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DECISION-MAKING AND ETHICS – A CASE STUDY OF STUDENT NURSES

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ABSTRACT

Previous studies have shown that student nurses find the analysis of ethical dilemmas difficult (McAlpine 1996). This may well be due to the nature of such situations, which are frequently complex and prone to ambiguity. This leads to uncertainties as to which course of action is the correct one for those involved.

The purpose of this study was firstly to explore the perceptions of a group of student nurses in relation to ethical dilemmas, which arose in practice both before and after exposure to the clinical environment, and secondly to evaluate the usefulness of modules dedicated to ethics, which the students undertook as part of the Project 2000 curriculum. The focus of the evaluative process was the development of moral responsibility and ethical decision - making skills.

210 students representing two consecutive cohorts on the Project 2000 pathway took part in the study.
An evaluative case study design was used to examine the responses of students using two instruments, a questionnaire and an in-depth interview.
The results from the questionnaire data indicated that student views had altered significantly after exposure to practice and theoretical input regarding the decisions taken in response to the ethical scenarios presented. Statistical analysis was conducted involving the variables student response and age, and student response and gender, but the results were not statistically significant.

Data generated from the interviews were divided into four major themes. The complexity of ethical issues for the health care team; the consequences ethical decision-making could have for society; the development of students' confidence when faced with ethical dilemmas, and finally how their theoretical input had prepared them for their forthcoming role as qualified nurses.

The results from the interview data suggest that nurses realised the importance of the decisions that are taken in practice and how these will influence the direction of health care in the future. The results also demonstrated the importance nurses placed on a theoretical basis in ethical decision-making as this provided a framework that could be used throughout a nurse's career allowing him or her to enhance their professional status.

The study results indicate that if nurses are to fulfil their role as professionals then the acknowledgement of moral responsibility and development of ethical decision-making skills are essential. In today's health service nurses will be involved with the moral decisions taken by colleagues, patients and their relatives. It is important that nurses cannot only respond to the moral aspects of individual patient situations but also have an in-depth understanding of the ethical frameworks which direct decision -making.

PATRICIA A O'SULLIVAN

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This thesis is dedicated to my husband William for his continuing belief in my ability and his immense pride in my achievement.

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Mrs. Doreen Wallace for her secretarial skills and the ability to read my mind.

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CHAPTER ONE

INTRODUCTION

The general scope and direction of this study was largely determined by the increasing importance of ethical decision-making within the health care services. The last few decades have seen rapidly developing technological advances. These costly developments within the clinical environment, which have undoubtedly been of great benefit to patients, have at the same time created ethical dilemmas that have impacted not only on the client and their relatives but also on the health care professionals who are responsible for their care and treatment. One effect of these advances has been to create an environment in which treatment regimes are available for patients living in certain health districts but not others. Cases such as these are often highlighted in the press and on television and the Health Service is asked to account for these discrepancies in opportunities for patients.

For example, the increasing knowledge and ability of health professionals has allowed them to be able to sustain the lives of increasingly premature neonates and prolong the lives of the critically ill (Keenan, 2000). These situations are accompanied by many ethical decisions in relation to quality of life, the cost of maintaining life support for a prolonged period of time and the effects that this will have on the relatives of the patients involved.

Users of the health services are now in a much stronger position to expect a level of service that is outlined by the Department of Health in their recent document The NHS Plan (2000) and many wish to take an active part in decision-making regarding the management of their treatment. Although this is a positive step forward situations will inevitably arise where either lack of

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understanding or the ignoring of advice may lead patients to make a decision that may not be in their best interests. The health care professional may then be placed in a difficult situation, torn between their duty of care and upholding the patients' right to freedom of choice.

The purpose of this chapter is to provide a background to the study describing its location, rationale, context and finally a statement outlining the aims of the research. In order to begin to provide the reader with the background to the research it is necessary to introduce the researcher within the context of her role while undertaking the study and the way in which this role has developed since her first involvement in the health and educational field. During the study the writer will be referred to as the researcher or in the first person where this is appropriate.

The researcher qualified as a registered nurse in 1981 in a large teaching hospital in the north west of England and worked as a staff nurse in neurology. She then moved to a hospital in the south of the country in order to undertake a specialised clinical course in burns and plastic surgery. On completion of this course she continued to work in this specialty for two years. In order to broaden her experience the researcher returned to the north of England and worked in the Intensive Care Unit/Theatre suite of a large teaching hospital. In 1988, having worked in the health care services as a qualified nurse for 15 years she then moved to the educational field. This move was one that the researcher had planned to make as she had qualified as a teacher prior to entering the nursing profession. With a recognised teaching qualification but without experience of teaching nurses, the researcher worked for a year as an unqualified tutor involved with the teaching of student nurses. After this time she continued to teach in this field as a qualified tutor. A move then took place

to post-registration education in a different hospital. In this department the researcher's responsibility involved the development of a variety of short courses designed to provide professional updating study days and conferences in a number of different clinical specialties. The researcher has continued to teach in this area but now organises specialized clinical courses in neurosciences and burns/plastic surgery. These courses are designed to develop the theoretical knowledge base, clinical skills and research expertise of qualified nurses who have chosen to work in these particular fields of health care. The students are encouraged to take an active part in the learning process and to return to their clinical areas to act as agents of change in order to improve practice, lead new innovations and encourage a research ethic within the clinical team. The researcher has continued to develop these courses in response to the changing health environment for the last twelve years. Over this period the researcher has introduced discussion and reflection on ethical issues that impinge on the students' practice so that they will be able to make an effective contribution towards the resolution of ethical dilemmas in the clinical situation. Alongside this the students' abilities to analyse their own values and beliefs and consider societal values are also part of the courses.

During this time the researcher found that nurses who had been qualified for several years were commenting that they were finding it increasingly difficult to adjust to the growing number of challenges presenting themselves in practice where the individual had found it difficult to know what was 'the right and good thing' to do for the patient. These nurses, by their own admission, had very limited skills in managing ethically difficult care situations. Ethics as a subject in its own right had never been introduced in their basic training and it was now proving to be a great disadvantage as these nurses found themselves in situations where they felt unable to act as the patient's advocate. This left

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them with feelings of inadequacy, frustration and a realisation that they were not as effective as they could have been in the particular situation. In 1995 the researcher completed study at Master's level into the subject of Health Care Ethics. It was while a student on this course that the researcher began to realise that the ways of approaching ethical problems are strongly linked with personal experiences, together with pre-conceived expectations that have not been challenged. (Benner,1991) described ethical behaviour as:

> An action, which is related to experiences, cognition, emotions and circumstances (p.57).

According to Dimond (1995) historically nurses had not been in a position where their ideas would be challenged because due to the nature of their role the expressing of opinions was not encouraged. With this in mind the author became interested in the concept of what Harré (1983) describes as "agency". He has described this concept in the following way:

> To be an agent is to conceive oneself as a being in possession of an ultimate power of decision and action (p 43).

In order to achieve this, a nurse needs both personal and professional freedom in order to act on his or her convictions. The character traits necessary for this to occur must include the following – autonomy, altruism, a conscience, the ability to think rationally and the courage of convictions held. (Beauchamp et al 1994). The nursing role must also encompass a large degree of commitment together with a strong will. However, the possession of this personal freedom means that the decisions that are taken must bear some moral significance and involve responsibility for those actions. If nurses are going to possess a sense of "agency" then they need to be able to view themselves as having control and moral responsibility.

Within the Health Service environment, Salvage (1985) has described the sense of helplessness felt by nurses in this particular organisational context. There appears to be a sense of being reactive instead of proactive; nurses feel subject to manipulation and therefore not able to resist the unseen forces operating at management level. Many writers including Kelly (1998) have described the differences that are apparent between the expectations of undergraduate nurses and their experiences working in the health organisation. Many nurses described a hierarchical structure where their organisational accountability and their moral responsibilities to patients and each other were detached. If this is the case a sense of "agency" that should exist is replaced by a sense of inadequacy and feelings of guilt. The nurse may feel that the fault lies at his or her door or may feel it is the fault of the organisational environment. In the researcher's experience it is often a combination of both factors.

If "agency" is important for underpinning responsible practice then the teaching of the discipline of ethics is important for several reasons. Wilmott (1993) outlines the following two reasons. Firstly, the issue related to freedom and "agency" is most concrete when questions about the right and wrong of individual actions are discussed. Secondly, an ethical framework allows exploration of the question in a more focused way.

Ethics has been described as the ability to look both ways (Beauchamp et al 1994). For example, an action can be judged by its consequences, a utilitarian view, or from a deontological viewpoint where the moral significance of an action can stand free of its consequences or its causes. In a situation where an action can trigger events that were unforeseen, which is common when

working within the health environment, the nurse can be helped to find a balance between self-blame and non-acceptance of responsibility.

The Code of Professional Conduct (UKCC, 1992) does imply that nurses have the freedom to choose between right and wrong actions. This freedom can be interpreted in several senses. The nurse is accountable for the performance of his or her professional duty and for some of the consequences of those actions. This code does not give any ready-made formulae for identifying right and wrong in given situations but identifies certain actions that are considered consistently right or not. However, these things are not always easy to identify and may conflict. It can be argued that the nurse cannot act as a free agent when he or she is unable to recognise these situations to make use of the Code of Conduct.

Nursing therefore, may need an ethical theory base, and even if the nurse finds that this base conflicts with his or her own it will be part of their professional responsibility to decide whether they are willing to work within it, (Thompson et al, 2000). Studying ethics allows the nurse to make a considered choice about his or her own ethical stance with regard to freedom and agency.

Since the completion of the Masters Course undertaken in 1995 the researcher has been invited to give lectures on ethics to both pre-registration and post- registration nurses. However this has often been on an ad hoc basis and it could only serve to briefly introduce the main concepts. As the researcher was unfamiliar to the students it was difficult to develop any meaningful group cohesion to allow students to begin to discuss their beliefs and opinions. This experience has strongly influenced the researcher to undertake the present study. At this point the researcher would like to remind

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the reader that although this study discusses philosophical theory in relation to the ethical dilemmas that arise in clinical practice it is primarily concerned with the student's ability to confront and adequately deal with these situations and how their ethical decision-making develops in the light of formal teaching in ethics.

The lack of formal teaching in relation to ethics in pre-registration education has recently been addressed in the Project 2000 curriculum within the University of Greenford, which will be outlined later in the chapter. Modules specifically dedicated to ethical subjects are taught at regular intervals during the training programme. The study will follow four cohorts of pre-registration students, two of whom commenced their training in September 1998 and two in January 1999. The September 1998 cohorts were the first groups to undertake modules specifically dedicated to ethics. The study aims to investigate the opinions of student nurses in response to ethical scenarios through the use of a questionnaire given to the students prior to undertaking clinical practice with the intention of examining these responses in relation to certain dependent variables. The study also aims to evaluate the ethics modules through the use of an interview designed to allow students to comment upon any ethically challenging situations they encountered in practice. During the interview process the students will be invited to discuss whether their responses to the ethical scenarios outlined in the questionnaire have changed in the light of their exposure to clinical practice. In addition they will be asked if undertaking the modules on ethics has had any effect on their ability to handle ethical issues which they have encountered in clinical practice and whether studying ethics has helped prepare them for their role as qualified nurses. The interview will be conducted after the students have been in clinical practice for a period of time

within their respective branch programmes, which will be outlined later in the thesis.

The students' attitudes to ethical problems that arise in clinical practice and their ability to deal with these issues will be investigated in the light of undertaking the specialised modules.

The students who are participating in this study are studying at the University of Greenford (a fictional name). The University is situated in the centre of Greenford. With a population of 115,000 it is one of the largest towns in the UK without city status. The Wentworth campus combines modern and nineteenth century buildings, several of which are listed due to their architectural or historical interest. The School of Human and Health Sciences, the department in which the researcher works, is housed in extensive new premises that opened in March 1999. There are other university premises and halls of residence situated around the town, the largest of which, is the student village situated at Lloyd Hall in extensive parkland on the outskirts of the town.

The University has over 17,000 students and offers a wide range of courses leading to a variety of qualifications ranging from a BA (Hons) in Accountancy and Finance to a BSc (Hons) in Virtual Reality Systems. The School of Human and Health Sciences offers professionally-validated diploma and degree programmes in health and social work and a wider range of degrees in the behavioural sciences and health-related subjects. The School has over 4,000 students currently on both academic and vocational programmes. The School of Human and Health Sciences also has over 2,000 part-time students and the programmes are devised to support the learning needs of people from a wide variety of backgrounds.

With the completion of the School's new building in March 1999 on the Wentworth campus the School underwent a mass relocation from 12 outlying sites throughout the region, which dramatically increased the opportunities for shared learning. Most courses within the School of Human and Health Sciences are practice-based and therefore links with external organisations are strong. In response to a government initiative which outlined new strategies for nurse education a local College of Health Studies successfully amalgamated with the existing School of Human and Health Sciences at the University of Greenford in April 1996.

As far as the existing students were concerned they continued to be taught by the same people in the same teaching accommodation as previously. Due to the problems posed by housing a large number of employees from a variety of satellite sites within the existing University accommodation the process was staged over a period of 3 years. The researcher was included in the final stage of the move and transferred to the University in March 1999. Having worked in a hospital-based environment for many years the transition to a higher education institution was a difficult process even though the amalgamation had taken place over a period of time. The major differences that were immediately noticeable were the numbers of students that were registered on the courses offered by the University compared to the much smaller numbers that were taught within the College of Health. This factor was certainly important in the differing approaches to teaching and the management of courses in general. The administrative systems within the university were also new for both the academic staff and the students. Many students had been familiar with a system where the teaching environment was intimately connected to the clinical environment, and they had to adapt to a new university system. This separation of the teaching and clinical environments also caused problems for the staff that had established close links with the clinical areas and found the

geographical distance from some of these areas rather disconcerting. It was necessary to ensure that these links remained as strong as they had been previously for several reasons. Firstly, in order to remain credible when leading specialized courses teachers must keep up to date with changes occurring in practice. Secondly, the continuation of the involvement of guest speakers from the clinical areas who support the courses and finally, the obligation teachers have to work in practice for a certain length of time per year in order to maintain their professional registration.

Within the School, the Department of Nursing runs the Diploma in Higher Education (Dip HE) in Nursing Studies. Pathways on this course lead to both an academic award and to professional registration in the following branch programmes, which make up the latter 18 months of training-

    Adult Nursing

    Mental Health Nursing

    Learning Disability Nursing

    Child Nursing

To ensure that the requirements for both qualifications are met the course has been developed with reference to The National Committee of Inquiry into Higher Education (1997) and the English National Board for Nursing, Midwifery and Health Visiting requirements for educational programmes (ENB 1997). On completion of the course students are awarded the academic qualification and will be entered onto the appropriate part of the United Kingdom Central Council Professional Register for Nurses, Midwives and Health Visitors. The pathway is delivered over three years. Each academic year consists of three semesters or trimesters. Each semester is 15 weeks in length and the student is required to demonstrate a minimum of 2,300 hours of academic study and 2,300 hours of clinical practice. The pathway is based on 10 credit modules at

pre-foundation, foundation and advanced levels. Successful completion of these modules attracts 240 credits plus 90 credits for clinical experience successfully completed. There are two main parts to the pathway - the 18 month Common Foundation Programme (CFP) and the chosen branch programme also lasting 18 months. Within the nine trimesters the students divide their time between theoretical input, directed study and clinical practice. Nurses work with all client groups in a variety of settings and undertake nursing activities and acquire skills in a wide range of clinical and multi-agency settings. The Common Foundation Programme (CFP) makes up half of the course and is undertaken by all students. During this programme the students are provided with opportunities for correlation of theory and practice, the development of observational, assessment and care skills; and the application of knowledge to the development of problem solving and communication skills. In trimesters two and three the students spend 360 hours in a variety of community settings. One hundred and fifty hours are devoted to childcare and paediatrics, 150 hours to maternity care and the remainder to experience with a qualified health visitor. The clinical placements are designed to meet the European Commission Nursing Directive (77/453/EEC). In trimesters four, seven and nine the students undertake purely clinical placements within the four specialties outlined previously, which make up the branch programmes. Trimesters one, two, three, five, six and eight combine both clinical placements and theoretical input. The Common Foundation Programme is considered to be the essential building block enabling the development of knowledge and skills, which will ensure smooth progression to any branch speciality outlined above. During the above programme twelve modules are accredited at pre-foundation level, ten modules are accredited at foundation level and twelve modules at advanced level. Throughout the Common Foundation Programme students have supernumerary status while in the clinical areas. Teaching is

designed to illuminate and complement practice through exploration of the appropriate knowledge base. The practical experience is designed to give the student an insight into the four areas of nursing which make up the branch programmes. The exploration of the knowledge base of nursing is organised around 5 major themes –

Nursing Theory and Practice

Human Development

Research and Information Management

Professional Issues and Management of the Care Environment

Professional Development and Interpersonal Skills.

The arrangement of modules within the above themes provides the students with the continuity necessary for effective learning. The modules on ethics are found in the Professional Issues and Management of the Care Environment theme. The modules taught at pre-foundation and foundation level introduce the student to the legal framework and general ethical perspectives. The fundamental ethico-legal issues relevant to the professional contexts in which nursing occurs and in which care is delivered are also discussed. During the modules taught at advanced level, ethical, legal and organisational frameworks, which inform, empower and constrain professional practice, are examined.

The five modules that will be evaluated within the study are taught within the Common Foundation Programme and the respective Branch programmes. (see Appendix 1). The first of these modules introduces the student to the ethical and legal principles that guide the development of accountable professional practice in health care. It lays the foundations for student development of the awareness of ethical and legal issues as components of health care practice. The syllabus covers ethical duties, moral goodness, beneficence, non-maleficence and moral consequentialism. The student is assessed by a written

response to a series of sentence completion tests. The second module enables the student to develop an understanding of the ethical principles of justice and rights. The syllabus covers justice as fairness and equality, rights theory, truth-telling, consent, confidentiality and offences against the person. The assessment takes the form of a seminar presentation on a selected clinical situation. The third module aims to extend the students' understanding of a moral and legal duty of care and the role that they play in the delivery of care. The syllabus includes ethical decision-making in relation to paternalism and liberalism and the meaning of a moral duty of care. This is assessed by an oral presentation of a negotiated ethical issue. The fourth module aims to help students understand their contribution as a member of the health care team and their role in managing change. The syllabus includes leadership roles, power and authority in professional practice and change management. The student is required to complete an essay discussing an element of care that demonstrates how the ward leader enabled change to be managed. The last module focuses on the legal relationship that exists between nurses, patients, employers and the UKCC. The syllabus includes the concept and domains of formal accountability, professional accountability, the impact of the UKCC document 'The Scope of Practice' and employee responsibility. The students are required to give a presentation on a chosen topic discussing aspects of formal accountability and show how legal liability was dealt with. The theoretical part of the Project 2000 programme is delivered at the Wentworth campus. Clinical practice takes place in both hospital and community placements within the surrounding districts.

As early as 1983 Johnson stated:

> It has recently become clear that more and more nurses recognise that they have a professional and personal obligation to get involved in ethical decision-making within their work role (p.58)

It is clear from this statement that the need for the teaching of ethics within the health care professions has been recognised for some time. This has been underlined by the Pond Report (Boyd, 1987) recommending training in ethics for the medical profession, by Project 2000 (UKCC, 1986) and the Joint Institute of Medical Ethics and RCN study (Gallagher et al, 1991), which focused primarily on the nursing profession. Gallagher and Boyd conducted a survey, which demonstrated that 98 per cent of those employed in nurse education in the United Kingdom agreed that ethics should be taught as a separate module to student nurses. The reasons the respondents gave for this opinion was professionalism, the need to understand one's own and others' value systems, reasoning skills and the humanitarian aspect of nursing.

There have been various codes written over the years from the time of Florence Nightingale by different professional bodies including The International Council of Nurses, The Royal College of Nursing and The United Kingdom Central Council. These codes provide a general framework of values and practices as well as accepted standards of conduct, and are important according to Jupe (1987) for several reasons. Firstly, nurses represent a range of professional roles and standards must apply to the profession as a whole. Secondly, patients represent a diverse group with their own beliefs, which may be in contrast to the views held by nurses. Thirdly, nurses are confronted with situations not normally experienced in life; and finally the codes provide the nurse with the framework to self-examine and realise their own beliefs and attitudes. However, these codes do not provide the answers to ethical dilemmas and nurses need guidance in coming to terms with these situations together with the knowledge to approach the situation and be able to make an independent, informed decision in the particular situation.

Hussey (1990) noted that although the study of ethics was generally included in many diplomas, degrees and other post-basic courses it was not common in pre-registration education. He commented on the fact that by the nature of the work undertaken by nurses they face far more difficult and demanding situations than most people face in everyday life. The needs of patients placed in extremely vulnerable positions, the possible conflicting opinions of colleagues, technology changing at an ever-increasing pace and a general lack of resources can be responsible for creating complex moral dilemmas. A recent government-funded report (Coombes, 2000) has brought to light a 'postcode lottery' in specialist nursing care for sick babies sent home from hospital to recover. A postcode lottery is the term used to describe the situation in which access to specific areas of health care is dependent upon where the individual lives as some services are provided in certain health districts but not in others. The report claims that parents of over 6,000 babies cared for in the home have to learn to master technically complex equipment such as ventilators, which may be sustaining their child's life. Caroline Glendinning (2000) who is one of the authors of the report commented:

> Some of the nurses felt that parents had been pushed too quickly into agreeing to taking the child home. Because of pressure to discharge, hospitals might sometimes build on parents' natural desire to have children at home (p.65)

These infants, that also included premature babies, often had more than one health problem, which necessitated interventions such as a tracheostomy or oxygen therapy. The inevitable stress that this places on parents is increased by the fact that the day-to-day care of these children by the primary care team is poorly organised due to resources being stretched too thinly. It is not long into his or her training that the student nurse is exposed to environments such

as these and can easily become involved in situations that he or she may not have the experience, power or influence to deal with.

