room.

This situation made me feel very frustrated as Dr. A did not holistically assess the needs of the patient and her husband. Dr. A knew that I did not understand his reasons for offering treatment in this case, but he didn't make any effort to communicate his rationale to me. Mr. M came to the clinic desperate for any kind of intervention that would help his wife feel better, and we failed him by not contextualizing the treatment options so that he could make an informed decision based on what was best for Mrs. M. Providing further medical interventions is not always in the best interest of the patient and I believe that Mr. M would have been better served if we had empowered him to consider not seeking further treatment at this point. Overall, I wish I could have had a stronger influence on the situation, since I believe we would have served Mr. and Mrs. M better in a supportive role rather than in an active treatment role.

Analysis of the narrative

While the questions in the previous section were used to guide this analysis, we did not use them in a formulaic fashion. Instead, we examined the narrative as a whole, using the questions as a way to alert to us to the subtleties of the narrative.

The narrative is primarily one of relationships, in particular the relationship between Author 2 and Dr. A. who are taking care of Mrs. M. and Mr. M. Early, in the narrative Author 2 states that she is "partnered with a physician, Dr. A". The use of the term "partner" suggests a moral understanding of a relationship that is, minimally, one of equality both in terms of shared responsibilities and power. Specifically, together they are responsible for the care and treatment of patients with lung cancer which sometimes includes radiation treatment for pain control. On this occasion they are responsible for the care of Mrs. M who is suffering from Stage 4 non-small cell lung cancer with metastasis to multiple parts of her body. This shared responsibility is the product of a long history of moral-social negotiations that have determined who does what and why in healthcare, especially pertaining to professional roles and responsibilities. Historically, nurses would not have referred to themselves as a physician's partner, but instead more likely would have referred themselves as an assistant, or even instrument, of the physician.[12] Changing gender roles have influenced the socialization of nurses which in turn have altered perceptions of what a nurse's relationship to a physician is, at least, Author 2's perception. The lack of involvement of Author 2 in decision-making reveals an understanding of their relationship by Dr. A that is not in keeping of a partnership. It is impossible to know with certainty what he is thinking, but it appears that he believes that the physician is the cognitive and decision-making authority for all.

The relationship between Mr. and Mrs. M is also significant. Mr. M's emotional and physical exhaustion attests to his devotion to his wife and the responsibility he has taken for her well-being.

Often the needs between he and his wife's needs are inseparable-both are vulnerable as a result of illness and their dependency upon the healthcare system and both are suffering. The inseparability of many of Mr. and Mrs. M.'s needs and interests is consistent with a feminist conception of persons as connected and interdependent.[13] Their understanding of their moral responsibilities may stem from societal expectations surrounding marriage and also their own agreements, both implicit and explicit.

Author 2 is attentive to the wide array of Mr. and Mrs. M's needs and recognizes the importance of maintaining the bond between them, but Dr. A seems to have a much narrower view of his scope of responsibility. He is focused exclusively on Mrs. M's medical treatment, namely radiation. It is through Author 2's moral distress that we can gain insight into what normally would be considered an appropriate moral response and what moral understandings direct those responses. Lapses in everyday moral comportment, often erroneously believed to be merely a lack of acceptable etiquette, are identified in Dr. A by Author 2 as problematic, including his notorious lateness and his mumbling in response to her comments regarding Mr. and Mrs. M. These lapses reveal what would be expected by a physician in a similar context such as being punctual and actively engaging in discussion with colleagues. More significant is Dr. A's failure to involve others in the care of Mrs. M, including Mrs. M herself, despite patient centred care being the agreed upon approach in most Canadian healthcare settings.

In theoretical terms, Dr. A's behaviour is not consistent with historical expectations of team relationships that reflect recognition and cooperation. Although these expectations are certainly not always fulfilled in real experience, they do shape an important aspect of the moral-social order. Author 2's apparent distress regarding the treatment of Mr. and Mrs. M and her overall sense that she did not influence the situation adequately demonstrates that the outpatient radiation clinic at this hospital is not morally habitable in the fullest sense. Instead of fostering recognition and cooperation, it is engendering suffering and the silencing of almost all involved. Her self-reflection and distress also represent a smaller narrative of moral identity, contained within this larger narrative of relationships, which reveals her history of being focused on patients' best interests and needs and demonstrates her concerns that she cannot care for the patient as she usually would.

Overall, the narrative uncovers significant moral knowledge. First, it shows up Author 2's understanding of the significance of the web of relationships that affect care. There is not simply a relationship between a nurse and a patient, or a physician and a patient, but an entire web of people. The negotiation of moral responsibility occurs within this network and is simultaneously nested in broader networks of care. Second, the ethics of the everyday is emphasized. There is no dramatic dilemma, but instead recognition of the importance of everyday decision-making and action that in this situation had serious implications for the well-being of Mr. & Mrs. M. Third, the moral distress of Author B opens up everyday moral experience by exposing unmet expectations of care and response that normally would be taken for granted and invisible. These expectations contain moral knowledge in that they represent negotiated understandings of how people ought to behave in particular situations.

CONCLUSION

Walker's[3-4] model of morality offers a naturalized, feminist method to moral inquiry in nursing ethics and to healthcare ethics more generally. Walker's project is to challenge the conception of morality commonly held by the majority of moral philosophers. The conception proposed by Walker allows for several paths of inquiry not open to present understandings. She is feminist in that she challenges the authority of presently held views of morality, seeking to make transparent the situated knowledge, practices of responsibility, and the identities, sustainable responsibilities, valued relationships, and general values that constitute moral understandings.

Our methodology opens up many possibilities for nursing ethics. By going beyond the narrow boundaries of mainstream scientific approaches, this methodology opens up new ways in which moral knowledge can be developed, expressed, and made transparent in narratives. Just as morality is not socially modular, neither is any kind of healthcare work. This approach opens up how we are interconnected and accountable to each other as healthcare workers. It shows that science and philosophy can and should work operate together to connect normative reflection with empirical information and that the genuine collaboration among healthcare workers is necessary to develop the kind of moral-social orders in which we all can thrive.

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