The struggle to emancipate nursing and establish it as a recognised profession has been ongoing for many years (Rose et al, 1994). According to Sellman (1996) nurses have tended in the past to be seen as unthinking individuals who performed repetitive tasks at the request of doctors, and therefore it is necessary to educate an individual who can think analytically and argue rationally and logically. If nurses aspire to be professionals, this means that they are obliged to meet exacting standards. They are responsible for their actions, those they consciously take, and those they avoid. Campbell (1984) pointed out that novice nurses should not be exposed to these situations without clear guidance. The student nurse must be guided in the reflective process asking themselves fundamental questions such as: What does it mean for me to be a nurse? As a nurse what do my patients expect of me? How should I perform to uphold the nursing role and fulfil the professional status of nursing? These questions are an important stepping -stone towards a personal and professional assimilation of moral values. Education in ethics therefore, is an essential part of developing an autonomous practitioner, who is capable of constructive critical appraisal of dilemmas arising in practice. The complex environment in which nurses function sees them not only as providers of health care but as important players in the political and social arena.

This fact results in many decisions being taken at higher levels of management, which often involve moral value judgements. If nurses are going to represent their profession at this level then it is vital that they are able to argue effectively and understand the nature of the process of decision-making that has an underlying moral foundation.

When a nurse is practising on a day-to-day basis there is constant interaction with others, be they patients, relatives or other members of the multi-disciplinary team. This inevitably means, therefore, that there is always a moral dimension to that practice. There are moral decisions that have consequences for patients, affecting their rights and the quality of care they receive. These consequences however are not limited to the patients. Practitioners are also affected in that they will be asked to call into question their perceptions of what is right and wrong, just and unjust, beneficial or non-beneficial for the patient. There are some decisions that are taken in the health care forum, which can have implications for society in general. The withdrawal of treatment from patients that have been diagnosed as suffering from irreversible brain damage and are in a persistent vegetative state was highlighted in 1993 when Tony Bland, a victim of the Hillsborough disaster, was allowed to die by the withdrawal of his feeding tube. This decision led to a reappraisal of other patients who were in a similar state and relatives of these patients who were asking if a similar decision could be taken for their relative (Ford, 1993).

There are many reasons put forward to support the inclusion of ethics in the nursing curriculum. Scott (1995) outlines four such reasons. Firstly, Scott believes that the quality of the constant interaction of a practitioner with patients must have some moral relevance to the type of care the patient receives. Therefore it is necessary to furnish the nurse with the ability to reflect on the morality of their actions. Secondly, in the clinical situation patients who are ill and lack the appropriate knowledge about their condition are at the risk of an ill-prepared nurse failing to take into account the rights of the patient. The nurse needs preparation to appreciate the moral dimensions of their practice.

Thirdly, nurses will practise more effectively if they develop a moral imagination. Finally, if they are involved in decisions that have wider implications in society they must be aware of the potential of the decisions in which they are involved.

The necessity for nurses to have a sound understanding of ethical issues is greater now than at any other time in the history of the Health Service. The rapidly developing technology, the increased public awareness and expectations, and the limitations in resources increase the number of potential ethical dilemmas that can arise in practice. The current Secretary for Health and Social Services Mr. Milburn in a report entitled 'An Organisation with a Memory' (DOH, 2000) has called for a national database to be established to record any incidents that are reported either officially or anonymously. He is encouraging nurses to 'blow the whistle' if they are concerned about a colleague's conduct or have doubts about the systems in place to deal with the day-to-day running of the clinical environment. This move has come about due to the recent scandals including the GP who killed 15 patients (Bale, 1999) and the gynaecologist whose operations led to many women suffering severe side effects that virtually ruined their lives (Boseley, 1998). In the above-mentioned report The Health Secretary stated:

> The terrible thing about them, apart from the harm that was being done to patients, is that all too often the problem was well known. It was often gossiped about in the hospital but nobody did a thing about it. Now that isn't good enough (p. 23)

The new measures outlined in this report have their critics who see them as another layer of NHS bureaucracy. The ethical problems that can arise from acting in this way are many and varied. The issue of confidentiality when reporting an incident can be questioned. The report suggests that nurses will

initially report colleagues anonymously and then if the correct backup systems are in place decide that they wish to make an official complaint. The recommendations made in this report are based on similar systems that have been established in both the aviation and nuclear industries. However, to compare the National Health Service to the aviation and nuclear industries is not, in the researchers' view, a fair analogy as the services that are provided by these industries are very different from the services provided by the Health Service. Many recipients of health services are in a vulnerable position and are not always able to cope with difficult situations or make decisions that in the course of their daily lives would normally not cause a problem. Payne (2000) comments that the pressure group 'Public Concern at Work' suggest that the system could undermine local reporting of incidents and has doubts about the alternative of anonymous reporting on a national basis.

Articles, which appear in the Nursing Times sometimes, present ethical and professional dilemmas experienced by readers, and demonstrate the increasing importance of a nurse's ability to deal competently with ethical dilemmas arising in practice. A panel of experts often offer advice on the best way to respond. One such article outlined a case of suspected cruelty towards elderly patients reported by a staff nurse from information related to her by health care assistants working on the ward (Hayward et al, 2000). This type of article appearing in this journal whose main readership is student nurses perhaps suggests that the teaching of formal ethics within the nursing curriculum is essential so that nurses will be equipped to deal with situations such as these in a more competent manner and not have to rely on the advice provided by a panel of experts writing in the nursing press. It is vital that nurses feel that they have the theoretical knowledge underpinning moral decision-making that can continue to develop throughout their initial training and

beyond, so that they will be able to deal with situations at ward level, which encompass ethical issues and demand an understanding of the nature of moral decision-making.

The cultural discipline of nursing has its roots in a 'modern' society which saw the growth of science, rationality and reason after a period in which religion had been the dominant perspective. This was known as the period of Reason or Enlightenment that originated in seventeenth and eighteenth century Europe (Jones,1999), and it was a time of progression both scientifically and technologically. During this time it was believed that the methodology of science could lead the human sciences to an understanding of people and social issues. In the mid twentieth century a new perspective emerged, that of Postmodernism, which began due to a loss of faith with the modernistic dream (Dallas, 2000). It can be described as the belief that society is now based on the decline of absolute truths and the rise of relativism. Since World War Two and during the 1950's there has been a growth of relativism within sociology and other fields. It is based on the argument that there is no such thing as objective truth, everyone has different values, and ethics is just a matter of taste (Shawyer, 1999). It supports the view that all ethical judgements are relative to the individual or to the society in which they live. Moral philosophers who have developed this idea recognise the importance of the social environment in determining beliefs (Clark, 1999). The diversity of these environments has led to the conclusion that there are no universal standards of good or bad, right and wrong; in other words no agreed, objective absolute standards. Tarnas (1991) observes that some philosophers of science have taken up this idea of relativism maintaining that there is no such thing as an objective, historical knowledge of things and that the person who perceives any object is influenced by the societal context. An example of relativistic thinking can be found in the work of Foucault (1926-1984). He examined the history of

medicine and mental illness and the language surrounding them. He argued that the term mental illness arose due to circumstances. Buildings left vacant by lepers that were cured in Medieval Europe began to house people who displayed signs of 'possession'. These buildings became known as asylums; the caretakers became known as psychiatrists and the condition of the inmates known as mental illness. This being the case individual perceptions are open to a multitude of interpretations (Jencks, 1996). Advocates of a post-modern world believe in no certain, single truths. Every question is alleged to have an infinite number of answers, each one being as equally valid as the other. Macklin (1999), who argues against this rise of relativist thinking, makes the point that it is currently fashionable to avoid the language of rights, to reject the importance of individual autonomy and to focus instead on the importance of the community. However, it can be argued that health professionals champion individual autonomy and rights in the face of paternalistic practices (Rosenau, 1995). Macklin believes that ethical universal ideals do exist but they need to be compatible with numerous cultural interpretations.

Nursing continues to thrive and develop in this changing world and the researcher believes that the moral judgements made by nurses in the clinical situation, will be based on what are perceived to be absolute truths, but at the same time there will be a relative element to that decision based on consideration of the circumstances that exist at the time. In the light of this ever-changing lively philosophical debate outlined in the work of Macklin (1999) the nursing profession must be equipped with the skills to manage ethical decision–making competently.

This chapter has attempted to set the scene within which the research study has been conducted. It has also outlined the background and interest of the researcher in the subject. There is a discussion of the importance of the inclusion of ethics within the pre-registration curriculum in response to the

changing social and political environment, which has direct repercussions within the Health Service. The importance of the development of the concept of "agency" for the recognition of nursing as a profession has been investigated. It is argued that this concept can be developed fully only if the teaching of ethics begins when the student nurse commences training. The rise of post-modernism based on a relativistic theory of knowledge and the influence that this can have on the ethical decisions that nurses face has also been addressed.

The following are the aims of the research study:

- To analyse the opinions of student nurses concerning ethical issues that might arise in clinical practice prior to exposure to the hospital environment

- To examine the opinions of student nurses on ethical issues arising in practice following clinical placements

- To analyse the opinions of student nurses on the value of the ethics modules in helping them to deal with ethical problems in practical contexts

CHAPTER TWO

REVIEW OF THE LITERATURE

In order to conduct a literature review the topic under research will be divided into five major subject areas and each area will be reviewed in relation to the literary material that is relevant to the study. The literature review will also put the current study into context within the educational and nursing fields.

The five subject areas are as follows:

1. Professional Ethics

2. The nature of moral problems in clinical practice

3. The development of moral decision-making in nursing

4. Curricular approaches to teaching ethics in nursing

5. Self-determination and autonomy in nursing practice

These five subject areas will provide a framework for the analysis of the data that will be collected through questionnaire and interview.

Professional Ethics

The first subject area to be considered is the role of professional ethics within the workplace. Any professional role will be a reflection of the particular institution's expectations and the practices that take place within that organisation. Beauchamp and Childress (1994) argue that these roles encompass virtues as well as obligations. They will also bring with them various conventions, procedures and customs. These authors recognise that any body of professionals will have a history that sustains a tradition and

requires the individuals that are part of that body to develop certain virtues. They suggest that the standards of virtue may incorporate criteria of professional merit and distinction and if a person is in possession of these he or she will fulfill the standards required of that profession. Hunt (1997) sees a growing conflict between the traditional professional ethics of health care, the economic policies and what he calls 'neo-laissez-faire'. He describes the increasing development of 'whistle-blowing' due to the fact that professionals are unable to sustain appropriate standards in the face of dwindling resources and the commercialism of health care.

The practice of nursing must, by the very nature of its role, encompass social expectations as well as its own internal standards and ideals. Pellegrino (1985) categorically claims that the traditional virtues attached to the health care professional stems from health care relationships. The virtues that are necessary to fulfill the professional health care role are many and varied. It would be impossible to name them all but several will be mentioned here such as trustworthiness, compassion, benevolence, integrity, truthfulness and justice.

Possession of these traits will, it is hoped dispose individuals to act in accordance with the goals and expectations of the health care institution (Pelligrino, 1985). It is important to remember that individuals who exhibit a moral perspective in life, may well fare better in others' assessment of the praiseworthiness or blameworthiness of their actions. This is illustrated by Bosk (1979) who relates a story of medical error where two professionals commit the same error of judgement but the one who has a record of being conscientious is not subjected to moral blame in the same way as the other. Friedson (1986) commented that academics from the 1940's and 1950's emphasised certain characteristics that they believed were central to their

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profession. These were complex formal knowledge, skill and an ethical approach to their work. These particular characteristics tended to set professionals apart from other occupations and to enhance the reputations of the institutions in which they practised.

Koehn (1994) states that the concept of the professional is intrinsically normative and who qualifies for the label will vary according to the norms with which it is thought they should comply. He believes that it is essentially a dialectical term. Durkheim in a book republished in 1957 after his death has written comprehensively on the subject of professional ethics. He places them between family morals and civic morals. He comments on two aspects of the subject. Firstly, the general nature of professional ethics compared to other fields of ethics and secondly the conditions necessary for establishing professional ethics and their function within the working environment. Durkheim argues that what differentiates professional ethics from other branches of ethics is the way in which the public may regard them. If the moral order is infringed the public look on this with indulgence. Transgressions that are concerned with the practice of the profession may only mildly be censured. This feature of professional status is due to the fact that its practice is outside the common consciousness. Everyone does not perform the functions of the profession and therefore the majority of the general public is unable to have a sense of what these functions are or what they ought to be. Neither are they aware of the special relationship that should exist between the members of the profession applying these functions. It is only when the transgression is so grave as to have general repercussions that the public become alarmed.

Durkheim points out that there is a very important condition without which no professional ethics would exist. In any group there will be a moral order that will

only operate if the group protects it with a certain degree of authority. This system is made up of rules, which govern members of the group and compel them to act in a particular way, imposing limits on their actions and not allowing behaviour that will go beyond those limits. The greater the strength of the group structure the more numerous the moral rules that are appropriate to it and the greater their authority over the members of the group. If the group demonstrates a close coherence and the individuals are in frequent contact with one another with a rich exchange of ideas and emotions the opinions of the group will be similar in relation to moral behaviour. The better the organisation and stability of the group the better developed and more advanced in their operation will be the professional ethic of that group.

No professional activity can exist without its own ethics argues Thompson, (2000). Historically, within the health care field professional virtues were closely integrated with obligations and ideals in various codes. The Hippocratic oath is a prime example of this, commending such virtues as modesty, sobriety, patience, promptness and piety. Percival (1803) was the first to attempt to establish a definitive set of virtues in medicine. He stated that the patient's best medical interest should be the ideal goal of medicine and therefore the physician's traits of character ought to mirror this.

Beauchamp and Childress (1994) comment that the virtues of nurses similarly reflect the different models of the profession and its role responsibilities. The historical model of the nurse as the 'handmaiden' of the doctor was encouraged to develop the passive virtues of obedience and submission. Current models work towards the nurse developing active virtues, which will allow them to practise autonomously (Wade, 1999).

The role of an advocate, which is important to protect the interests of patients, will necessitate virtues including justice, persistence and courage.

Winslow et al (1991) pointed out that obedience to certain rules was demanded in the historical model, but attention to patients' rights and the preservation of the nurse's integrity are more important in the current models. However it is relevant here to point out that any virtuous act that is carried out requires the appropriate judgement. It is necessary to have an understanding of what is right and what is good.

Koehn (1994) reminds us that many attempts have been made to investigate exactly what is the moral relationship between professionals and the general public in whose midst they practise. It can generally be divided into three main categories. In the first category the professional who is entitled to act as an exclusive agent of the clients' welfare is governed by norms that are different from most others', in the second category the professional does not stand in any special moral relation to their clients but are bound by the same moral norms as everyone else in society. Finally, in the last category, the professional has moral obligations to their clients that are special but which have been established in accordance with the moral norms of a particular community and which bind each member of that community. Koehn cannot entirely concur with these categorisations of the professional role and with reference to the nursing profession the researcher must to some extent agree with her comments. She points out that the above descriptions are rather naïve in that they ignore a profession's own understanding of itself as having responsibilities to people other than their current clientele, people who may well qualify as potential clients.

The second category which includes those professionals that do not stand in any special moral relation to their clients ignores the special relationship that develops between the professional and their client. It is both mutually and morally centred in the promotion of a particular good. The professional chooses his or her career path and is motivated to do so because they feel they will derive a degree of satisfaction from the act of doing good. (Friedson, 1986) The philosopher Goldman (1980) stated that:

> Professional morality is like ordinary morality, it must consist in
> honouring the rights of all rational autonomous persons (p.146)

If everyone, as an autonomous individual, has the right to know in order to plan their lives then the patient's moral right to know a prognosis must be honoured as well as the moral right not to hear an unpleasant diagnosis. This category also forgets that certain goods such as health, justice and beneficence must be at the moral centre of the professions.

The third category recognises the importance of professional loyalty to the client and, according to Camenisch (1983), professionals are under a special obligation to help clients because they have made promises to do so and the public have accepted those promises. Therefore professional roles are sanctioned by the morality of that particular community in which the professionals exist. The public has granted the professional a monopoly of practice and they have been given an infrastructure in which to practise to earn a living. Koehn (1994) highlights the fact that all may not accept the promises that professionals make. All parties affected because someone may be harmed by the fulfilment of that promise, may well not have accepted a promise of confidentiality. Neither does it give clear guidance; the answers to difficult dilemmas seem to depend on the public's current moral consensus. The professional is unable to bring any special moral expertise to a situation and

must bow to the values and norms of the community. This must then bring into question the legitimacy of the professional role.

> If we can show that there is a professional ethic that affords a ground for sometimes opposing a particular community's moral consensus, while at the same time being an action-guiding extension of genuinely moral public norms or values, the main problems would be avoided. A pledge-based ethic provides such a ground.   (Koehn, 1994 p.153)

Encompassed in the notion of the pledge-based ethic is the notion that the professional will act morally and this will give them authority if they abide by the conditions of the pledge that has been publicly made. The pledge will outline the terms necessary for the professional to meet in order to be worthy of the clients' trust. This trust then becomes a moral trust. Larson (1977) believed that the promises made as part of a professional pledge committed the individual to furthering an end that was good and to pursuing this good in accordance with publicly known limits that were understood and acceptable to reasonable men and women. If professionals are able to fulfil their pledge then it may be possible to avoid problems arising when they are put in a position where the interests of one client are in conflict with those of another.

In the health care environment the professional is dealing with clients, each one unique, with their own particular histories, who will often act in an unpredictable fashion. A professional working in this environment will pledge to adopt a client-centred approach but cannot guarantee a certain outcome. As early as 1880 Ryan stated:

Duty, not success, is the law of the professions (p.78)

This leads into the second area of analysis of the literature, that of the nature of moral problems in clinical practice.

The Nature of Moral Problems in Clinical Practice

The study of the ethical health care problems created by rapid technological advances is known as bioethics, and McAlpine (1997) believes that originally, health care professionals shared a common objective - the provision of ethically sensitive health care by morally accountable practitioners. Currently she feels bioethics can be viewed as a battlefield. In her article 'Critical reflections about Professional Ethical Stances: Have we lost sight of the Major Objectives?' she focuses on three professions - nursing, psychology and philosophy. She feels the dichotomous views within psychology and philosophy have strongly influenced ethical thought within nursing. Holm (1997) points out that medical ethics or bioethics as it has become known is a relatively new subject which has developed rapidly since the 1960's due to several scandals that occurred in clinical practice, most notably the establishment of the 'God Committee' in Seattle which chose candidates for dialysis based on the notion of social worth. It is agreed that ethical dilemmas are a recurrent feature in nursing practice and can often be attributed to the rapid advances in science and technology, which will be addressed later in this chapter. Holt et al (1999) note that ethical dilemmas in clinical practice are often complex and require careful consideration and identification of the underlying issues before any judgement can be made. It is interesting to note that the following comment formed part of an editorial appearing in the Lancet in 1997:

> The ethics industry needs to be rooted in clinical practice and not in armchair philosophy. Departments of ethics that are divorced from the medical profession, wallowing in theory and speculation are quaintly redundant (p. 9082)

This is an interesting view which the researcher feels is justified to a certain extent albeit, a little harsh. However it does illustrate an important point that ethical problems must not be divorced from practice and the essence of these problems is that they arise from situations that can only be found in this unique environment. In other words the practitioners who are faced with these problems must have the skills to be able to unravel the complex issues that will inevitably surround each individual case within the environment in which it is occurring. It is only in this way that the consequences of any decision can be evaluated taking into account all the potential effects of that decision on everyone concerned.

It would be ideal if every encounter between a health care professional and a client demonstrated the values of trustworthiness, compassion, respect and honesty together with a commitment to pursue shared goals. If this were the case communication would be morally unproblematic. However, at times there may be disagreement about values, or choices may be faced which challenge beliefs and strongly held values. These situations cause ethical problems in practice. There will be ethical features in every clinical encounter and occasionally problems will arise.

Jonsen et al (1998) make the point that clinical situations are often complex because they involve a wide range of medical judgements, many different circumstances and numerous values. They feel that it is necessary to provide clinicians with a simple way to sort out facts and values in each case in a way that will facilitate discussion and provide a resolution to the problem. In order to do this the authors suggest that each clinical situation which involves an ethical problem should be analysed by division into four areas - medical indications, patient preferences, quality of life and contextual features such as the social,

economic, legal and administrative influences. The above areas serve to organise the varying facts of the case and the topics call attention to the moral principles appropriate to the particular case. They also provide a systematic way to identify, analyse and resolve the ethical problems arising in practice.

If we bear the above ideas in mind we can focus on how they may work in practice. Looking at the medical indications it is necessary to consider the history and prognosis of the patient's condition and how acute the problem may be. What are the goals of treatment, the probability of success and what will happen if the course of treatment fails? In summary how can the patient be benefited by medical and nursing care and how can non-maleficence be guaranteed. The area of patient preferences highlights issues such as patient information with regard to the benefits and risks together with an understanding of these in order that the patient can make an informed consent. With reference to informed consent the competency of the patient must be taken into account and if this cannot be guaranteed a choice of the most appropriate person to act as an advocate must be considered. Finally, the expression of prior preferences in the form of an advance directive, which outlines the patient's wishes if they are unable to express them personally, should be taken into account. In summary, the following crucial question must be addressed - is the patients' right to choose being respected as much as is possible within the limits of the organisation? Issues important under the heading of quality of life must include the prospects of a normal life after treatment, prejudice which may affect the evaluation of the patients' quality of life, deficits that the patient can experience as an effect of treatment and a life that the patient feels, is no longer desirable to them. Under the final contextual area it is important to consider family issues that will influence treatment decisions and religious beliefs that can strongly influence the treatment options, which can be

undertaken. In addition, situations, which may justify a breach of confidentiality, problems with the allocation of resources and any conflict that may occur between the provider of care and the institution, are other important issues.

Moral dilemmas in clinical practice occur in two forms according to Beauchamp et al (1994). The first contains some evidence that a particular action is morally right and some evidence that the same action is morally wrong, but the evidence on both sides is inconclusive. Abortion is an example of this type of dilemma because the rights of the foetus to life and the right of the mother to control what happens to her own body are in direct conflict with each other. The second form of dilemma occurs when a person believes, that on moral grounds he or she both ought and ought not perform the action. In this type of situation the person involved is obligated by certain moral norms to act in a particular way but at the same time due to other moral norms, is also obliged to act in the opposite way. Therefore in the circumstances the person may be precluded from doing either. Neither set of reasons is dominant and taking either course of action may lead to the person doing something that is morally unacceptable. The cessation of life-saving treatment in the case of the patient who is in a persistent vegetative state (PVS) is an example of this kind of dilemma. On the one hand the patient does not appear to have any quality of life with no awareness of the world around them; but on the other hand taking life intentionally is not acceptable either, particularly when the patient is maintaining their vital functions of breathing and circulation.

It is clear that the nature of moral problems in clinical practice is extremely complex and therefore cannot follow any clearly defined plan to manage the ethical dilemmas that will inevitably arise. The nurse, as we have already mentioned, is one of those at the forefront of the professional-patient

relationship and therefore it is important to examine the nature and development of his or her moral reasoning and decision-making in clinical practice.

The Development of Moral Decision-Making in Nursing

The ethical decision-making of health care professionals cannot conceivably occur in a vacuum. It is almost inevitably influenced by societal attitudes, by the social environment in which the individual lives and the organisation of the health care institution in which the professional works. In 1973 Frankena argued that moral reasoning is philosophical thinking about morality, moral problems and moral judgements. This implies that for any judgement the application of reason, intellect and logic must occur. Several early studies including Munhall (1980) and Frisch (1987) have shown that student nurses are unable to reason at what Kohlberg (1976) [who introduced a cognitive theory of moral development] called the post-conventional level of moral development. This means that they are not able to differentiate themselves from expectations, rules and norms and therefore, be able to define moral values independently. At this point it is necessary to describe the process of moral reasoning and ethical decision-making. Rest (1979) outlines at least four steps in the process from the identification of a moral problem to an appropriate ethical action. There is ability to make an interpretation of the situation in terms of what actions are possible and who might be affected; the ability to make a judgement about which course of action is morally right, the ability to give priority to moral values above personal values and the strength to follow through an intention to behave morally in the face of opposition. Blum (1994) identifies seven steps in the process, some of which overlap with those of Rest. He identifies the following - accurate recognition, identification of morally

significant features, questioning action and judging whether to take it, selecting the principle behind the decision and marrying this with the appropriate act before carrying it out. However, it is very important to remember what Blum points out, that correct identification of a moral problem does not guarantee correct moral action. The connection between reasoning and action has been discussed extensively by Audi (1989) in his book [*Practical Reasoning*] in which he talks about 'akratic failure'. This is the phenomenon of people not acting morally, even when they are aware of the morally correct action. However, even though we can say that there is no guarantee that correct moral reasoning leads to the correct action it is more than likely that individuals will choose the right action if it is the one that their deliberations lead them to. In the researchers experience within the health care field there is a professional obligation to follow individual intuition even if the results of that action may not always be seen to be morally right by everyone. Whilst the freedom does exist to act on one's intuition, organisational injunctions will protect the patient from any undue harm and if this occurs disciplinary action will ensue.

Numerous instruments have been used to measure ethical behaviour. With reference to ethical reasoning the three most frequently used were the Defining Issues Test (Rest, 1976), the Nursing Dilemma Test (Crisham, 1979), and the Moral Judgement Interview (Colby et al, 1983). The instrument most frequently used to measure ethical practice was the Judgement about Nursing Dilemmas (Ketafian, 1985). However more recently Duckett et al (1992) have shown that the above tests have produced inconsistent results and therefore feel that they cannot be relied upon to demonstrate nurses' ethical reasoning. According to De Casterle et al (1997) the results from studies, which have used the tools mentioned, have shown that nurses do experience difficulty in carrying out 'the ethical dimension of their function'. These findings concur with the earlier work

of Duckett et al (1992). A study that looked at nurses' abilities in this area using qualitative methods was undertaken by Omery (1985). She studied the ethical reasoning of ten nurses who worked in intensive care. In this study Omery identified two different kinds of moral reasoner, the 'accommodating' and the 'sovereign'. The accommodating group seemed to adapt or reconcile their moral judgments to conform to what they believed were the norms of the dominant group whereas the sovereign group based their judgments on their own moral principles, which they valued. Her study showed that these two different types of reasoners used certain principles. The sovereign group used care, advocacy, fairness, non-maleficence and autonomy. The accommodators used paternalism, reciprocity, avoidance and consensus. Omery also identified other external factors that influenced ethical reasoning; the three major ones being the situation, the nurse-doctor relationship and legal constraints.

Both Killen (1986) and Ketefian et al (1988) had highlighted the notion that nurses are required to make numerous ethical clinical judgments on a daily basis and therefore must be able to function at a higher level of moral reasoning.

Weber (1992) realised that, in order to make prudent decisions that were to affect not only the nursing profession but also society at large, nursing students need to be prepared to identify and analyse moral dilemmas. However a study by Corley and Selig in 1994 showed that nurses attached greater significance to the practical issues of time management and the acquisition of resources, than to ethical principles.

A study conducted by Wurzbach (1995) demonstrated the inadequacies nurses had in understanding and explaining an ethical dilemma as well as in the

implementation of the appropriate solution. When a decision that had been taken by a nurse was counteracted by various factors the nurse experienced special difficulties in putting decisions into practice. These factors included personal principles, institutional policy, doctor's orders and the support of staff or the patient's relatives. Nurses also appeared to have feelings of powerlessness and anxiety.

Another study conducted in the same year by Oddi et al (1995) pointed out that research findings suggested that nurses might lack awareness of their role in the ethical aspects of practice, often relying on intuition for resolving ethical conflicts. They were also more likely to suffer moral distress when subjected repeatedly to such conflicts. This general consensus demonstrated that an in-depth investigation into nurses' ethical decision-making was needed. However at that time there was only very limited research into this area.

In 1997 McAlpine et al piloted a new research instrument - The Ethical Reasoning Tool (ERT). It aimed to reveal unprompted ethical thinking about a practice dilemma rather than asking subjects to rank order existing lists of issues as the previously discussed tests did. This method said little about the individual's own thinking. The ERT was designed to categorise subject responses to an ethical case study into three professional response levels. The traditional response, which showed a low recognition of ethical issues involved, the traditional or reflective response, which showed recognition of some of the relevant issues, and the reflective response, which demonstrated critical thinking about ethical issues. Pierce (1997) also highlighted the fact that value judgements cannot be reduced to scientific or technical decisions. They must also involve individual character, a sense of integrity, personal

ideals and virtues. This can be demonstrated by the comment from a nurse working in an oncology unit:

> I don't know if it has to do with just background.... how I was raised.... the values that were instilled in me from my parents. I think probably that's it. I was brought up to respect other people. We are all human. We all have wills. We have desires. We have wishes; and, we, as individuals, will and desire and wish to be respected (p.484)

Pierce uses this comment as an example of the fact that a person is necessarily influenced by their self-view, values and worldviews. She points out that any model used to explain moral reasoning must take this into account. Therefore any model that represents this complex personal dynamic must consist of more than reasoning alone. The model proposed by Pierce (1997) is a two level model. The first level outlines the components of the health care provider's moral dynamic and show how these are related, while the second level shows how those components are put into operation in relation to the individual's perspectives. Pierce has described three different perspectives within her model demonstrated by practitioners who took part in her study. The science-dominant perspective practitioner who favours the use of scientific knowledge to solve dilemmas; the person-dominant perspective practitioner who, although believing science is important, is more strongly committed to a person as a human being; and finally, the science-person-equilibrated perspective practitioner who views science and the person as equally important in any decision that is taken. Pierce feels that all of these perspectives have potential faults from callous implementation to decisions made on a whim rather than fact, but provisionally she feels the third perspective is the most respectful of the person as well as bearing in mind the knowledge to be gained from medicine, technology and bioethics. However, the researcher has noticed that in the clinical environment practitioners from different disciplines display either the scientific outlook or the person-dominant outlook. The former is seen

primarily among doctors and the latter among nurses. In order for nurses to achieve equilibration [although the person perspective brought by nurses to a situation is important] Pierce states:

> The challenge for nurses and nursing is to articulate the data that they have about concrete, particularised, personalised needs, desires and goals in such a way that they receive equal stature. Recognising that science-dominant perspective physicians operate from a world of objective, proven data, the goal in presenting existential personalised data is to make that data worthy of consideration, based upon its accuracy, thoroughness and substantiation (Pierce, 1997 p.494)

The results from the study conducted by de Casterle et al (1997) in the same year shows that nursing students function at the conventional level which means that they are still guided mainly by their professional duties and have not succeeded in making personal ethical decisions based on their own principles and acting accordingly. De Casterle et al (1997) describe moral reasoning as the cognitive and developmental process of reasoning about ethical issues. Ethical practice they describe as the domain of nurses' ethical decisions and their implementation in nursing practice.

The researchers involved with the above study have come to certain conclusions as to how these findings will affect practice. The following is a quotation from their conclusions about the research.

> The influencing of students' ethical decisions by the situational context might lead to care situations that do not contribute to patients' welfare.
> (p. 25)

Holm (1997) conducted an empirical study into how healthcare professionals reason about ethical issues and how the organisation of health care influences clinical decisions with an ethical component. He conducted two interviews - the first consisting of general questions on ethical problems, the second consisting of case studies, which contained potential ethical problems, and for each case the respondents were asked several questions. The results showed that there were approximately six different ways in which a situation can be misconstrued

and not seen as an ethical problem. These included observer insensitivity, work pressure and a problem in which the non-ethical component overrides the ethical one. Holm (1997) believed that in order to gain a full understanding of the structure of ethical reasoning of health professionals it was necessary to appeal to a larger framework. He suggests the use of a framework designed by the British philosopher Ross in the 1930's. Ross thought that everyone has an irreducible number of different ethical duties, all of which are of a prima facie nature.

> Any possible act has many sides to it which are relevant to its rightness or wrongness...we are quite incapable of pronouncing straight off on its rightness or wrongness in the totality of these aspects; it is only by recognizing these different features one by one that we can approach the forming of a judgement on the totality of its nature; our first look reveals these features in isolation, one by one; they are what appears prima facie. And secondly, they are prima facie obligations...Prima facie obligation depends on some aspect of the act; obligation or disobligation attaches to it in virtue of the totality of its aspects. For a while an act may well be prima facie obligatory in respect of one character and prima facie forbidden in virtue of another, it becomes obligatory or forbidden only in virtue of the totality of its ethically relevant characteristics (p.123)

The health care professional has a number of prima facie duties, which are balanced against each other on consideration of an ethical problem. There can be no absolute duties and no higher level of morality than prima facie duties. In solving an ethical problem a decision is taken that one prima facie duty is overriding and that the conflicting duty is not seen as a real duty in this situation. However Holm found in the course of his study that this framework did not provide an adequate description of the health care professionals' ethical decision-making process for two reasons. Firstly, the respondents saw their reasoning as much more integrated and secondly they believed the duties that were overridden could not be automatically dismissed. Holm therefore had to search for another model to explain the findings from his study. He decided that a model whose central core was protective responsibility was able to

provide an adequate explanation of the ethical reasoning of health care professionals. This type of responsibility is linked to personal responsibility towards the vulnerable state of patients. Two figures summarise the ethical reasoning process Holm believed was displayed by the subjects of his study (see Appendix 2).

The first figure shows the interrelationship between the components of the ethical framework involved in the reasoning stages of the process. The second shows the whole process from perception of an ethical problem to implementation of a solution.

This model does resemble the model in Ajzen's theory of planned behaviour (1989). This theory explains behaviour as intentions influenced by control, social norms and attitudes. A study was conducted in 1991 by Randall and Gibson into the willingness of nurses to report other professionals who were delivering care that was substandard. They found that the above theory could explain 'a significant amount of the variation in the intent to report a colleague'.

Although a wealth of literature exists about nursing ethics, there is little about nurses' ethical practice. Kelly (1998) believed that the moral nature of nursing practice is inherent in the nurse-patient relationship. There is a professional expectation that nurses practise ethical conduct but studies such as Holly (1993) have shown that although nurses working within the hospital environment know what ethical conduct in practice is, they state that hierarchical pressures make it difficult to maintain ethical standards. Kelly (1998) conducted a follow-up study to describe, explain and interpret how newly-qualified nurses perceived their adaptation to hospital life and what they thought were the major influences on their moral values and ethical roles. Her

findings revealed that these nurses found it very difficult to preserve their moral integrity. This led to what she describes as moral distress caused by self-criticism and self-blame. The subjects of the study realised that they would never be able to deliver the level of care that they had envisaged and therefore felt that they would never become the kind of nurse they had aspired to. The findings from this study according to Kelly confirm that individual ethical standards are influenced by group norms. She feels this has serious implications for new, inexperienced nurses. If these nurses are intimidated by the actions of their peers, poor practice techniques may predominate. It is only in the last few years that that some empirical studies have been undertaken which involve both qualitative and quantitative approaches in their methodology (Blake, 1996, Davies et al, 1999, Holland, 1999).

Research is still continuing into moral reasoning and ethical decision-making in practice and a study reported in *Nursing Ethics* in the year 2000 analyses the types and frequencies of ethical dilemmas and the rationale of ethical decision--making in student nurses. It also evaluates their decision-making. The authors of this study, Han et al (2000), make very interesting points in their subsequent discussion. They state that student nurses have no right to participate in ethical decision-making in clinical settings, but believe they can consider the ethical dilemmas and try to analyse and evaluate these situations through their knowledge gained in the classroom where they can evaluate similar cases presented as case studies. They state:

In this way student nurses can learn how to be critical and reflective.
(p.120)

The authors of this paper believe that through the use of case analysis in the classroom nurses will learn to base their judgements on what they have learned in class. Their results showed that with regard to the moral reasoning

process the nurses primary concern was the welfare of the patients and they therefore felt that this showed that the nurses could analyse cases without exposure to patients.

I suggest that this is a rather limited viewpoint and it is preferable that student nurses are able to be involved in ethical situations with patients in order to understand the complexities of the situation, which cannot be appreciated solely in the classroom.

Curricular Approaches to Teaching Ethics to Nurses

Bearing the quotation made by Han et al (2000) on the previous page it seems appropriate to consider the teaching of ethics to student nurses and how this can equip them with the skills necessary to deal with ethical problems that arise in everyday practice. It is necessary to examine the numerous curricular approaches to the teaching of ethics and how, if at all, these have prepared students to cope with the real life situations they find when they enter the clinical environment. However, before we start to examine the current trends in teaching ethics it is necessary to consider firstly the rationale for teaching ethics to nurses. Hunt (1993) questioned this and he suggested that nurses already possess an intuitive understanding of:

> The need to treat people in their care decently...and have the responses of honesty, promise-keeping and respect for others (p.22)

If this were to be accepted then the teaching of ethics would appear to be unnecessary. Other authors such as Baier (1985) believed that teaching applied ethics left the student feeling inadequate and confused. Brock et al (1995) use a quotation from Aristotle to argue that not everyone is ready to discuss ethical issues or will profit from those discussions. They believe that because ethics is a reflective process and because it is fundamentally practical

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rather than theoretical those who have little or no experience will have little on which to reflect. The authors use the model of nursing development introduced by Benner (1984) and state that the nurse at the first stage of development, a stage which Benner refers to as the novice, is unlikely to benefit from ethical discussions because he or she would lack basic nursing experience and judgement. Whether these ideas are with or without foundation, it is important to address them.

When the Project 2000 curriculum was first written the document outlined how it aimed to develop a critical and questioning practitioner able to argue articulately for the benefit of patients. The inclusion of ethics in the curriculum was important in the production of a self-aware, reflective nurse. Hussey (1992) suggests that nursing students need some form of moral guidance in order to prepare them for the kind of ethical situations of which they were unlikely to have any previous experience.

Brock et al (1995) make an important point that educating nurses about ethics is far more complex, multi-dimensional and takes longer than education about the practical skills of nursing. There are a lot of factors to take into consideration, which include the nurse's ability to be able to view situations holistically, individual moral development and the differing institutional ethics.

Thompson et al (1989) point out that the existence of ethical codes for nurses demonstrate that ethics must be a crucial part of nursing practice. They outline certain goals such as the stimulation of moral imagination to enable students to recognise their own values and their moral point of view of life; the teacher's responsibility to encourage the student to differentiate between what appears right and what is in fact right and the recognition of ethical issues. The latter

includes the students' ability to identify the ethical dimensions of clinical practice and how ethical theory can be applied to a situation in order to make an ethical decision. It is also important to allow students to recognise the dimensions of a moral obligation together with the ability to analyse it. In order to achieve this discussion about the tolerance of ambiguity and disagreement is necessary in which the teacher's role is to enable students to respect others and disagree without personal attack.

Another factor to consider is where teaching of ethics should take place. Kendrick (1994) makes the point that practitioners have continued to see the teaching of ethics as belonging in academic institutions, which creates an abstract image of the subject. He sees the present situation placing ethics in the traditional gulf of the theory-practice gap where the researcher feels it still remains. He also feels that ethics cannot be addressed purely in lecture format as the issues can only be explored and applied in the practice setting. Tschudin (1993) argues that there is a very strong link between ethics and nursing. She says:

Ethics is not only at the heart of nursing; it is the heart of nursing (p.31)

Her belief was that concepts such as advocacy, truth telling, informed consent and empowerment if taught in the classroom, offer a student no real guidance on their application to practice. As nurse education completes its move into the university sector the problems that existed in relation to the theory-practice gap have been compounded. The geographical distances between the clinical areas and the academic sites, which the researcher has mentioned in the previous chapter and a much-increased workload, have made it very difficult to maintain close contact with the clinical environments. 'The harmony of didactic ethos of the ivory tower with the pragmatics of clinical reality' pleaded for by

Kendrick writing in the *Journal of Nursing Ethics* in his paper "Building Bridges: teaching ward-based ethics" (1994) still seems to evade the nurse education system.

There have been many different approaches to the teaching of ethics employed over the past few years and the researcher wishes to outline several of these. White et al (1987) found that nursing students experienced difficulties with the analysis of ethical dilemmas due to the ambiguity and uncertainty they see in these situations. The authors felt that nurses did not need a heightened sense of inadequacy in the face of ethical problems but would benefit from an enhanced ability to tolerate high levels of uncertainty as these problems are being analysed. They therefore recommended the development of games as an appropriate strategy for the teaching of ethics. The following two authors who have written about the theoretical use of games identify uncertainty as one of the essential features of games. Crancer et al (1980) and White et al (1987) believe that this element of uncertainty is a major characteristic of studying ethics and applying moral reasoning to the analysis of complex dilemmas. A game suggested is known as Helter Skelter. The object of this game is to help students to identify their initial assumptions in a selected situation and understand the rational conflicts, which emerge from a variety of rights claims. A post-game discussion would take place focusing on the following areas. This discussion aims to outline the value of rights, the adequacy of rights as a basis for justification of an ethical argument and what else may be used in their place.

In (1990) Quinn wrote a paper identifying the essential ethics content for the undergraduate nursing curriculum at the University of Miami. She referred to a large study that was conducted in 1980 by the Hastings Centre Institute of

Society, Ethics and the Life Sciences to assess ethics teaching in American higher education. The study identified goals for ethics teaching. She also outlined another report published in 1986 by the American Association of Colleges of Nursing defining the knowledge, practice and values for the education of the professional nurse. Quinn compared these two documents and found that several of the characteristics of the professional nurse closely resembled the goals outlined by the first report. The link between clinical ethics and the professional nurse she felt:

> ...provided a workable approach for identifying and integrating the necessary ethics content. (p.727)

At the time this paper was written the rationale and guidelines for developing the ethics element of a nursing curriculum were scarce. Quinn believed that through linking traditional ethics with the moral nature of the nursing professional a framework could be established for selecting appropriate curricular content.

By 1995 the inclusion of ethics was commonplace in nursing curricula in this country; however, as Allmark (1995) pointed out there were still doubts about what to teach and how to teach it. He suggested that this was due to uncertainties within nursing, ethics and education. Nurses wondered whether ethics was being taught to professionalize their occupation or because nursing is a profession and questioned whether there was such a thing as 'nursing ethics'. In ethics there were competing theories of moral development and ethical theory. In education there were differing views on theories of learning and models of curriculum planning. Bowman (1995) makes the following statement:

> In order to develop moral literacy, nursing students should be exposed both to traditional rules and justice-based ethics, and to a feminist care perspective (p.33)

She emphasises the importance of the validation of women's ways of knowing in order to put aside preconceived ideas about moral reasoning among women. She believes in a feminist view of morality, which is not the sole domain of women but can also include men who assume the caring role driven by a concern for human relationships. Bowman suggests the inclusion of story telling in the nursing curriculum, which will provide the student with the opportunity to relate ethical dilemmas they face in practice. Discussion around these stories can lead to questioning about practices, standards and ethical behaviour.

In 1996 both Guillett et al and Leavitt recommended interdisciplinary teaching of ethics as the best way forward for professionals working in the health care environment. A study undertaken by the former authors showed that few curricula had a multidisciplinary focus. Leavitt ventures a prediction, which he feels we will have to wait twenty years to either prove or disprove, that nurses will be among the most important people in bioethics. He sees that this situation is fitting because of the increasing scientific nature of medicine, the limitations of philosophical ethics in health care and the unique relationship the nurse has with patients. He makes the point that although some nurses will use the knowledge in their clinical practice others will go on to be teachers and researchers in bioethics. Therefore their training must be broad and interdisciplinary including such subjects as substantive philosophy, bioethics, religion, genetics and research skills.

Krawczyk (1997) conducted a study in Boston to determine the level of moral judgement of nurses enrolled on three different programmes, which differed significantly in ethical content. The results from that study showed that an

ethics course with group participation and a decision-making element was the most relevant approach to the facilitation of nurses' development of moral judgement. These results have led to ethics courses adopting more active learning strategies that involve students in the analysis of situations, as well as the analysis of their own thinking. Stone (1998) recommends that students should start to be introduced to ethical principles during their induction into university life as well as increasing their awareness of the effects of the environment on behaviour. She employs examples such as the consideration of how policies and the organisation of the school affect the moral environment on campus; and the way in which the principle of respect for persons is displayed when they interact with personnel within the university such as secretaries, canteen staff, library staff, and security staff. Stone also suggests that principles such as autonomy, paternalism, beneficence, non-maleficence and truth-telling can be demonstrated in situations such as course choices, drink and drug abuse among colleagues and plagiarism. This approach has as its basis the belief that students will learn from observation what is considered ethical behaviour in academic and clinical environments. It is the responsibility of the lecturers to make explicit the examples that are implicit in these environments in addition to what is taught in formal ethics courses.

Lipp (1998), conducting a study in Glamorgan into a combined approach for nursing ethics, used grounded theory to illuminate the methods student nurses used to make ethical decisions. She found that the subjects of her study used both care and justice to come to their decisions; this is known as the combined approach. The results of this study showed that no pattern could be detected between methods of education and ways of making ethical decisions. The data, when analysed, found that practice shaped the subjects' decisions and therefore theory should be taught before or alongside practice at the early

stages to enhance what Lipp calls: 'a knowledge-based practice-driven approach' (p.136).

Much has been written about the way that ethics should be taught, the best way for students to learn and the timing of that experience. Studies outlined above have found that it is better for the nursing student and the patients they look after for the nurse to be introduced to ethics at an early stage in their education. Some cast doubts on this type of thinking believing that the student lacks life experience. One study, which the writer came across suggested incorporating 'the caring ethic' into the school curriculum. (Noddings, 1984).

However ethics is taught and learnt within a nursing curriculum the important issue is that nurses are able to develop the skills necessary to achieve a 'sense of agency' outlined in Chapter One. Therefore the last section in this chapter is dedicated to a discussion about self-determination and autonomy in nursing students and professional nurse autonomy. The researcher understands the concept of 'self' as being able to recognise oneself as a person and to be able to see oneself from the outside. Respect for autonomy according to Edwards (1996) is defined as being able to respect the fact that an individual has the capacity to reason and make decisions, which will concern their own futures. Beauchamp et al (1994) point out that being autonomous is not the same as being respected as an autonomous agent. To respect an autonomous agent they agree is to acknowledge that person's right to hold views, to make choices and to take actions based on personal values and beliefs. This type of respect involves not only a respectful attitude but also respectful actions. It includes obligations to maintain the capacity for choice while trying to prevent conditions that might disrupt autonomous choice. Respect must involve enabling autonomous action by both attitude and action. Therefore to be an autonomous

agent means having the capacity for self-governance which includes the power to reason, the ability to understand and deliberate, and the freedom to make a decision independently.

Self- Determination and Autonomy in Nursing Practice

Professional autonomy, as classified in 1968 by Hall, is a structural or attitudinal attribute and it has formed the basis for many definitions since then. He described structural or work autonomy as the employee's freedom to make decisions based on the requirements of the job. Management dictates the responsibility and authority of the individual. Attitudinal autonomy he described as the belief the individual has that they are free to exercise judgement in decision-making. This he believes is the way that professionals feel and view their work. Hall defined professional nurse autonomy as the belief in the client at the centre of responsible decisions taken both independently and interdependently that reflect advocacy for the client. Schutzenhofer (1987) stated:

> Professional nurse autonomy is the practice of one's occupation in accordance with one's education, with members of that occupation governing, defining, and controlling their own activities in the absence of external controls (p.278)

If autonomy is one of the goals of the professional nurse, a consequence is arguably that of accountability. This acceptance of accountability may well lead to empowerment of self and others and may influence the nurse's ability to change the working environment. This will be reflected in increased job satisfaction, commitment to the profession and will increase the professionalisation of nursing. Wade (1999) attempts to analyse professional nurse autonomy. She makes the point that professional nurse autonomy is a

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complex, multidimensional concept that may be the result of personal beliefs, life experiences and socialisation. She believes that more research is necessary to clarify the concept and its value to nurse education and practice.

Together with autonomy, self-determination is an important feature in nursing care. In the context of health care, the concept of self-determination is defined as the individual's interest in making significant decisions about his or her life. Valmaki et al (1999) define self-determination in terms of those actions that have been found to constitute the basic elements of the practice of health care. These are making decisions, being asked permission, obtaining information, freedom to express opinions and the ability to choose.

Valmaki et al (1999) conducted a descriptive study in Finland to examine nursing students' perceptions of student self-determination in a health care institute. They wished to find out how important self-determination was to nursing students; to what extent nursing students were willing to exercise their self-determination and to what degree they exercised this. The results from this study showed that although the students felt that self-determination was very important to them, the students varied in their willingness to exercise it or indeed put it into practice.

The researcher would argue that there is a need for education to encourage and aim actively to develop both autonomy and self-determination in the student nurse. Wade (1999) sums this up in the following statement:

> A student-centred, process-orientated curricular design provides an environment for learning professional nurse autonomy. To support the development of professional nurse autonomy, the curriculum must emphasise knowledge development understanding and clinical decision-making (p.310)

At this point it seems appropriate to revisit the concept of 'agency' discussed in chapter one. The possession of an ultimate power of decision and action is necessary to be an 'agent' and the feelings of helplessness that nurses often complain of when faced with ethical problems destroy this sense of agency. The purpose of education is to counteract these feelings and empower nurses in clinical practice. As Tschudin (1998) points out:

> The reality is that ethics is about doing what we really believe is right; these days this often means courageously making a point, going against the flow, attacking wrongdoing. These are the sorts of situations where praise is absent (p.57)

Any curriculum that enhances the nurse's autonomy must emphasise understanding, encourage autonomous decision-making and facilitate a questioning practitioner.

CHAPTER THREE

METHODOLOGY

It is important for the researcher to be clear about the purpose and the role of research design. According to de Vaus (2001) social research needs a design or structure before it is possible for either data collection or analysis to commence. He states:

> The function of research design is to ensure that the evidence obtained enables us to answer the initial question as unambiguously as possible.
>
> (p.9)

The research design can be seen as different from the method of data collection. De Vaus (2001) has observed that research design has been confused with research method and the former has been treated as a type of data collection method rather than the basis for the structure of the inquiry. Even though, for example, case study has been associated with participant observation this is not necessary to satisfy the logic of the design structure. It is also important to remember that one of the major roles of research design is to lessen the chances of drawing incorrect inferences from the data (Becker, 1998). In 1993 Kellehear indicated the importance of clarifying research questions before developing the research design; without this the design would be compromised. There are two fundamental concepts to be taken into consideration when designing research, internal and external validity. Internal validity may be defined as the extent to which the research design allows unambiguous conclusions to be drawn from the results. Alternative explanations of the results must be kept to a minimum and although it has proved impossible to eliminate all ambiguities they can be reduced. External validity, the extent to which results can be generalised, can be difficult to

achieve using a small number of cases. However, Stake (2000) has argued that:

> Case studies may often be the preferred method of research because they may be epistemologically in harmony with the reader's experience and thus to that person a natural basis for generalisation.
>
> (p.19)

Focusing on the aims of the study the researcher has chosen to use a case study approach. Gomm et al (2000) point out that the most important aspects of this approach are the number of cases under investigation, the amount of detailed information that is collected from the participants and its contrast with the experimental approach. This contrast is the difference between the creation of cases in the experimental arena and the use of naturally-occurring cases in the social environment. The study is an evaluative case study setting out to explore part of an educational programme in order to focus on its value. Its purpose is to provide educationalists with information that will help them to judge the merit and worth of the programme. Although it draws on theoretical notions it is not intended to contribute to the development of theory and is therefore different from other kinds of educational case study. The study is what Parlett and Hamilton (1977) have described as illuminative. They placed this type of study in the interpretive paradigm rather than the positivist paradigm because:

> The aims of illuminative evaluation are to study the innovatory programme: how it operates; how it is influenced by the various school situations in which it is applied; what those directly concerned regard as its advantages and disadvantages; and how students' intellectual tasks and academic experiences are most affected. It aims to discover and document what it is like to be participating in the scheme, whether as teacher or pupil; and, in addition, to discern and discuss the innovation's most significant features, recurring concomitants and critical processes. In short, it seeks to address and illuminate a complex array of questions (p.10)

The subjects of this current study are students who have chosen to study nursing. The minimum age for entry to the Dip HE Nursing studies is

seventeen and a half but applications are invited from mature students. Within nursing it is recognised that the learning experience will be enhanced by the recruitment of students from culturally different backgrounds to ensure that the composition of the student cohort is representative of the range and variation in individual differences within the national population. [The university in which the researcher is employed operates in accordance with the spirit of equal opportunities legislation].

The qualifications necessary for entry to the above course of study are a minimum of five subjects at GCSE at C grade and above or the equivalent. Students can also gain entry by achieving a specified pass standard in an educational test approved by the United Kingdom Central Council for Nursing, Midwifery and Health visiting (UKCC) if they are twenty-one years of age or older. The students are selected by personal interview conducted by two members of the teaching staff. Candidates are required to show an awareness of general health care issues as well as some knowledge of the role of the nurse within their chosen branch.

The programme the students will be studying is delivered over three years and each academic year consists of three trimesters. This structure is not unusual on health-related vocational pathways but differs from other universities who choose to adopt the common bi-semester structure. The design of the pathway is organised around five themes, which have been outlined in the introductory chapter. The diploma pathway consists of two parts in accordance with the ENB (1996). These are the Common Foundation Programme (CFP) and the Branch Programmes. During the CFP that runs for 18 months, 12 modules are accredited at pre-foundation level and 9 modules are accredited at foundation level. The branch programme is also of 18 months duration and within the

various branches there is a focus on the distinctive features of each nursing specialism. Topics introduced during the CFP are built upon in the respective branch programmes demonstrating increasing depth and complexity as students progress. Within the Branch programme three modules are accredited at foundation level with a further 12 at advanced level. The pathway is practice- based and students must undertake a minimum of 2,300 hours clinical learning experience and 2,300 hours theoretical preparation. The students achieve this by attending theoretical modules, theoretical-practice modules and clinical learning experiences.

The ethics modules that will be evaluated in this study are included in the Professional Issues and Management of Care Theme. One is taught at pre-foundation level – The Introduction to Law and Ethics in Nursing Practice, the second and third are taught at foundation level - Justice and Rights in Nursing Practice, and Introduction to Management and Duty of Care. The fourth and fifth are taught at advanced level - Accountability and Responsibility in Nursing Practice, and Leadership in Nursing Practice. Of the students participating in this study some were following the Adult Branch, some the Child Branch, some the Mental Illness Branch and a smaller number the Mental Handicap Branch Programme after completing the Common Foundation Programme. All the modules outlined are compulsory for the nursing award and comprise 75 hours of learning - 24hrs of which are directly taught and 51 hours which consists of unsupervised study. The learning outcomes for all the modules are divided into knowledge and ability and students must achieve all outcomes successfully in order to pass the assessment and gain the credit. If students are referred in an assessment they have the opportunity to re-sit at an agreed date.

Nurses work in a dynamic environment and are expected to respond to a fluid context of care in an effective and efficient manner (Hendrick, 2000). This requires the individual to possess problem-solving skills, the ability to analyse situations critically, to manage time effectively and work as a valued member of a team. Bearing this in mind each module employs a variety of learning strategies including lecture, debate, tutorial, group work, discussion and reading. The modules have a variety of assessment strategies designed to test the learning outcomes, which include sentence completion tests, seminar presentations and essays. The ethics modules are taught by staff that work in the Department of Nursing. The lecturers that deliver the various modules have studied ethics either at degree or masters level and have a commitment to enabling students to recognise their own value systems and the development of their ability to take decisions with understanding of ethical principles. The teaching on the modules is shared between several lecturers each contributing in their area of special interest.

At this point I would like to discuss in more detail how the modules were facilitated and the methods used within the classroom environment to enable students to develop their knowledge and skills. The introductory module; Introduction to Law and Ethics in Nursing Practice, focused strongly on allowing the students to develop an awareness of their own ethical perspectives and how these views had been formed. In order to facilitate this, subsequent to a formal lecture introducing them to an aspect of ethics, the students were divided into small discussion groups numbering between eight and ten. Each of these groups was guided by a member of the teaching staff, of whom the researcher was one, who would encourage the students to talk about their own viewpoints in relation to a chosen topic and explore the differences that were evident within the group. Working in this way the students were able to voice their opinions and discuss issues at some length. At the end

of these sessions each of the individual groups would summarize their views to the larger group and discussion would continue with all members of the class.

In the second module, Justice and Rights in Nursing Practice, the students were introduced to members of the clinical staff who were invited to give lectures on the issue of patient rights. These lectures took the form of patient case studies. Each case was described to the students and several pertinent questions in relation to the case were raised. Students were then invited to divide into groups and each group focused on one of the questions that arose from the case study. Each group shared their response with the larger group. The invited lecturer would then inform the students of the outcome of the case study and student opinions would be invited. It was during this module that students were introduced to the DECIDE model used in ethical decision-making (see Appendix 3). This model is a refinement of the SPIRAL model proposed by Thompson et al (2000). This model takes into account the structure of all intentional acts originally proposed by Aristotle (384-322 BC) – the causes, namely the background conditions, the means or agents responsible for the implementation of the decision and the ends which are the goals and intended outcomes. This model suggested an alternative way to classify types of theory based on the above structure. Under "causes" were placed the deontological theories that form the foundation for duties and rights; under "means" were placed the pragmatic theories which included for example, virtue ethics; and under "ends" the teleological theories which included the utilitarian approach. When nurses are faced with a situation where a decision must be taken then a proper assessment of the conditions of the situation are necessary followed by an informed plan taking into account available resources and realising in advance what the likely outcome will be. Thompson et al (2000) believe the use of this model will enable students to make sense of the different moral theories because they draw attention to different parts of the decision-

making process. In order to apply ethics in the practical situation students must learn how to reason morally, be able to identify ethical issues and make decisions when faced with a moral dilemma. There have been many models advanced for ethical decision-making that have been refined over the decades since the time of Plato and Aristotle. Each of these will have advantages and disadvantages but any model must do justice to the complex nature of moral decisions, as well as providing a framework that will serve to allow improvement of performance after evaluation. Students were encouraged to use this model when discussing the case studies and use it when making decisions about the ethical situations under discussion. This model continued to be used throughout the remaining ethics modules.

The teaching strategies used in the Introduction to Management and Duty of Care Module were influenced by the students' exposure to prolonged clinical practice in the previous semester. Students were invited to use their clinical experiences to discuss how ethical principles can be utilised to inform and influence decisions made about patients in different care environments. Small group sessions, which included a selection of clinical staff, were used to encourage the students to explore their responses to the ethical dilemmas, which they may have encountered in practice. The introduction of role-play using a video camera allowed the students the opportunity to take the part of the different individuals who were involved in ethical dilemmas, which had been discussed within the groups. This method gave students the opportunity to reflect on their reactions as captured on camera and enable them to become aware of how a situation such as this will affect the different individuals involved. Students were also encouraged to reflect on whether they felt that their own value systems had influenced or changed since their exposure to the clinical environment. Students had been asked to keep a journal in which to record instances where they felt an ethical component of practice had arisen.

During this module and subsequent modules students were encouraged to talk about entries in their journals and highlight the issues that they felt were important. This exercise was either conducted in the classroom environment or during their individual tutorials with their personal tutor.

The final two modules, which the students undertook, continued with the small discussion groups facilitated by lecturers and clinical staff, the completion of their reflective journals and formal lectures. However, students were introduced to debate during these modules and, as part of this exercise, students were selected to form two teams either to defend or reject an ethical position. After formal debate had taken place the remaining students were allowed to vote for the team they felt presented the best case and feedback to the teams the points they felt influenced their decision. The researcher believes that the greater the variety of teaching methods used the more freedom the student will have to respond to the teaching input on an individual basis.

As mentioned earlier in the chapter, this study is an example of an evaluative case study approach. It is now necessary to discuss in more detail the case study approach as a whole. In 1980 Simons stated that:

> Case study has antecedents in the disciplines of sociology, anthropology, history and psychology and the professions of law and medicine, each of which developed procedures for establishing the validity of case study for their respective purposes. But the use of case study in education has been comparatively recent; its specific relevance to education has not been explored to the same degree (p.1)

Educational research and the associated evaluative processes and methods have become known as the case study approach. In 1975 a conference was held in Cambridge entitled 'Methods of Case Study in Educational Research and Evaluation'. This conference aimed to outline the principles, procedures and methods of case study research in education but this, according to several

participants did not happen as clarification of the theoretical assumptions underlying case study and evaluation had not occurred.

Many writers have offered descriptions of the case study approach. MacDonald and Walker (1975) wrote a paper which was presented at the above conference in which they stated:

Case study is the examination of an instance in action (p.1)

Five years later Cohen and Mannion published the first of many editions of their book entitled *Research Methods in Education.* In the third edition published in 1989 the authors make the following observation.

The case study researcher typically observes the characteristics of an individual unit.... The purpose of such observation is to probe deeply and to analyse intensively the multifarious phenomena that constitute the life cycle of the unit with a view to establishing generalisations about the wider population to which that unit belong (p.124-5)

Robert Yin is a leading exponent in the area of case study design and he has written extensively on the subject. He regards case study as an enquiry that takes place in a real-life context as opposed to an experiment or survey, which to a certain extent takes place within a contrived context. He is a strong believer that case study must be an empirical enquiry that investigates a contemporary phenomenon in its real life context where the boundaries between the above are not clearly evident.

Stake (1995) has also been heavily involved with the practice of case study research but unlike Yin, who favours the experimental approach, Stake is a supporter of the interpretive paradigm. He used the following description of a case study:

The study of the particularity and complexity of a single case, coming to understand its activity within important circumstances (p.11)

It is evident from the above that the term case study can have a variety of meanings but, even though different writers have put forward their own interpretations of the term, it can be seen that the case study, much like other research strategies, is a recognised way of investigating an empirical topic using a set of specified procedures.

At this point it is necessary to look at the different types of case study that have been described by various writers. As far back as 1980 Stenhouse identified four types of case study: the ethnographic, evaluative, educational and action research study. The last three he saw as being concerned with educational principles in action. The second of these, the evaluative study has been mentioned earlier in this chapter as the method chosen by the researcher in relation to the study undertaken. This type of approach either comprises a single study or a collection of studies investigated in depth to provide data that can be used to judge the merit of an educational programme. Bond (1996) supports this by agreeing that evaluation must provide that information which is relevant for decision-makers in order to enable them to set priorities, guide the allocation of resources and allow the modification and refinement of structures and processes. As far back as 1987 Herman et al identified seven models of evaluation; however Cormack (1996) points out that only three main categories of purpose guide the researcher to choose the evaluative approach. These are needs assessment, formative evaluation and summative evaluation. The study undertaken by the researcher is of the formative type. It provides information, which will improve the current running, or future developments of an evolving service. It aims to understand how well an intervention is achieving its objectives so that remedial action can be taken if necessary. The second type is the educational study where the researcher is concerned with the understanding of educational action. He or she wishes to generate educational

theory or to refine existing theory through a systematic and reflective review of the evidence available. An action research study on the other hand is concerned with adding to the development of the subjects under study by feedback of information, which can act as a guide to aid the revision, and refinement of the action.

In 1993 Yin reduced his analysis of the number of types of case study to three. The first of these he chose to call the exploratory case study, which aimed to define the research question or hypotheses together with an attempt to develop theory by direct observation of a social phenomenon. He viewed this in terms of the grounded theory approach first described by Glaser and Strauss (1967). The second was the explanatory study, which presented data outlining cause-effect relationships and the third was a descriptive study that attempted to explain a phenomenon within its individual context. As well as the three approaches mentioned above, Yin also viewed the case study as an evaluative tool intended to assess and explain the results of specific interventions.

Yin emphasised the technical characteristics of the case study approach pointing out that the study should still include quantitative data if this is applicable and be judged by the same criteria as other empirical research methods in relation to validity and reliability. He feels that the above characteristics suit the needs of the evaluative process. The reasons for this are as follows. Firstly, the aim of a case study is to conduct an investigation in a real-life context and this therefore satisfies the part of the evaluative process that monitors and assesses the intervention and the implementation. Secondly, the case study is not limited to either quantitative or qualitative data but is able to accommodate both kinds of data. Thirdly, according to Yin, the exploratory case study is used to develop new hypotheses and it can therefore

assess outcomes and test these hypotheses, which will satisfy the evaluative process. Yin has contrasted the case study method with other evaluation tools including ethnographic evaluations, grounded theory and quasi-experimental evaluations. He claims that in comparison with these other methods the case study is distinctive in its ability to do the following:

- Attend to programme operation and context

- Accommodate single cases with small numbers of cases

- Capture process and outcomes in order to provide feedback

- Adapt to the availability of different types of evidence

- Assess outcomes and test theories

- Allow generalisability to the major themes in the field

However, even with these distinctions, Yin points out that it can be used in combination with other methods.

In 1995 Stake [in his book 'The Art of Case Study Research] talks of an intrinsic case study that he saw as research being carried out into a particular situation for its own sake irrespective of outside concerns. He also distinguished an instrumental case study which he saw as research carried out into a certain situation in order to try to understand an outside concern. He sums up the instrumental case study as follows:

> We will have a research question, a puzzlement, a need for general understanding, and feel that we may get insight into the question by studying a particular case...This use of case study is to understand something else. Case study here is instrumental to accomplishing something other than understanding... (pp.3-4)

Stake also comments on the role of the case study researcher, which can include that of participant observer, interviewer, advocate and evaluator. He makes the point that all evaluation studies are case studies as the

phenomenon being evaluated is the case. However, not all case studies are evaluation studies but there must be interpretation by the researcher, which will be evaluative in nature. The role of the evaluator is to outline a set of interpretations by which the subject's strengths and weaknesses, its successes and failures will be apparent. The qualitative evaluator highlights the quality of activities and processes through narrative description and interpretation.

In the light of the literature regarding the importance of the case study approach it would be inappropriate not to pay attention to the criticisms offered by various writers. The use of the case study approach in ethics teaching has been addressed in a recent paper by Pattison et al (1999). They argue that the users of case studies are often unaware of the pitfalls that can occur when this method is employed. Among the problems they perceive are the biases and presuppositions which can arise from the author of the study, the case study's partial relationship with reality due to the creation of a narrative as the author attempts to streamline the facts and the issue that the case study may serve to highlight poor practice rather than give an example of exemplary practice. The use of the case study method has been criticised previously by Coope (1996) who identified three limitations of using this method in ethics teaching. Firstly, the continued use of case study may lead people to believe that controversial issues are the essence of morality. Secondly, morality may not be taken seriously enough and we may not be able to see what constitutes a moral problem. Finally, there is the potential for the promotion of unethical practice as illustrated by Coope's discussion of the responsible treatment of the insane. It is important that the researcher is aware of the potential problems that the use of case study might raise. In the researcher's experience it is very easy to concentrate on data that highlights the problems occurring at the macro level rather than the ones that occur in everyday practice. They often appear more

dramatic and hence more interesting. Although cases are drawn from reality and hopefully reflect that reality the researcher's interests, both political and professional, may lead to a distortion of that reality especially when sensitive subjects are addressed. It may sometimes be the situation that the case study becomes too real and begins to make sense in a way that ordinary life does not. This, as Pattison et al (1999) point out, will have grave implications for the study and the conclusions that may be drawn from the results.

> The author has the power to implant particular moral issues, to change the plot, to resolve the issues, and even, supremely, to draw the moral at the end of the tale. In this way, case studies can become prime examples of eisegesis in which the author injects and creates the issues, problems and principles that are then presented as being discovered (pp.44-45)

It is interesting to note that Higgs (1999) in reply to the paper written by Pattison et al discussed whether people are misled by the use of case studies as much as the latter authors would suggest. Higgs believes that readers of this material should be alert to the inevitable element of unreality and make allowances for it and correct it. He describes three types of case study, from a very stark style to a fictionalised style ending with a personalised style. Higgs · identifies the second type as fitting into the category proposed by Pattison et al. Whilst acknowledging the move towards open and personal debate as advocated by Pattison et al, Higgs argues in favour of the protection of a certain degree of fictionalisation in order that cases can be discussed. He is a firm believer that moral questions contained within a case study must be approached from every available direction, but the readers must also be prepared to constantly change distance with the material.

> On the one hand, we need to be able to stand back; in order to see the principles clearly. On the other, we need to be able to get closer; ... to feel the real heart of the dilemma.   (Higgs, 1999 p.50)

Bassey (1999) points out that, although case study is a distinctive form of empirical enquiry, several research investigators have little respect for the approach. It has certainly been seen as a less desirable form of enquiry than the experimental method or surveys. (Simons, 1996; Kosko, 1994).

It would appear that one of the concerns was the alleged lack of rigour. Yin (1994) has highlighted the fact that there have been many instances of case study investigators who have been guilty of an imprecise technique allowing equivocal evidence or biased views to influence the direction of the findings and thus the conclusions drawn. However he also points out that bias can also be present in experiments and other research strategies such as the design of questionnaires for use in surveys. The major difference is that these problems have been more frequently encountered in case study research.

Another major difficulty is that the case study provides little basis for scientific generalisation. Yin believes that case studies, like experiments, are generalisable to theoretical propositions and not to populations.

The length of time taken to conduct case studies has also raised negative comments, which may well have been true in the past in such studies as Feagin et al (1991), but this is not the only way that they can be conducted. The strategy is often confused with the collection methods in the field such as detailed observational evidence. High-quality case studies can be achieved without such unwieldy documentary material. (Simons, 1996).

Simons has addressed the paradox between the study of what she calls the singular, compared with the search for generalisation.

One of the advantages cited for case study research is its uniqueness, its capacity for understanding complexity in particular situations. A corresponding disadvantage often cited is the difficulty of generalizing from a single case.... Looked at differently ...there is no disjunction. What we have is a paradox, which if acknowledged and explored in depth, yields both unique and universal understanding. Paradox for me is the point of case study. Living with paradox is crucial to understanding (p.225)

A research design is the logic that provides the link between the data to be collected to the initial questions of the study according to Yin (1994). A research design must resemble an action plan helping the researcher to get from the initial question to the final conclusions. The design deals with the question under study, the nature of relevant data, the type of data to collect and the analysis of the data.

For case studies there are five components that are important - the study question, its propositions, the units of analysis, the link between the data and the propositions, and the criteria for interpreting the findings. The form of the research question will lead the researcher to choose the case study option. Bearing the above in mind in order to explain how the research study undertaken by the researcher was designed, it is necessary to re-examine the aims.

The case study strategy is appropriate for questions that are asking "how?" or "why?". The study wishes to determine how the students feel about ethical issues before entering clinical practice, and whether these opinions change on exposure to the clinical environment. It also wishes to establish how effective the students feel the ethics modules are in helping to prepare them to deal with ethical dilemmas in the clinical situation.

The researcher wished to conduct the research at the University in which she works as the modules that are the object of evaluation are taught within the Department of Nursing. These modules have been introduced into the curriculum recently and the students who are the subjects of the study are the first students within the University to undertake them. The timing of the modules throughout the Common Foundation Programme will now be outlined. The first two modules were scheduled in Trimesters two and three. The first during months four, five and six and the second during months five, six and seven. Both these modules occurred before the students undertook semester four during which the students spent three months in clinical practice. The next two modules were scheduled in semesters five and six during months thirteen to twenty. The final module took place in semester eight after the second clinical placement trimester. The programme aims to facilitate the development of practitioners who have a thorough theoretical grounding and appreciation of research. The students also need to be able to demonstrate understanding of the complex demands of professional accountability. The curriculum is dynamic, within a modular structure, enabling effective response to changing needs, to government initiatives and to research findings facilitated through ongoing evaluation and review. The modules have been introduced in response to a national initiative, which recognises that nurses face an ever-increasing number of ethical issues within the clinical area. (DoH, 1994).

The development of any new nursing curriculum, or the updating of a current curriculum, needs to be subject to the process of evaluation in order to monitor the effectiveness of the training programme and make the necessary alterations as the students' education progresses. In this way the programme can adapt in response to the students' experience of the learning process.

Yin (1994) states that case study can include quantitative as well as qualitative evidence and should aim to use a variety of evidence so that all sources can be reviewed and analysed together. This is in order that the case study's findings will be based on evidence that is a convergence of the collected information both quantitative and qualitative. The collection of the data for this study was achieved in two ways - the distribution of questionnaires and in-depth interviews with the chosen students. The main aim in designing a questionnaire is to communicate with the respondent. The use of questionnaires is designed to gather a broad spectrum of data either regarding facts about events, or beliefs, attitudes and opinions. In order to achieve this successfully the subjects must understand the questions and the structure must facilitate a response. Barker (1996) suggested that in order to achieve this aim three important factors must be taken into consideration: the language used, the frame of reference and the lack of an assumption by the researcher that the respondents possess a specific level of knowledge. Any questionnaire can have various levels of structure. The types of questions that are asked are an example of this structure. The questionnaire designed by the researcher employed both open-ended and closed questions, the former allowing the respondent to give a written response and the latter allowing the respondent to choose from a variety of different options, selected by the researcher.

The questionnaire needs to focus on the specific aspects of the subject's experience necessary to satisfy some or all of the study aims. As previously mentioned closed questions involve the respondent choosing from a range of possibilities. Most of these questions are dichotomous, others give more freedom allowing respondents to select from a menu of responses, which are factual. However there is the danger that these types of questions may lead to a forced response from the respondent, as they need to commit themselves to

agreeing to one of the options presented. It can often, in the researcher's experience, be disconcerting to the respondent, and data may be lost. If there are a number of options the respondent may be open to suggestion when they may not even be aware of it. Open-ended questions are structured to allow the respondent to provide an answer in their own words. They are able to supply the kind of information they feel is appropriate. These types of questions allow the researcher to assess what the person completing the questionnaire thinks and also what they know about the subject. It may be that the information generated could identify new areas of interest that had not been considered previously. Possible drawbacks to the open question are firstly, the amount of information a respondent may supply, which can make analysis difficult and secondly, the comparison of responses could cause problems if respondents interpret the questions differently.

The questionnaire (see Appendix 4) used in this study employed scales in order to measure the attitudes and constructs of the respondents. Agreement-disagreement scales were used where a choice of several options was available to the participant. Likert scales were also employed. Using these, attitudes can be more specifically measured in degrees of agreement or disagreement. There are equal numbers of positive and negative statements without including a 'don't know' response.

The major part of the questionnaire consists of a number of clinical ethical dilemmas. The situations outlined are drawn from the researcher's personal experience as a practising nurse for a number of years during which time she has been in situations within the clinical area which have given rise to moral dilemmas. These have caused her to question the decisions taken at the time with reference to the patient, their relatives and members of the multi-

disciplinary team. It is the researcher's experience in the field that has provided the foundation for the ethical dilemmas within the questionnaire. The researcher piloted the questionnaire with a group of student nurses before being used in the study. This was in order to highlight any possible problems that might arise. As a result of the pilot, changes were made to the questionnaire. These changes were primarily concerned with the correction of terms that were misinterpreted or not understood.

Permission for the student nurses to agree to participate in the research if they wished was sought from the Head of Nursing Studies after which the questionnaires were distributed to the participants by the researcher. Before this took place the researcher spoke to the four cohorts, consisting of two hundred and twenty students in total, to explain the purpose and the aims of the intended research. Each cohort was given the opportunity to ask any questions which they had regarding participation in the research and any terms used within the questionnaire of which they were unsure. It was at this stage that students were offered the opportunity to opt out of the research. The questionnaires were then distributed and the groups were informed where to return them on completion.

The questionnaires were distributed to the students during trimester one in week nine of the Common Foundation Programme. The students were asked to return the questionnaires before the commencement of trimester two in week thirteen of the course. The distribution and return of the questionnaires occurred before the students had been exposed to clinical practice on a full-time basis, which occurred in trimester four during weeks twenty-five to thirty-six, and before the commencement of the ethics modules in trimester two.

The response rate for the questionnaires was 98 percent. The high response rate was due to the fact that the researcher was in constant contact with the students and therefore able to have access to them and ensure that the questionnaires were returned. Although the response rate from the questionnaires was high it became evident when reading through them that some students had failed to respond to some of the ethical scenarios. This, the researcher supposed, was due to the respondent's lack of understanding of the scenario or the fact that the subject matter was difficult for the respondent to address for personal reasons.

The researcher informed the participants that through the mechanism of random sampling several of them would be approached during semester seven to take part in informal interviews to discuss their experiences of any moral issues that had arisen while they had been in clinical practice. The sample chosen needed to represent the population under study. Simple random sampling ensured that neither the researcher nor any extraneous factors could influence the selection process as each member of the population had an equal chance of being selected. Once a sampling frame had been defined the researcher made sure that all members of the population had been included. From this, the sample was chosen by allocating each member a number. Using a recognised method as outlined by Atkinson (1996) the sample was chosen. The students who were selected using this method were informed by letter together with instructions with reference to the arrangements for the forthcoming interviews. Thirty students were selected for interview.

The interview schedule (see Appendix 5) was structured so that the participants had the opportunity to talk at length about their experiences while on clinical placement in relation to ethical issues that arose.

The interviews took place while the students were undertaking semester seven. Semester seven was the second clinical placement semester and the

researcher conducted some of the interviews within the clinical area and some within the university. The collection of this data occurred while the students were exposed to the clinical environment, which the researcher felt would be an advantage as the students were more likely to recall events that had taken place recently within the environment in which they were working.

The use of both questionnaires and interviews is an example of triangulation. It is a method employed to ensure the validity of the data. The collection of two different forms of data from the same subjects can lead to the overall conclusions being stronger if the same sort of results are gained using more than one technique. Frequently triangulation involves the use of both quantitative and qualitative data. Carter (1996) suggests that the use of different approaches in a single study can provide a much richer and a deeper understanding of the subject under examination than could be achieved using a single method.

Yin (1994) makes the observation that the interview is among one of the most important sources of information in a case study. Case study interviews are frequently open-ended, which allow both matter-of-fact questions and the respondent's opinions about events and situations. The information from the interview is important evidence in a case study because the subject of the study relates to human affairs. In other words the data supplied is a reflection of the 'real situation' that the participant is experiencing. The collection of data from the interviews conducted by the researcher forms the basis for the discussion that follows in the final chapters of the study. The students who were selected to be included in the interviews were written to and asked to contact the researcher at the university where both the students studied and

the researcher worked, in order to arrange a mutually convenient time for both parties to meet and for the interview to take place.

An interview schedule was designed by the researcher, which provided a framework around which the interview was organised. The interview took the form of a semi-structured interview where the interviewer asked the students to elaborate on their response through the use of supplementary questions chosen by the researcher. These types of interview produce large amounts of data. However they do allow for expansion of replies unlike structured interviews and are better used where the researcher is seeking to understand the meaning of particular events. During the interview process the researcher found that students provided her with large amounts of data, some of which was not relevant to the study. It was often difficult to steer the students back to the question in hand and I really needed to be quite forceful at times in order to keep the conversation relevant. I did not wish to curtail the conversational flow of the respondents but, at the same time, I did not want the dialogue to become irrelevant. In order to avoid this situation arising I asked the respondents beforehand for the areas which they wished to focus on during the interview. I was then able to continue to direct the conversation to some extent in the required direction without curtailing the dialogue. Another problem that arose concerned the students who found it difficult to relate incidents that had occurred in practice either because they were not sure whether what they wished to say was ethically relevant or they felt that nothing had occurred which they believed fulfilled the criteria I was applying. In this situation I asked the student to discuss what had happened to them while in practice generally and whether any problems had arisen over any aspect of care, irrespective of whether they felt it was ethically relevant or not. Using this approach I found that the student would discuss a problem, and in that discussion, come to realise that there were ethical issues within that situation that could be

addressed. As previously mentioned thirty students were selected to be interviewed and some interviews were conducted within the researcher's work environment and others within the clinical environment. The first part of the interview between the student and the researcher focused on the nature of the ethical dilemmas, if any, that the student had encountered whilst in clinical practice and how they defined the situation they experienced as having moral worth. The second part of the interview focused on the students' opinions as to the usefulness of the ethics modules in preparing them to deal with the situations that had been previously discussed in the first part of the interview. The students were also asked to comment on whether they felt the ethics teaching helped prepare them for their role as qualified nurses.

The data was collected using a tape recording machine and the students were able to enter into discussion and the material was collected over a period of about three quarters of an hour.

> The advantage of recording for the researcher is that she can attend to the direction rather than the detail of the interview and then listen intently afterwards (Bassey, 1999 p.81)

The information contained on the tapes was transcribed. This process can take a long time because the tapes contain a large amount of redundant text due to the nature of the way the individual speaks, often repeating themselves and becoming side-tracked, and discussing topics not completely relevant to the subject of the interview. The tapes contained discussion of sensitive issues which at times the students had difficulty expressing or were unsure how to describe. In this way it was possible to gain an insight into the emotions displayed by the respondents and how the issues they were relating affected them. In transcribing the tapes the researcher found that it was often difficult to piece together the story the student was trying to relate due to the erratic

nature of the discourse. The tapes were played many times in order that a coherent story could emerge. At times students would have to interrupt their discourse because they had become upset over the issues they were discussing. I can look back now and I realise that the information the students were discussing did not affect me in the same way as it did them. I believe that a certain degree of withdrawal takes place with experience and I was not experiencing first hand the situations the students were relating.

The students were allowed to talk freely about their experiences with minimal intervention from the interviewer apart from prompting or supporting when necessary. Students differed in the amount of information that they volunteered and therefore the interviews lasted for varied periods of time. Sometimes it was necessary for the researcher to prompt the student to recall incidents that had occurred in the clinical environment as they sometimes found it difficult to identify situations that had an ethical content.

On commencement the interviewer set the agenda for the interview giving an explanation of the aims of the study and objectives for the interview covering such areas as how it was to be conducted, who would have access to the data and why the interviewee has been chosen to be interviewed. It was important to make the subject aware of the anonymity of the information provided. Finally, the student was allowed to ask any questions they may had about any part of the interview process before commencement. It was important to establish rapport with the student to allay anxiety, which may influence the student's ability to participate fully in the interview. Barker (1996) points out that the quality of the information generated from the interview process is dependent on the behaviour of the interviewer. Certain characteristics of behaviour will have an influence, however small.

It must be remembered that interviews are verbal reports and therefore will be subject to effects of bias, poor articulation and inaccurate recall. Yin (1994) therefore makes the important point that interview data should be corroborated with information from other sources.

Finally in this chapter it is necessary to consider the ethical issues. There are inevitably a range of ethical problems that present themselves to any individual who undertakes research. Concerns in relation to validity and reliability are always evident in all forms of research. The investigation must also be conducted in an ethical manner. There are professional codes, which bind the individual as well as the guidelines for the conduct of research generally. Hendrick (2000) draws our attention to the 1996 UKCC guidelines for professional practice, which identify several criteria that must be met in order for research to be safe and ethical. These are based around consent, confidentiality and not exposing the participants to undue risks. The 1998 Royal College of Nursing (RCN) guidelines are designed to:

> Ensure that research, from the planning and commissioning stage to the dissemination and utilisation of findings, is conducted in an ethically acceptable way, consistent with current statutory ethical guidelines. (p.11)

The RCN emphasises the main ethical principles underpinning research. The first and second of these are beneficence and non-maleficence. Participants should be protected from harm, be it physical or psychological, and all research will inevitably carry some risk of harm. When asking students to relate their experiences of ethical dilemmas encountered in practice there is always the risk that exposure to and involvement with emotionally-charged situations could lead to a degree of psychological distress. On the other hand, failure to carry

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out the research will contravene the principle of beneficence as students and staff in this instance will be denied the knowledge and understanding gained through the research. There is obviously conflict between these two principles and therefore the risks and potential benefits must be assessed before commencement of the study. The third principle is respect for autonomy and the right each individual has to be treated as a self-governing agent who is capable of making his or her own decisions. Procedures for consent have been designed to enable autonomous choice as well as protection for the research participants and instilling a sense of responsibility in the researchers' interactions with the subjects. This right of self-determination means that every person who agrees to be involved in the study does so as a participant rather than a subject, with the right to decide freely whether to become involved or not. As Beauchamp et al (1994) states:

> An informed consent is an autonomous authorisation by individuals of involvement in research (p.143)

This right automatically means that they can withdraw from the study at any time without the threat of coercion or reprisals. The freedom to choose automatically assumes that the individual is competent to act, receives a thorough disclosure, and comprehends what that disclosure means. It also assumes that the individual acts voluntarily and gives consent. It is necessary that adequate information be provided by the researcher for the participants to base their decisions. It is important also to pay attention to the subject of unintentional non-disclosure, which can occur when the data collection and its subsequent analysis grow in an unanticipated way. It may be necessary to review the issue of informed consent as the research progresses.

Autonomy also covers issues such as privacy in relation to confidentiality and anonymity. It is taken for granted that some measure of privacy will be

surrendered when others are allowed access to an individual's thoughts and feelings but in principle we should retain some control over the information generated. It is important to protect information disclosed to us as researchers. If this information fails to be protected or is disclosed deliberately to a third party without consent, there is a gross infringement of the individual's right of confidentiality. If, however, the information is accessed without the knowledge of either the research participant or the researcher, then the right of privacy is breached. It is therefore necessary for the researcher to make sure that the research data is protected adequately. The RCN guidelines mentioned earlier point out that individuals have the right to control access to information about them. The fourth principle, that of justice, is about fairness. According to Capron (1997) this means making sure that the risks and benefits of the research are fairly distributed so that no group is discriminated against or benefits overwhelmingly. Distributive justice refers to fair and appropriate distribution of rights and responsibilities, which can include freedom of speech. Bearing this in mind the data collected by the researcher of the study should reflect the participant's freedom to relate the information that they feel is important in answer to the questions asked. Even though the researcher may feel it necessary to direct the line of conversation towards the essence of the subject matter, the participants must be allowed to talk freely about the issues they feel are relevant to the topic under discussion. The researcher not only needs to select participants for reasons directly related to the study but must make sure that participants are treated fairly, during the research and after it has ended, by providing support and assistance, if necessary, as side effects may occur which the researcher has probably not considered. In the case of the study in question students could have been affected by the ethical dilemmas they experienced in clinical practice.

The ethical issues that are relevant in case study research with respect to validity and reliability are different from those encountered in experimental research. According to Bassey (1999) a case study is the study of a singular subject, which is chosen because of its interest to the researcher. It is not often chosen because it is a 'typical' example and therefore the issue of external validity has limited meaning. Several writers have outlined ethical problems that have arisen while conducting case study research. These are the issues that the researcher feels she should pay particular attention to in her own methodology. The issues raised cover such areas as the involvement of the researcher in the situation under study, the confidentiality of the data, access and control of the data, the need to preserve the anonymity of the participants when publishing the study and problems arising from the audience being unable to distinguish between the data and the interpretation of the data by the researcher. It is at this point that the researcher wishes to discuss her role both as a researcher and as a teacher. The researcher was involved with the teaching of the ethics modules that have been discussed earlier. In this capacity she was involved, not in the delivery of the formal lectures but as one of the facilitators of the discussion group sessions. When not functioning in this capacity I was an observer during the other taught elements of the module, although it was not possible to be present at every session. The relationship between the observer and the observed has been written about extensively (Barker, 1996,Cormack, 1996,Gomm, 2000). De Vaus (2001) observed that the presence of a researcher would inevitably alter the dynamics of the cases being observed especially when participant observation techniques are employed. As early as 1982 Gans described case study researchers as researcher participants:

> One who participates in a social situation but is personally only partially involved, so that he can function as a researcher (p.54)

The researcher joins the group and therefore will be seen as wearing two hats; that of the member of the group and the other as the researcher studying the activities of the group from the inside. If this is to be avoided the researcher can choose to disguise their identity but here the ethical concerns of deception and failure to obtain informed consent must be addressed, but adhering strictly to ethical guidelines can affect the internal validity of the study.

I had initially introduced myself to the students before I had distributed the questionnaires, which I have previously mentioned in the study. At this time I discussed with the students that I would be participating in their classroom sessions in ethics. In my position as a teacher in the classroom environment the students reacted to me in the way that they felt that they should, in other words the student-teacher relationship prevailed. At the same time the students were aware of the reason behind my presence in the classroom and some felt a little threatened by that which I learnt subsequently during the interviews. It was interesting to note that certain students wanted me to facilitate their particular discussion groups. I asked the students why this was and they told me that they felt I had a special interest in them and they wanted my involvement in their discussions. Bassey (1999) suggests that the researcher can establish rapport with the participants by becoming involved in their routines, perhaps establishing certain things in common with them by helping out and showing an interest in their activity. However there are difficulties with observation not least of which are the effects the researcher's presence has on the group. Ideally, the researcher is a neutral individual. In reality, this is rarely the case (Murray et al, 2000) and therefore it is important to be able to monitor the effects that occur, minimise them as much as possible, and take them into consideration when analysing the data. According to Gomm et al (2000) there are three reasons why the behaviour of the observed may alter. Firstly, those

observed may feel apprehensive about the observation, they may feel that they are being assessed in some way or they may regulate their behaviour from feedback obtained from the observer. The above authors also note that the relationship between observer and observed is an interdependent one and the researcher may be changed as a result of the interaction. Within the classroom environment I found that the students demonstrated a mixture of apprehension together with a certain degree of curiosity about my presence but this diminished as I became a familiar face. It was not uncommon for the students to ask whether I was there as an assessor of their behaviour in the classroom and I had to make it very clear that this was not the case and my main interest lay in understanding the structure and content of the modules. It is difficult to predict whether students were altering their behaviour due to feedback they were receiving from me but I was aware of this possibility and tried to ensure that I did not purposely lead the students in any particular direction.

I believe that, as a researcher, the experience of participant observation must have its effects and I was aware that this was the case. Therefore it is important to acknowledge this in the study. The researcher believes that it is impossible not to embark on such a project without preconceived ideas about the reaction of students to situations. I found that student reaction in the classroom was more open and the approach more mature than I had at first expected.

Merriam (1988) made the observation that the emerging design of a case study makes it difficult to assess such things as the potential harm to participants. She also points out that the relationship between the researcher and the participants will change with growing familiarity and experience with the case in question. Evaluative case study does not involve cause and effect. Other writers including Lincoln and Guba (1985) introduced the idea of trustworthiness in this type of research, which they believed equated to the

ethic of respect for truth. Some of the issues, which are raised in respect of this ethic, cover issues under headings related to the collection of raw data, the analysis of that data, interpretation of the discussion and reporting of the research. While engaging in the initial collection of data it is necessary to consider the amount of time taken to build up trust with the subjects of the study and at the time of interview it is important to remember to report back to the interviewees in order to check that it is an accurate record as sometimes the respondents realise that they have not said what they meant to say and therefore misrepresentation may occur. It is also important to not knowingly put the respondents under pressure, as they may feel that they do not wish to answer certain questions because they are embarrassed about the opinions that they hold or their lack of opinions on that particular issue. Hendrick (2000) draws our attention to the possibility that in-depth interviewing may have unanticipated long-term effects. In relation to this particular study there could be residual effects for the student who encounters a difficult moral dilemma in practice, which may conflict with his or her personal views. This can lead to the student feeling frustrated and angry. Alternatively, they may find it difficult to express opinions about the evaluation of the modules, which they feel could have detrimental effects on their continuing studies.

There can however be positive effects stemming from the interview. The student can achieve the realisation that the teaching input has given them more confidence to manage ethical situations in the clinical environment.

The analysis of the data may be prone to the biases inherent in the interpretation of the researcher. She is the person who, in constructing the report, will decide what is important and should receive greater attention. It could be that the researcher does not realise that some bias exists and some

data may be excluded because of this, especially when dealing with sensitive subjects. The following quotation, although written some 22 years ago, is still very relevant today:

> There is simply no ethical alternative to being as nonbiased, accurate, honest as is humanly possible in all phases of research..... Biases that cannot be controlled should be discussed in the written report. Where the data only partly support the predictions, the report should contain enough data to let the readers draw their own conclusions.
> (Brenner,1978 p.162)

Attention to triangulation of the data will ensure that there is genuine analysis of the collected data. Interpretation of the evaluative statement must be carefully and systematically tested against the statements deduced from the data. The reporting of the research must provide sufficient evidence for the reader to conclude that the conclusions drawn by the researcher are valid. As Bassey (1999) points out:

> If case study is to be of value it must convey a justification for its end point (p.76)

The dissemination of the report findings and the subsequent attention the case will receive must alert the reporter to the dangers to which the participants can be exposed. These include the violation of anonymity, subjection to unwelcome publicity and the exposure of opinions, which may attract institutional sanctions. In order to achieve the respect for persons in case study research it is necessary to obtain the consent and co-operation from the potential participants in providing data and also the extent to which that data can be used in constructing the report. Permission must be granted to conduct the research and arrangements should be made for what is called transferal of ownership of the record. This entails allowing the respondents the opportunity to read a draft version and amend it if they feel it does not reflect the truth before agreeing for it to be included in the report. The issue of anonymity must be addressed before the commencement of the data collection. However

disguising people or places is not always easy and people working within a large organisation such as a university are likely to recognise their peers and colleagues in research, although attempts have been made to disguise them. According to Stake (1995) the 'respect for the ethic of democracy' demands that publication of the research is essential, and therefore clarification of the guidelines for publication must be established before commencement of the study. This is necessary in case there is opposition from any party who may be unhappy with the results of the study.

In any piece of research validity, reliability and ethical concerns are paramount. Internal validity is addressed by the use of triangulation and monitoring the data given by the participants for interpretation. Reliability is assured by attention to describing accurately how the study was conducted in detail including how the findings were derived from the data and the background information and aims provided by the researcher prior to commencement of the study. The responsibility for producing a study in an ethical manner must ultimately lie with the researcher. It is sometimes very difficult to be absolutely certain that no coercion is used or that the findings will not be used against the subjects that took part. Therefore, finally it is important to point out that the best a researcher can do is to be aware of all of the issues that have been raised in this chapter in relation to potential ethical problems and be as vigilant as possible in the conduct of the study.

CHAPTER FOUR

REAL LIFE ETHICS

During the interview process the respondents engaged in discussion with the interviewer and from these discussions the data that was gained by the researcher was transcribed. The data is presented within four themes. The following chapters will explore these themes in depth in order to address the aims of the study. The data provided by the respondents during the interview process is an account of their personal experiences while in clinical practice and therefore the opinions they express do not necessarily reflect the opinions of nursing students generally.

I have chosen to address the aims of the study in the following way. In this chapter and the next the second aim of the study is addressed, the examination of student opinion on ethical issues arising in practice following clinical placements. I wished to discuss the data from the first part of the interviews undertaken with the students in order that I might then compare and contrast these opinions with the responses in the questionnaires that the students had completed before their exposure to the clinical environment. Therefore the first aim of the study to analyse student opinions about ethical issues prior to clinical exposure is addressed later in the text.

The third aim of the study to evaluate the ethical modules undertaken by the students is addressed in chapters six and seven. The data generated from the second part of the interviews is discussed in these chapters. The data included in these chapters is discussed in the light of the data provided by the students in response to the second aim of the study.

The first theme that will be explored is one that the researcher has chosen to call real life ethics. This theme examines the students' views on ethical problems that they encountered while in clinical practice. One recurring comment made by the respondents concerned the complexity of the ethical problems that they encountered. These situations, which at first seemed to be relatively straightforward were, on examination and consideration of all the relevant facts and viewpoints, extremely complex. This resulted in any solution being far more difficult to reach than was first imagined.

One student commented:

> *I thought that a decision to withdraw active treatment from a patient who was extremely ill would be really easy. Surely the Consultant in charge of the case would be able to instruct everyone involved to cease treatment, as he knew best. All the differing opinions from so many people made it an almost impossible task. The relatives were violently opposed to the cessation of treatment and therefore there was a stalemate situation or so it seemed to me.*

The statement above illustrates the issue of the complexity of ethical dilemmas. In discussion with the student she felt that the decision about ending the patient's life was prolonged and made more complicated because the individuals concerned were unable to reach agreement. I asked her what she meant by 'the Consultant knew best'. Her answer was interesting, quoting both his seniority and his experience. She felt that the patient was suffering unduly because no-one seemed to be taking control of the situation. When questioned about the role of the relatives she felt that they could not fully understand the consequences of the proposed course of action and were confused by the differing opinions. Her statement highlights the increasing phenomenon of human existence being strongly influenced by scientific and technical advances both in medicine and associated disciplines. Thompson et al (2000) argue that certain aspects of our lives remain constant using a well-known quotation from T.S Eliot's *Samson Agonistes*:

Birth, copulation and death. That's all the facts, when you come down to brass tacks.

I would disagree with this statement as it is becoming more common that a patient, who at one time would have certainly died, is now experiencing an extension of life through scientific intervention. Some patients may exist in a state of unawareness of the world around them for many years from which they are unlikely to recover. In these types of situations various parties will have an interest in trying to determine what is the best way forward for the individual concerned. It is bound to lead to conflicts of opinion, which are extremely difficult to resolve.

Complex ethical issues which are of common concern to health care professionals relate to the way that professionals exert power over the people in their care or how that control is shared between members of the multidisciplinary team including the relatives and friends of the individual concerned. There is no doubt that we are moving away from a position where the medical fraternity had total control over decisions made and towards the defence of the patients' rights.

The comment made by the respondent above demonstrates that this is in fact the case. She continued:

> *Surely, it would be much easier if there was less involvement from such a large number of people and then the patient would not wait for an even longer period of time before a decision could be taken. Should we be wasting such valuable time arguing over these decisions?*

This is an interesting viewpoint. Would less involvement of team members in this sort of decision be less problematical? The student felt that from the patient's point of view it would. It is, however, important to remember that

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employment in any large institution assumes the need to work with others as a team and therefore have an input into decision-making. In the case of the health service the teams will consist of people representing different disciplines that have day-to-day contact with clients and also staff who have specific responsibilities at various stages of the clients recovery. This adds to the strength of the team enabling it to function more effectively as long as each member of that team understands his or her role and responsibilities. However, the larger the team the more scope there is for non-cooperation, overlapping of roles, power struggles and differences of opinion. The complexity of ethical situations in an institutional setting has been thoroughly investigated by Emmett (1966) who recommended that we take note of the so-called "4 R's". These are the diversity of roles, rules, responsibilities and lines of reporting. She believes that the organisation and sharing of power with its attendant responsibilities means that we are unable to use simple models for ethical decision-making. Emmett believes that one member of the team must accept public responsibility which is the nature of institutional life. If there is a lack of clarity in relation to each team member's roles and responsibilities, then the result may be a lack of clear, quick decision-making in relation to ethical issues.

Thompson et al (2000) point out that each discipline has always undergone separate training and this may be one of the reasons why there are difficulties in team collaboration when involved in ethical dilemmas. The following comments serve to illustrate that the problems that have been discussed are currently causing concern in today's health service.

A student commented:

> When there is a meeting on the ward to discuss the patient's care no

one seems to agree about anything. There is sometimes confusion about the way forward.

I was involved in the care of a patient who was unable to make a decision for himself; the team members had different views as to who should take responsibility. Little communication took place except between staff from the same disciplines who complained about members of another discipline. I felt sorry for the patient who got no action - right or wrong.

For the student, the experience of attending this meeting allowed her to reflect on the conduct of the members of the team. In discussion she made the point that it was only when the team members from all disciplines met together that she was able to see the emerging differences in opinion between them. She also commented on the fact that most members of the team were female and questioned whether this would have an influence on the team dynamics.

Student:

Most of the team members were female. However, the Consultant and the Registrar were male. If this were not the case would it make a difference to the way the team functioned?

According to Bowden (1997) the issue of gender may have an important influence in the way that members of the team are viewed and this could lead to further complications in the conduct of interpersonal relations. The predominance of women in the caring professions is noted by Thompson et al (2000) who argue that although this is the case men still seem to occupy the senior positions in the organisations. Within a health care team, roles such as physiotherapy, occupational therapy, social work and counselling are predominately female. These stereotypical roles in the health care team will influence the way that power is shared or not.

The 'traditional sexual politics' in the health care services which Gilligan first mentioned in (1982) is well recognised by females working within a team and they are increasingly able to assert themselves and confront gender issues on a professional level. However, it is often the case, outlined by the student

above that this results in conflict within a team that leads to lack of decision-making and almost inevitably ineffective management of the patient.

The complexity of the ethics involved in a particular case leads to it being compared to previous typical cases in order that similarities can be uncovered, and lessons learnt from the manner in which issues were resolved. The knowledge that is gained from these cases may be used to develop guidelines that can help resolve new ethical dilemmas. This general approach based on the precedents set by other cases is known as casuistry. Thompson (2000) described casuistry as:

> An attempt to help us bridge the gulf between the universal and the particular, between moral absolutes and the relativities of everyday life, general moral rules and specific problems in concrete cases (p.98)

In order to be able to deal with all the various components of a moral dilemma it must be important to be able to recall previous decisions in similar circumstances and under what general rules those decisions fell.

One student related the following:

> *I did not believe that anybody should be refused treatment until they had fulfilled a criteria prescribed by the consultant. Surely this was a gross infringement of the patients' rights?*

Patient X had come to see the consultant needing a hip replacement. The consultant told patient X that she would be placed on the waiting list but needed to lose 3 stone before the operation could take place. Generally, a hip replacement operation performed on someone who is overweight will be problematic. Firstly, from an anaesthetic point of view and secondly, from the strain placed on the implant, which could shorten its life considerably. In the light of previous experience the consultant would be aware that it would be preferable for the patient to lose weight in order to prevent other problems in the future and ensure a greater chance of success for the operation. The

concern of the student in relation to the rights of the patient is understandable. Campbell et al (1999) suggest that the specific rights of patients will be dictated by the type of relationship that the patient has with his or her practitioner. When the patient enters into a contract with the doctor then responsibility is assumed by the health care professional, but in return the patient must agree to cooperate in the suggested treatment.

The student goes on:

> *I realised afterwards that the patient did not appreciate the risks she was exposing herself to and therefore she would not have been giving informed consent for the operation - yet another ethical consideration.*

Particular rights and duties exist where people are subject to rules or agreements with others. The patient in this case had a particular right, the right to health care but only if she agreed to abide by the rules governing the operation. The consultant had a particular duty to inform the patient of the risks to which she would be exposed, and to delay the operation if he felt that these risks were unacceptably high. Informed consent is a necessary part of the contract mentioned above. There is an obligation to give patients all the relevant information to enable them to make an informed choice as to whether they wish to continue with the treatment.

The medicalisation of life has led to the complex nature of ethical dilemmas. In 1977 Illich attempted to analyse the meaning of 'medicalization' of life. According to him the isolation of the family unit has led to an inability of ordinary people to deal with illness, injury and death within the community. This has had the effect of leading to a dependence on health professionals who now control life and its vital stages. Two of these vital stages are life and death and because of this they are now responsible for life and death decisions, which inevitably bring with them more and more complex ethical problems.

The British Medical Association (BMA 1999) has published guidelines on the moral principles that should underlie practice. These are as follows:

- treatment of patients should reflect the inherent dignity of every person, irrespective of age, debility, dependence, race, colour or creed

- actions must reflect the needs of the patient (taking into account such issues as the effect on the family, staff, the hospital and the community as well as resources)

- decisions taken must value the person and accept human mortality.

The primary goal of any medical treatment must be to benefit the patient and minimise harm. If this is not possible then active treatment can be ethically withheld and palliative symptom control become the priority. However, there are occasions when the prolongation of life can be harmful to the patient and it may not be in the patients' best interests to have their lives extended by medical intervention. As the BMA (1993) suggests:

> Treatments which might be regarded as intrusive ones, in circumstances where the patient's capacity to experience life and relate to others is severely impaired or non-existent (p.165)

The euthanasia controversy raises some very complex issues and embraces several different situations. The deliberate withholding of treatment from a patient is often termed passive euthanasia. On the other hand, the administration of a drug with the intention of killing a patient is termed active euthanasia. 'Assisted suicide' is the term used when a patient asks for assistance in terminating their own life. Finally, voluntary euthanasia is the situation when a patient desires no further treatment that may prolong their life. The students who completed the study questionnaire were asked to respond to a statement about the right of each individual to take their own life. Sixty-three percent of the respondents agreed that individuals should have that right. The

researcher conducted statistical analyses in relation to this statement, which can be found in Appendix 6 (Tests 1 and 2).

Is it fair to say that there is an ethical obligation to save life?

A student makes the following comment:

> *I was working on a ward where there was a patient who had been suffering from cancer for several years. He had undergone a lot of treatment some of which was very unpleasant with dreadful side effects he told me. I asked him why he was in hospital this time and he said the doctors wanted to try a new form of treatment on him to assess the effects although they could not say whether it would benefit him or not. His family was very keen for him to have it but he was not. He did not want any more medical interventions. He said he felt like a child who had to be looked after all the time and it was not living.*

The sanctity of life compared with the quality of life lies at the root of the euthanasia debate. The first of these stems from the Christian belief that all life, however humble, is worthy and therefore should be protected at all costs irrespective of its quality. The right to control what happens to our lives does not belong to the individual, it is argued, but to God. The quality of life argument emphasises that if a life exists without any quality for the individual concerned then they should have a choice as to whether they wish to continue in a way that they find unacceptable or terminate a life that appears to have no value. According to this there must be other factors, which should be taken into consideration when making the decision to prolong life. However it is not easy to decide what those factors are simply because they will be different for each individual.

The student continues:

> *When I asked the patient what he considered to be a satisfactory life; he said not this. He said he felt like a piece of meat that had things done to it. I asked what he missed, he said going for a pint, working, watching the racing, sex. He then laughed and said being a person. He could see his family just wanted him there physically but did not understand that it meant little to him.*
>
> *If I die they will recover eventually and look back with happy memories, if I continue like this it is living death for me.*

I did not know how to answer that.

Faced with this kind of scenario the student found it difficult to disagree with the patient. She said that she felt torn between her nursing role, that of trying to sustain life and her private feelings which were in support of the patient.

Student:

> *After hearing the patient say that, I felt a degree of obligation to help him achieve what he wanted. That's a risky course of action.*

The student realises that any action taken would incur great personal risk and could never be sufficient grounds for condoning any intervention. Hendrick (2000) points out that more emphasis should be placed on the important physical and social elements that go towards making someone's life worth living and assessing what it is that the patient themselves would like to happen to them, consideration of their hopes, wishes and desires. If this is to be the case then a lot more emphasis must be placed on weighing up the pros and cons of life-prolonging treatment, not just consideration of its physical effects.

The student continued:

> *When I talked to him on another day he said that he had refused treatment and that the doctors were trying to persuade him to continue. He said that he had told them he knew the consequences of refusal and was happy about that but wanted the inevitable to hurry up. He hoped that the doctors or the nurses could hasten things up.*

The acts and omissions doctrine refers to the distinction between killing and letting die. (Beauchamp et al, 1994). The doctrine maintains that any action that results in some undesirable consequence is morally worse than a failure to act. Therefore taking a positive action that will lead to death is worse than not intervening in the course of events that will ultimately lead to the same consequence. Pace (1996) argued that withdrawing treatment could be justified by saying that nature is being allowed to take its course and the patient is dying from the natural progression of their disease process, whereas giving the

patient an injection of a lethal dose of opiate is actively causing death. Whichever way death is achieved it may be argued that the intention to cause it is established in both situations, and therefore it would seem that there is moral culpability in both cases.

The student ends:

> I was not at work for a few days, when I went back the guy who I had been talking about was more cheerful and said that his daughter was expecting a baby and he was looking forward to becoming a grandfather. It appeared to me that his intention to die had either been put on hold or he had changed his mind.

When I asked the student how she felt about the patient's change of mind she said that she was relieved and happy that he now had a purpose in life. She also said how acutely aware she had become about allowing the patient time to reflect and not to act on a decision quickly.

> It is absolutely vital to examine each case thoroughly because I was astounded that a patient could have such a change of heart

Lebacqz (1999) believes that the support system for the patient can be lacking and the position of the patient must be examined thoroughly before any decision is reached. The decision that a patient may take about the quality of his or her life can alter in relation to what events take place to change their perception of the worthiness of their existence. This must add to the complexities surrounding the issue of euthanasia. Downie et al (1994) agree that a person's capacity to function at a physical, emotional and social level in order to derive a degree of satisfaction from it is fundamentally important. However, aspects of these that were once important to a person's life may change over time becoming less or more significant at different times in their life. These quality of life issues are therefore extremely subjective due to the fact that an individual may view the quality of their existence by many differing standards.

The issue of confidentiality is an area of health care that raises concerns for both the patient and the health care professionals looking after them. A student comments:

> I was present when a doctor was examining a patient and she was asking some very personal questions that the patient did not object to answering or if they did they didn't want to say. I thought at the time that there were not many people that knew that much about me – even my nearest and dearest.

In the researcher's experience the health professionals' knowledge of health care gives them power to give help where it is needed. However, it must also give them power over the people they are trying to help. The people who are willing to divulge such personal information make themselves vulnerable by doing so, thus allowing the health care professional to wield greater power over them.

The student continued:

> The patient I was talking about earlier asked me what would happen to the information that the doctor had taken. I made a remark to the effect that she did not trust the doctor. I joked about the well-known remark – trust me I'm a doctor! The patient replied that she found it hard to trust someone she had only just met.

In making this comment the student assumes that the patient is willing to put complete trust in the doctor. She did say that she did not expect the patient to enquire about the information that the doctor had acquired and therefore did not take the patient's comment seriously at first. Thompson et al (2000) make the important point that although patients are willing to disclose information to health care professionals they are aware of how vulnerable this can make them. They are also aware that the possession of this knowledge gives a degree of power over them. There are obviously legal safeguards against the misuse of patients' records and data to help prevent inappropriate disclosure. Brody (1997) argue that confidentiality was essential to the preservation of human dignity. The principle of confidentiality as outlined by many writers on

medical ethics states that information gained in a patient-professional relationship must be subject to secrecy even if its disclosure may serve the greater good. All health care professionals are expected to maintain this principle and patients on the whole take this for granted. In response to a statement in the questionnaire about confidentiality eighty two percent of the students who answered agreed that information that was given by patients in confidence should not be disclosed whatever the circumstances. However, in practice maintaining this principle is sometimes extremely difficult, as the following example will show.

Student:

> *The patient I had previously been talking to happened to mention the fact that she had not told the doctor something which she felt would be relevant to her condition. She said that she felt that the doctor would blame her for her present situation. I was not sure what I should do. If I said anything I would be breaking her trust in me.*

In this situation other considerations have arisen which leave the student nurse in a difficult position. She felt as if the patient had put her in the middle and what had been the patient's vulnerability was now hers.

> *I was in a dilemma, do I keep the patient's confidence or do I tell the doctor who has a right to know the truth if he is going to administer the correct care? If something went wrong I would be held to account.*

These considerations can lead to an obligation to disclose information without the patient's consent. The student was faced with the uncertainty of whether it was morally right to pass on information and the sense of guilt that she felt breaking a confidence. However, Gillon in 1985 outlined two conditions that were necessary for the creation of a moral duty of confidentiality. In the first of these the person must undertake, either implicitly or explicitly, not to disclose a confidence and secondly, the other person must disclose to the first person information that is secret.

The student added:

I thought about what I had been told for some time and eventually decided to tell the sister of the ward. I was not sure whether the patient would have told anyone else and the information may come to light anyway. As it happened the patient changed her mind and told the doctor later on that day. I wish she had done that earlier and I would not have had to agonise about it so much.

In this situation it is important to remember that confidentiality is a two-way process and the patient did not say that she wished the information to be kept confidential. However, the student felt as if the disclosure of it would be betraying the trust of the patient even though the information was important to the eventual decisions that were taken regarding the treatment options for the patient concerned. If patients withhold significant information, which they feel is sensitive, their care can be compromised, as accurate diagnoses may not be possible. The overriding duty of care and the best interests of the patient often complicates respect for the patient's intimate details. In this case it involved the carer passing on information to another professional in order that the patient was not compromised in any way. Carers do have a duty to ask patients if they may pass on information given to them, but this is not always possible and the carer faces a dilemma – the patient's right to privacy or the professional's duty to provide the best possible care which can only be provided if all relevant information is known.

The student concludes:

It left me in a strange situation because next time I could be told something far more significant that could have far-reaching effects for a lot of people. This would be really scary indeed.

This comment raises an extremely important issue that lies at the heart of confidentiality. In what circumstances is it justifiable to break a patient's confidence? Hendrick (2000) agrees that confidentiality cannot be an absolute principle and the decision as to when the nurse's professional duty of confidentiality can be overridden by other moral considerations is far more difficult in practice.

Another area that students felt demonstrated the complexity of the ethical dilemma was that of the nurse-patient relationship. This relationship according to Thompson (2000) is a complex power relationship with the patient usually assuming the weaker position. It may involve labelling of the patient in connection with various aspects of their illness, personality, appearance or behaviour. It is not a new phenomenon. In 1963 Becker proposed a theory of labelling arising from the sociology of deviance, involving our attitudes to people who possess traits that we find abnormal. Labelling within health care can have advantages for the patient in that they are able to adopt particular 'roles' that may be beneficial to them in relation to work and financial remuneration. If this labelling becomes more personalised in relation to patient behaviour it is often because the patient is deemed to make the carer's job more demanding and difficult. If a patient is described as 'awkward' this label may encompass a whole range of behaviours that are to be expected or in most cases feared from that individual.

A student made the following observation:

> Mr. X was due for admission that day. I was asked to accompany the qualified nurse who was conducting the admission interview. Before we met the patient nurse Y used a nickname for him and laughed saying that she knew exactly what to expect when we met the patient.

It is possible that this type of labelling may sometimes result in a stereotype. This can pose quite serious problems for the patient who can find that the attachment of such a label is at best not serving their best interests and at worst may compromise the quality of care the patient receives.

The student continues:

> On the way to meet Mr. X nurse Y told me a little bit about him and how he had behaved when he was last on the ward. He sounded like a patient who would be a nurse's worst nightmare and I could feel that when we met him he could see what I was thinking. It shouldn't affect your judgement but it does.

The student, in this situation was influenced by the account of the patient's behaviour he had been given before encountering the patient. I enquired what he meant by 'nurse's worst nightmare'. In his opinion this meant patients who were uncooperative, didn't wish to help themselves and were taking advantage of the system. Bond et al (1994) point out that labelling of the patient in this way may negatively affect the nurse-patient relationship and that if the patient is seen as making the nurse's job more difficult then the ability to muster support for this labelling from colleagues may strengthen the nurse's position. The student has found himself in this position.

> I knew I was prejudging the patient; I had a responsibility not to do that because the patient is not in-charge in this situation.

The student here is aware that the attachment of a label had occurred before he had met the patient. He assured me that it is not an uncommon situation in clinical practice but as far as he was concerned he was aware of the potential problems this behaviour caused, not least of which was disregard of the patient's rights. Patients can be labelled for a variety of reasons ranging from the patient who remains non-compliant with treatment regimes, to the patients who believe the nurse is only there to fulfil their particular needs. However justified a response is seen to be, even in the face of verbal abuse for example, the health professional is responsible for treating individuals as people whose rights must be respected, even if in exercising those rights, the patient oversteps the mark.

It may be difficult to treat everyone equally when situations arise that lead to a natural emotional reaction.

The following student comment illustrates this:

> I witnessed the admission of a woman who had caused an accident because she was over the limit. At the same time the occupants of the car she hit were also admitted and one of them was quite badly injured. I felt very angry towards the woman who had caused the accident and felt that she didn't deserve treatment.

In this situation the fact that the student felt antagonistic towards the first patient is completely understandable and judgmental labelling is often inevitable. Personal moral values are confronted and must be addressed. If not then the patient is likely to be compromised in some way and it may be impossible for the nurse to fulfil her duty of care in relation to this particular patient.

The attachment of labels to patients in clinical practice carries many dangers. The label may simply be applied when the individual appears not to conform to the norm and this has many ethical implications relating to fairness and non-discrimination and the right to the appropriate level of care and treatment.

The student continued to observe:

> *I wondered how I would react to seeing the woman who had caused the accident. Part of me knew that I would have to appear professional and ignore it all but when she asked how the occupants of the other car were I had to leave. Luckily there was a qualified nurse with me so I didn't have to face that situation.*

The inability that the student felt at being unable to face the situation she found herself in is entirely understandable. The basic right of every patient to be given adequate care and treatment is put to the test in this situation. Subsequent to this comment the student went on to explain that she found great difficulty coming to terms with the fact that the individual who had caused the accident should be treated in the same way as those who were the victims of her over indulgence. The protective, professional, duty of care is tested to the limit and at this time it was important that the student did face the situation and not evade it because she was in a junior position. She acknowledged that this was the case but felt that she had experienced the clash between personal emotion and professional duty.

> *That is a unique experience that I needed to feel. When it happens again I'm sure that I will be better prepared.*

The ability of nurses to balance the rights of the individual against the rights of other involved parties has been a commonly-mentioned area by the students interviewed. The nurse is most frequently involved with care on an individual basis and as such is responsible for the values of beneficence and respect for the person (Sidell 1997). However, in this role a nurse will also be familiar with responsibilities associated with caring for larger groups of patients. This can and does give rise to conflict because it is necessary to make a decision that has to take into consideration the interests of all concerned.

The following student comment shows this:

> *I was on a ward where a patient who was being nursed on the main ward became quite aggressive and began to threaten staff. This made the other patients upset and frightened. A decision was taken to remove the patient to a side room so he would be out of the way of the ward patients. This patient was suffering from depression and being in a room on his own could lead to a worsening of his condition as he would be isolated and could not be monitored as closely*

The student involved in this situation was concerned over what he saw as his divided responsibilities. On the one hand he felt responsibility towards the aggressive patient and the protection of his rights and on the other upholding the interests of the other patients on the ward. The dilemma facing the ward manager is whether to risk isolating a patient who may react negatively due the nature of his illness or risk traumatisng the other patients in the ward. The duty to care for the patient who has been removed to the side room and the duty of care to the other patients on the ward causes a conflict. In circumstances such as these it becomes very difficult to make what appears to be the responsible decision because either the rights of the acutely disturbed patient or the rights of the other patients may be infringed. The decision that is taken has to be the one that will be in the best interests of all. It is reasonable to conclude that it may not be possible to resolve these conflicts of rights unless other considerations are taken into account.

Student:

The ward manager I think had to take the decision because other patients were involved. The patient was monitored closely while in the side room in case his condition deteriorated even though he wanted to be on the main ward. This was only fair to all the other patients but it still wasn't fair to him.

The demands made by the principle of distributive justice meant that one patient had to suffer infringement of his rights in order to protect others. Although the student felt that this patient suffered the restriction of his rights he realised that his responsibilities were determined by not only an individual's rights and freedom but also by the consideration of the wider needs of that individual in relation to the community at large.

Nobody can be allowed total freedom. If patients are going to be managed properly it is necessary to use a degree of control. This, I think is good patient care

Further difficulties may arise when a personal viewpoint of what will be in the patient's best interests conflicts with the opinions of others. If an individual feels strongly about an issue and these views oppose trust policy the repercussions from this can be quite serious in relation to colleague and management support.

A student comments:

I have seen patients decide that they no longer want to be in hospital for one reason or another and have wanted to discharge themselves. If I were them I would not want someone trying to persuade me to stay. Some of the staff on the ward disagreed and said that health care professionals knew best and the patient should be persuaded to stay if possible. I was not popular and I got the impression it was my duty to do all I could to get them to stay. I still don't agree with it.

Although the student may have thought it unreasonable to persuade the patient to stay, hospital policy requires the individual to sign a form accepting personal responsibility. As part of this procedure it is pointed out to the patient the risks he is taking and the benefits of remaining under hospital care. The patient's rights would not have been compromised as he was free to leave after the form

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had been signed, but it could be argued that persuasion infringed his right of free choice to leave.

The student adds:

> *I can understand that the hospital must cover themselves legally but surely it must be easy to influence a patient by using the knowledge that health care professionals possess. A patient can be given the impression that they will really cause themselves great harm when this might not necessarily be the case.*

The student felt very strongly about this situation and in discussion with her she said that she thought that the staff had given the patient information which would create a sense of anxiety for the patient in order that he would change his mind and stay.

The student nurse raised the following question:

> *Is it in the patient's best interests to influence their behaviour in order that they comply with treatment? This can't be freedom of choice can it?*

The question posed by the student is an interesting one and one for which there are no easy answers. Clause One of the UKCC's Code of Conduct (1992) clearly states that beneficence is a major part of a nurse's professional duty and as Rumbold (1999) states:

> Beneficence is commonly seen as a moral injunction always to
> do good   (p.16)

If it is the duty of the nurse to promote well being then the ward staff would seem to be acting in the correct manner. However, in practice it is often difficult to decide what obligations this places on the nurse. What is going to be in the patient's best interests can be difficult to decide. According to Edwards (1996) words such as benefit and interests are subjective terms depending on an individual's assessment of the situation. The student here thinks differently to others on the ward.

> *I thought that it would harm the patient more if he were forced to stay in hospital when it was not what he wanted.*

The researcher finds some agreement with Henry (1996) who believes that non-maleficence is less morally demanding than beneficence because it does not demand positive action. Nevertheless it can still be problematic in the clinical situation because, as with beneficence, the term harm depends on an individual's assessment of the situation. In this situation the balance of benefits against potential harm is necessary to morally justify a course of action. The student realised that it was important to assess the risks the patient was exposing himself to if he chose to leave and decide on a course of action which would minimise harm and promote beneficence.

The student concludes:

> There is a balance between benefit and harm and this is important. Sometimes the patient can't see this until it is too late.

Another area highlighted by students which they felt was extremely complicated in nature was the issue of truth-telling to both patients and their relatives. The results from the questionnaire indicated that sixty eight percent of students agreed that a medical practitioner did have the right to withhold information from a patient in response to a request from a relative. The right of an individual to know comes from the principle of respect for persons (Beauchamp et al 1994). The individual with rights it is acknowledged, can exercise freedom of choice and therefore control what happens in their lives. In order to do this they need the knowledge and information to enable them to make the most advantageous life choices that they possibly can. This particular dilemma can most clearly be illustrated in the care and treatment of the terminally ill.

The following student comment shows this:

> It is unfair not to tell a patient that they are dying as soon as that fact is known. I nursed a patient who did not know their diagnosis although the relatives had been told previously. When the relatives came to see the patient they appeared very cheerful and were talking about what would happen next year. When the patient said he might not be here

next year they laughed it off and told him not to talk like that. I was sure he was trying to get them to tell him the truth.

The student had difficulty understanding why the relatives placed in this difficult situation wished to ignore the fact that the patient was dying. She said that she felt the patient was desperate for the truth so that he could face up to the inevitable. In the researcher's experience this kind of situation is not uncommon and generally it is evident that the patient is aware of their circumstances and just wishes some one to confirm the truth. As long ago as 1979 Hinton conducted a study, which showed that in clinical areas, where it was not the policy to inform patients that they were dying, over 75% were nevertheless aware that this was the case. Patients are able to gather information from a wide variety of sources. They talk with other patients, pick up snippets of information from members of staff, accurately read the non-verbal signs, which are displayed by a number of individuals who attend at the bedside and most importantly observe their own physical deterioration with no sign of improvement. The common myth is that if the patient is aware that they are dying they will be frightened and be unable to cope from that day forth. Parkes (1998) demonstrated that this was far from the case and patients displayed fear because they did not know the truth. Patients were reassured when they knew because the anxiety and fear that had been hanging over them was suddenly lifted. The quality of the life they had remaining was suddenly improved.

The student was present when the following situation occurred and she commented:

> *It turned out later on that week that the relatives had become very upset when they found out that the patient had been told his prognosis by the doctor. They demanded to know why this had happened. The doctor told them that the patient had asked directly and therefore he had told him. I was pleased that this had happened because the patient was*

more at ease. I also felt that if the patient was not told I would be partly responsible for that as I was looking after him.

The student felt relieved that the patient had asked about his prognosis even if this meant that the relatives had been upset by the situation. This student had been placed, she felt, in an awkward position feeling that she possessed knowledge, which should have first and foremost, been available to the patient. The student continued:

That knowledge should have been the patient's as soon as it was known because it is his life to control and organise as he sees fit.

Arguably if a person remains in a state of ignorance while those around him are in possession of the facts it deprives that person of power and therefore they become dependant on those around them. The duty of veracity demands that health care professionals should not lie or deceive patients. Fletcher et al (1995) point out that if direct questioning by the patient occurs it is morally indefensible to withhold information from that patient. The UKCC (1996) state:

Patients who want information are entitled to honest answers.
                                                                    Clause 24.

If patients do not want to know the truth then that right should be respected which is also supported by the UKCC guidelines.

If the truth is going to be told it brings with it responsibility to accept the consequences of the action. This can mean that the health care professional must be prepared for the reaction from the patient in whatever form that takes. This, in the researcher's experience, has ranged from expressions of anger, depression, and extreme anxiety to complete shock. Doyle (1994) makes the important observation that if a well-established support system is not in place it is very difficult for the nurse to provide what the patient needs at the time and in the light of this, truth telling becomes a cruel and irresponsible act. It is

necessary for the nurse to be able to tailor the truth in relation to the needs of the patient in order to prevent unnecessary alarm or complete panic.

The following situation described by a student illustrates a different problem, which can occur in relation to truth telling.

> *There was a patient on the ward who had been given the news that the cancer that he had was inoperable and therefore he was to be transferred to a different ward for some treatment to ease his symptoms He had told the nursing staff that he did not want his wife and daughter to be told his prognosis when they visited that evening and he was going to tell them that he was being transferred for some rehabilitation before he was discharged.*

It can be argued that relatives do not have the right to know but there is always an overriding feeling that they should be told because they occupy such a unique position in the patient's life and will be severely affected by the outcome. The nurse, faced with this situation, may also feel that this information should be shared. Discussion with the patient to make him more aware of the consequences of his actions and the feelings of those that are close to him may relieve the anxieties that the nurse may feel. If the patient is still insistent, as the patient in the above case was, that no information should be given to his relatives, then a decision one way or the other must be arrived at. It is a conflict of responsibilities between the interests of the patient and the interests of the family.

This student continues:

> *Several people spoke at length to the patient pointing out that his wife would eventually find out as his condition deteriorated. This could place a great strain on their relationship when they would not have too much time left together. The patient said that he had always protected his family from anything that was unpleasant as much as he could and could not bring himself to tell them this.*

The important point made by the student with regard to the patient's relationship with his wife suggests that when the truth is withheld for any

reason, the consequences of that action may have long-lasting effects that in this case could remain unresolved. This dilemma about telling the truth concerns the rights of patients and the duty of care of the health professionals. These include protecting the vulnerable from painful information, a beneficent action and being fair, which involves sharing information with individuals who will be directly affected, often seen as the appropriate action in relation to what is owed to someone.

Student:

> *After much discussion had taken place with the patient he finally agreed to tell his wife the truth. When he did it became apparent that he no longer carried the burden of the prognosis alone both he and his wife seemed a lot closer. She actually came to thank staff for persevering and getting him to change his mind.*

During the interview process it became apparent to the researcher how the students found that the ethical dilemmas that arose in practice were never quite as simple as they might first have appeared. It was obvious during the course of the interviews that students found the situations in which they became involved or which they observed, demanded a lot from members of the health care team. Although only a small number of examples are explored here, students discussed cases that demonstrated that ethical issues are not only relevant at the level of the nurse patient relationship but also at the team, institutional and public level. In the next chapter another theme will be explored. This concerns how particular ethical situations can have an effect on society in general and how those effects are likely to be manifested.

CHAPTER FIVE

ETHICS AND SOCIETY

The demands made on all members of the multi-disciplinary team by the nature of complex ethical dilemmas have been examined in the previous chapter. Students found that the many facets, which make up an ethical problem, contributed to the complexity of the moral problems they encountered. These included the reciprocal rights and duties of the health care professional, balancing the rights of one individual against another, issues concerned with conscience and those concerned with intuition.

In this chapter another theme will be explored in relation to student experiences within the clinical environment. During the course of interviewing it became evident that the ethical problems that the students were encountering led them to question whether the decisions taken in these particular situations had an influence on society in general and if so, in what way.

For example a student commented:

I was caring for a man who had smoked for many years and continued to do so even when he was in hospital. He said that he had tried to give up but not too seriously. The surgeon was reluctant to operate unless he promised to cut down considerably. I thought that if his surgery were performed then other patients would not be so inclined to give up either. What state would the health service be in then?

The student feels aggrieved that a patient should receive surgery whilst continuing to engage in an activity that has been proven to damage health. He

feels that a precedent should be set because otherwise the resources of the health service will be unable to cope. However, is the setting of such precedents ethically sound? The World Health Organisation formulated a policy document, which they entitled 'Health for All in the 21st Century' (WHO 1999). It was based on global health needs and epidemiological trends. It charged the countries involved to create strategies to achieve the objectives, which had been set out in the document. The main aims of these strategies were to create health care, which would provide comprehensive provision for all.

The Geneva Code of Medical Ethics adapted from the World Medical Association (1948) states that: 'The health of my patient will be my first consideration'.

It does not however address the problem of lack of facilities and other resources, which may impinge on the ability of the health care professional to provide that care adequately without imposing restrictions. The continuing advance of medicine will, without doubt, create a need, which may well not have existed before. As Powell (1966) wrote:

> Every advance in medical science creates new needs that did not exist until the means of meeting them came into existence, or at least into the realms of the possible (p.26)

Treatment in the light of a poor outcome raises the question of its ethical justification when this may be done at the expense of other patients whose outcomes may be higher.

Choosing between individuals must entail establishing criteria to justify the decision taken. It would be easy to say that if an individual is ill then they need treatment and the greater the need, the more justified the moral claim to

preferential treatment. However the distinction between needing and wanting can become blurred. No one would argue that life-saving interventions were necessary and that a person has a legitimate moral claim to the time and resources necessary to restore them to health. If, on the other hand, the primary aim of treatment is to improve somebody's appearance, failure of which will cause a degree of psychological trauma then what was primarily a want has been transformed into a fundamental human need.

According to Butler (1999) the difficulty of distinguishing needs from wants can be solved by dividing needs into those that are subjective and those that are objective. Subjective needs are defined as those the individual sees themselves as having and objective needs as those others perceive are necessary. The criteria used to decide who should be allowed access to limited health resources can cause many problems within the health care setting. Whose needs are of greater importance in a particular situation? Gillon (1985) outlined several possible criteria for justifying treatment. These were need, relative need, age, personal appeal, social esteem, lottery and personal merit. The case outlined by the student above focuses on the latter criterion, that of merit. Using personal merit to make a decision must rest on the assumption that the individual deserves advantageous treatment and it can be seen as a reward for their behaviour. If, however, they demonstrate what a health professional would regard as a negative behaviour trait the individual may find that they are disadvantaged because of this. This method of selection is arguably unjust but as our example shows is used to discriminate between individuals.

The above student reported that:

The patient needed surgery as a direct result of his smoking habit. The surgeon eventually refused to operate and the patient was sent to enroll in a smoke-stop clinic. If he stopped smoking then he could come back to be reassessed for the surgery to take place.

In discussion with him subsequent to this the student thought that enrolment in a clinic was an appropriate course of action. However, if patients' health problems are a direct result of their own reckless behaviour and therefore treatment is refused at that time, the patient appears to suffer twice. Once because their behaviour is causing them health problems and secondly because they have been refused treatment as the health problems are seen as their own fault.

The highly publicised case in 1993 of Harry Elphick (Wilkinson et al, 1993) who was denied treatment for heart disease and subsequently died following a further heart attack drew the public's attention to the fact that a hospital department appeared to be making a moral judgement to withhold treatment because a patient had brought the condition on himself. The health care professionals insisted that they were acting in the patient's best interests and to operate while he still smoked would be placing him at greater risk. This no doubt was the case but is it ethically allowable? Smoking is not the only self-induced health risk. Excessive alcohol consumption, over-eating, participation in dangerous sporting activities such as bungee jumping or parachuting and working to excess in a highly stressful situation, can all lead to potential health problems. This being the case, is it reasonable to exclude individuals who fall into these categories from the appropriate health care unless they alter their behaviour? Results from a scenario in the questionnaire about patient behaviour and their right to surgery proved interesting. Fifty two percent of students thought that a surgeon should not operate on a patient to replace his

liver until he had given up alcohol completely, even though the patient had made an attempt to cut down his consumption.

This perhaps raises the question of the obligations that each society has to its members in the sphere of health care. In 1995 a booklet on ethical guidance forbade the medical profession from refusing treatment to patients who indulged in unhealthy habits.

> A doctor cannot insert his own views of a patient's lifestyle and punish the patient by withholding treatment for, say, smoking. (Laurance, 1995).

The student concludes:

> As a non-smoker I feel that the patient should not be given his surgery straight away, not because I am passing judgement on his habit but if it is not successful then the money that has been spent could have been used to better effect elsewhere. The chances of success for a non-smoker would be higher and if it were my relative who didn't smoke I would object to them having to wait longer for their operation.

The reaction of the student in this way must raise the issue of how resources are spent within the health service and how any action can be justified ethically. Students were faced with a scenario in the questionnaire which asked them to decide between the policies of two health authorities, one that had chosen to invest in preventative measures in relation to smoking and the other which had chosen to continue to treat patients irrespective of their previous behaviour. The researcher wondered whether age would make a difference to the response of the students. Therefore a test of association was performed between age and the response to the question under consideration. The results and subsequent discussion are contained in Appendix 6 (Test 3).

Another area that students felt was an issue that would have serious repercussions within society was the QALY (Quality Adjusted Life Year). The

development of this tool aimed to measure life enhancing and extending aspects of treatment. (Singleton et al, 1995).

Certain medical treatments were assigned a QALY value, which corresponded, to the number of QALY's a patient could experience with treatment minus the number of QALY's without treatment. It was then possible to calculate the cost of each QALY gained. From this it can be seen that the treatments seen as beneficial, cost-effective and high priority will be those that generate the most QALY's at the lowest cost. Using this method it was possible to calculate standard life tables, which have been used for many years. This tool claimed to offer a utilitarian method of allocating health resources in the best way possible which was also morally defensible. This method tried to measure the expected quantity of life in relation to its quality. Quality can be defined in several different ways. In a practical sense it has been based on the work of Rosser et al (1978) who defined severity of illness in terms of the disability it caused and the associated distress to the patient. She devised an index of illness states that combined both disability and distress into a scale of health states from 0-1.0.

A student related the following:

> I looked after a young boy who had been trapped in a shed when it had caught fire. He was very badly burned and there was not much of his body that had escaped injury. His genitals had been destroyed and the medical opinion was that the boy's quality of life would be so poor and his level of disability so great that maybe it would be better not to actively treat him.

The student, faced with this kind of situation, is forced to question her beliefs in relation to the patient's percieved quality of life. Nord (1992) points out that a life confined to a wheelchair is considered by the QALY as less healthy and of less value than a life without disability. If patients survive their initial injury but are left with a permanent disability they are bound to suffer in any subsequent

evaluation of their QALY. The use of this tool imposes the subjective views of others on a life that is no longer taken into account and dismisses the value and uniqueness of that life to the individual.

The student continues:

> *I thought that it was very wrong to impose personal opinions onto a young boy who may well have a full and worthwhile existence. This was a decision taken quickly and I felt there was much more to discuss. Who are we to say that treatment will or will not be given in a particular situation. Are health care professionals there to do that? Could I be in that position one day? My life may not be considered worth fighting for.*

This is an interesting comment and raises some important issues regarding the role of the health care professional. The student questions decisions that health care professionals are forced to take in an unenviable situation. She also questions whether they should be taking these decisions at all. A challenge such as this must entail reflection on action and a clear explanation as to the reasons for acting in a particular way. In this situation choosing one course of action, a treatment option, suggests the exclusion of other options. The consequences of this decision may be irreversible and long lasting.

The student continues:

> *I felt a great sense of responsibility for this patient. He was the same age as my own son and I could not imagine how I would feel if some one was making a judgement on my child. I was in very unfamiliar territory.*

The student faces an unfamiliar situation and this causes a crisis in itself, causing her to feel that her confidence is undermined. A solution to this patient's problem is urgent and the acceptance of a degree of responsibility leads the student to justify her feelings in order that she can answer any criticisms that may occur after the event. Health care staff are committed to respecting the patient's autonomy and acting in such a manner so as to

prevent harm and promote good. The use of this tool will inevitably create friction when situations arise as previously shown where patients who are in desperate need of treatment do not receive that care. The quality of life measures that were used in the development of QALY's made assumptions about the nature of 'health'. The measures were based on a state of good life expectancy, freedom from disability and pain and the ability of the patient to be in employment. However, not only quantity but quality makes life worth living and the meaning of health is an individual interpretation. The value of life does not necessarily decline with advancing years. The focus on aspects such as mobility, pain levels, length of life and the ability to maintain employment are, the researcher feels very limited in relation to the diverse aspects of psychological, social, spiritual and emotional dimensions of life, which contribute significantly to an individual's perception of the quality of their existence.

There is a sector of society where the use of these measurement tools will lead to gross inequalities in care. The number of elderly individuals aged over 65 has doubled in the last seventy years and it is estimated that the number of people over 90 will double in the next 25 years. (DOH, 2000)

A student highlights this:

> *An elderly man on the ward I was on was suffering from renal failure that he had had for a long time. His condition was deteriorating which was why he had ended up on the ward. He needed renal dialysis but there was a shortage of beds for this treatment and the doctors said that he was being considered together with a younger man who had a young family. It turned out that the younger man received his dialysis first. I had never thought about patients not being able to have the treatment necessary before. I took it for granted.*

The student here is faced with the dilemma of inequality of opportunity to access treatment. He has made an automatic assumption that an individual that is in need of treatment will be provided with that treatment without

question. However, as Butler (1999) points out this situation outlined above is becoming increasingly common. This sort of case raises many questions in relation to discrimination against the elderly, not to mention the possible infringement of the principles of justice, autonomy and non-maleficence that will be discussed later in the thesis. The student believed that age had clearly influenced the judgement about the value of the patient's life and had probably been the most important factor in making the decision about the allocation of resources.

The student continues:

> This situation is most unfair. Why should this patient be put to the back of the queue because he might not have as long to live as the younger man? It seems to me that someone decides how long you should live for – what is an acceptable number of years before you must sit back and accept the inevitable.

The student poses the inevitable question, that of the consequences of ageing in relation to treatment. According to Harris (1985) the primary argument regarding the moral relevance of age in the selection of patients for treatment is the fact, to use a colloquialism, that they have had a fair innings. It can be argued that to treat an older person in preference to a younger one is to deny the latter the opportunity for achievement in life while adding only a few years to an older person's life. In New Zealand patients who are older than seventy-five are not considered for renal transplant or dialysis (Honigsbaum et al, 1997). The argument for this decision relates to life span and that in order to give each individual the ability to achieve a similar 'span' of life it is the correct course of action to increase the life span of the younger candidate.

However, Grimley-Evans (1997) argues that people of all ages have a right to be treated as individuals. He makes the point that although older people as a group have a shorter life expectancy this may not be the case for individuals

and if we treat according to a group stereotype, then a case of ageism may exist.

The above student makes the surprising observation:

> *I asked some of my friends about this who were working in other areas and I was surprised when a few of them could not see a problem in not treating the old man. They thought that the younger you were the more you deserved treatment.*

Campbell et al (1999) reported the results of a national survey conducted in 1997 that showed the selective treatment of younger people, particularly those with family responsibilities.

However, recently the Government has addressed the issue of ageism in the NHS. In March 2001 the Department of Health produced the National Framework for Older People. This framework set new national standards of care for all older people. The first of those standards entitled: 'Rooting out Age Discrimination' recommended that NHS services be provided, regardless of age, on the basis of clinical need alone. This document lays the foundations for the abolition of ageism within the health services and clearly states that denying access to services on the basis of age alone is no longer acceptable.

Equality of access to health care is ethically desirable but is it a practical possibility?

The following student made an interesting comment:

> *Why doesn't everyone have the same amount of health care entitlement, a bit like money in a bank? They can decide to use it when they want or need to.*

The idea that we can be in a situation where our ability to access health care is the responsibility of the individual is an intriguing one. When questioned further about this statement the student explained that she felt that it was the only way

of ensuring fair distribution of scarce resources. This however, may prove to be unfair, as it is often in situations beyond our control where we require hospital care. This being the case we may 'use up' our entitlement early in life and therefore be unable to access the care we need later on in life. It could be the case that congenital deformity or childhood illness may lead to a similar situation, or a condition that requires on-going treatment throughout life leads to an empty 'bank account' in middle age.

In 1988 Daniels, an American philosopher put forward a theory, which he applied to the allocation of health care resources. He proposed that health care systems should be designed in such a way that health care is allocated differentially over a lifetime and the more that is allocated in early life the less will be allocated in the later years.

As the student suggested:

> *I am healthy now so I want to save my entitlement until I need it. If I*
> *have an accident, because I am young I will recover quite quickly and*
> *won't drain my account too much.*

The concept of the allocation of a certain amount of health care per individual is · an interesting one. Instead of each health district aiming to provide care, which covers the entire life span, in some, the policy could be directed towards investment in services for children and young people which would be likely to result in lower infant mortality rates and a higher proportion of individuals living longer. Under this system people would use these services in early life and therefore investment in services for the older age group would be less. In other districts the investment could be directed towards care of the older person but less to the younger age group. The result is obviously a trade off between the majority of individuals in a health district who will have the prospect of reaching

old age but not many reaching very old age, and individuals in another district less of whom will reach old age but the majority of those who do will have a chance of achieving advanced old age.

The student continues:

> *I may not use all my health entitlement I hope, if I don't then what will happen to it? I guess it could be used for those people whose entitlement has run out. That will be difficult to manage. Who should decide?*

In 1989 Rawls suggested that society makes the decision about the allocation of health resources rather than health care professionals because that would eliminate bias. Society needs to approve the priorities that are devised because the resources used belong to society. It is acknowledged that very difficult moral decisions must be made in the light of health care provision. During this century there has been a growing expectation that good health is an entitlement. Thompson et al (2000) point out that people have come to demand access to health care as a political right. The political debate has certainly alluded to what extent the state should attempt to define quality of life for various groups of the population. The impact on the nurse caring for the patient at the bedside will be dramatic and therefore it is imperative that they become politically aware and contribute to the debate.

> It is something nurses can hardly avoid, for not only is it in their own interests as nurses, but it is also a moral duty flowing from their responsibility for the well being of their patients.
>
> (Thompson et al, 2000 p.221)

A second area that students identified as having an impact on society was the continually changing definitions of life and death and what actions should be taken in these situations. By this, the students refer to issues surrounding in - vitro fertilisation, the use of foetal tissue for research, patients who are described as being in a persistent vegetative state (PVS) and the diagnosis of brain death prior to organ donation.

A student observed:

> *I find the patient who is described as being in a persistent vegetative state very difficult to understand. If they have no awareness of anything around them it must I imagine be like being dead.If this is the case then the decision to continue treatment does not seem appropriate. Having said this they are still continuing to breathe and their heart is still beating therefore can you just decide to stop.*

The student making the above comment has great difficulty with the concept of the state of PVS. When I spoke to her about this she said that it would take her a long time before she could accept a patient as dead in this state. This particular student had not come across this situation before and therefore the researcher would propose that her unfamiliarity is likely to mirror the feelings of relatives of such patients who are required to take a decision about ending life. As the student continued:

> *If I was involved with relatives who had to decide what would happen in this situation how could I guide them in the right direction if there is one? This decision in which I will play a part can affect other patients in similar circumstances.*

This comment encompasses the difficulties faced by nurses who are often at the forefront of care. The impact of increasing technology that can open up new avenues of treatment creates situations in which ethical decisions will not only affect the individuals concerned, but also those who are in similar situations in the future. It can be argued therefore that the moral responsibility that nurses are faced with now, and in the future, necessitates the development of these skills from the commencement of their training.

The definition of death has become an issue within health care, since the boundaries are often blurred. This is, in part due to the medicalisation of life, which has been discussed in an earlier chapter. Campbell et al (1999) states:

> The moment of passing on from this world is ...a very important point in the human live story. However, advances in medicine have made the

determination of the time of a person's death less simple than it used to be. (p.153)

Historically the cessation of breathing and the absence of a heart beat were the definitive signs that death had occurred but today death may only be defined as occurring after a period of time in which the patient is the recipient of intense medical intervention. Classically the patient who is attached to a ventilator but shows no sign of brain activity is one for whom the diagnosis of life or death is difficult.

Patients who are diagnosed as being in a persistent vegetative state do not possess any higher brain activity. They are unable to think, experience sensation or dream. This means that they must live in an environment totally cut off from the world around them. The medical evidence suggests that recovery rarely occurs. According to the Stanley Report (1992) these patients have no self-interests and therefore there are no patient-based reasons for the continuation of treatment. However the patient possessed values and ideals before he or she was no longer capable of consciousness and therefore these perhaps should be taken into consideration before any treatment is withdrawn. The wishes of the relatives as well as members of the health care team are important.

A student commented:

> I looked after a patient who had been in an accident nearly a year ago; he is in a PVS state. He breathes without a ventilator, he is fed and sometimes he appears to be looking round. How can a decision be taken not to give treatment when it is necessary, for a chest infection? It cannot be ethical to do that.

The student making this comment much like the previous student finds this state difficult to comprehend. He feels that the refusal to treat him for a simple

infection would be unethical. This scenario will always present difficulties and the patient in this state, it can be argued, is functioning at a basic biological level and the elements that made up the person have all but disappeared. If this is the case then the individual is incapable of benefiting from any care given and therefore treatment is not justified. However, who should take the decision to stop treatment? We would hope that the decision would reflect the individual's wishes as far as possible and therefore the family must be closely involved, but the decision should not rest on their shoulders alone. Mitchell et al (1993) made the following observation:

> In the case of the PVS patient, the determination of irreversibility can only be made by the doctors.... the determination of continued treatment as futile and thus optional, should be a shared judgement. (pp.74-75)

I asked the student who made the previous comment who should be involved when a decision of this type needed to be made. He stated:

> *No one person should have to carry such a responsibility. The patient has been cared for by a team of health workers and therefore each of them needs to carry equal responsibility for the decision. In this way there is support for everyone.*

The researcher also feels that other members of the multi-disciplinary team need to be included in this process, especially the nurse who has often been closely involved with the patient for what can be a lengthy period of time. It is not unreasonable to suggest that an expertise in clinical diagnosis does not automatically mean the same skill in making ethical decisions. Often the solutions to these problems lie in the co-operation of all members of the health care team, the patient if possible and the patient's family.

The definition of death has been questioned in relation to patients in this state of unconsciousness. Advocates of what is known as neo-cortical death see the death of the person occurring when the cortex is destroyed to the point where

the patient will never recover from profound coma. Life is seen as ending when this happens even if the patient may appear to be alive and may continue like that for some considerable time.

One student argued:

> *If the doctor or the relatives or both take the decision to remove a feeding tube from the patient then if I have to continue to look after that patient until he dies I feel I am agreeing in principle with the decision they have taken when my opinion may be quite different.*

Here the student feels that she is being placed in a position in which she is acting against her will. This situation is difficult. Technology has extended the patient's life beyond the point where it ceases to be of benefit to the patient and a decision to withdraw that treatment can lead to very personal dilemmas. If this student were to refuse on conscientious grounds to continue to care for the patient it may have implications for future nursing care as nurses become more aware of the ethical considerations in health care. One way in which nurses can feel that their opinions are considered is through team consultation. The importance of the team approach can be illustrated by the following comment. The student continues:

> *I realise that I will probably not agree with every decision taken. However the fact I could be part of the decision process and that my point of view had been listened to would make it easier.*

This type of situation, which, at times seems insoluble, is often concerned with communication and relationships. As Charlesworth et al (1993) point out, the ability to:

> be sensitive to the autonomy of the individual patient.... making decisions about the manner of their dying (p.60)

is a most difficult task and the authors believe that this can be achieved most successfully if ethical issues are taken into consideration.

According to a number of students another area in which decisions taken in the clinical environment could affect society at large, were those taken in relation to organ donation when patients are pronounced brain dead before harvestation is performed. The criteria that are set for the confirmation of brain death are laid down in law (RCN 1993). However, problems arise because it is necessary to transplant most organs as quickly as possible in order that the recipient has the best chance of the organs being in prime condition. The concept of brain death replaced the traditional cardio-respiratory criteria in the 1960's as the advent of organ donation became more popular because it allowed the preservation of patient organs after death. In the late sixties a report was produced from the Harvard School of Medicine, which examined the definition of brain death. (NEJM, 1968). This definition was that of irreversible coma which was characterised by clinical signs that were diagnostic of a non-functioning brain. Although legally accepted, the definition caused confusion between total brain death and irreversible coma, which has been discussed in the previous paragraph. This confusion led to the President's Commission for the Study of Ethical Problems in Medicine to propose a legal statute in 1981,which became known as The Uniform Definition of Death. In 1987 this statute was adopted in legislation. It stated the following:

> An individual who has sustained either irreversible cessation of circulatory and respiratory function or irreversible cessation of all functions of the entire brain, including the brain stem, is dead (p.95)

The patient who satisfies the above criteria can be declared dead by a doctor and it is not necessary either ethically or legally to gain permission from the family in order to do this. According to Jonsen et al (1998) the family should be informed that the patient has died. However, there are situations where it is necessary to continue life-supporting therapies for a period of time after death has been declared.

A student commented:

> *I think it is extremely difficult for relatives to accept that the patient is dead especially when they are warm and their chest is going up and down. There are stories about patients that wake up in the mortuary when they have been declared dead. How can anyone be sure?*

The student here raises a crucial issue that has been at the forefront of health care practice for many years. It is vitally important that the difference between death according to the above criteria and a persistent vegetative state are clearly stated. The researcher has certainly, during her clinical experience, heard the term brain death used to refer to patients who are in an irreversible coma or persistent vegetative state. There are many philosophical questions relating to the use of the above criteria to determine death. It is not uncommon in many cultures for the head and hence the brain to be regarded as the most important part of the body. It is viewed as containing the essential elements, which make that individual the person they are. However there are objections to this idea, which can be illustrated in the writings of Omine (1991) who argues that it is totally implausible to call an individual dead when they are warm, they bleed and are a source of living organs. Therefore the idea of brain death and the transplant of organs from such patients have caused moral conflict.

A student agrees with the previous comment:

> *I don't think I could look at someone in a bed who looked alive in most senses of the word and refer to them as a dead body.*

This view can be equated with what most people would regard as the normal experience of death and also what they would expect. Rix, on behalf of The Danish Council of Ethics (1990) supported this view and therefore gave his support to the cardio-respiratory criterion, which increases the scope of life definition. The committee stated:

the process of death cannot be said to have ended while respiration and heartbeat continue, the body remains warm and the colours of the body normal. Such a state is, of course compatible with brain death, and few people would be prepared to refer to a body in this state as a corpse (p.5)

Most religions now accept the brain stem definition of death except for one, Orthodox Judaism. Followers of this religion still believe in the cardio-respiratory criterion for religious reasons (Truog, 1997). Of the thirty students who were interviewed, twenty-three commented on the reactions of relatives who hold strong religious convictions, whether they be Christian or otherwise, to the issue of brain stem death and organ donation.

A student commented:

> When a patient's relatives were asked to consider organ donation they said that as Catholics they believed that the soul stayed in the body until the heart had stopped beating and breathing had ceased. Therefore it was not acceptable to remove organs until this had occurred. They could not accept that the patient went to theatre still warm and breathing to have organs removed.

There are Buddhists who believe that the soul does not leave the body until three days after the diagnosis of death and therefore the removal of organs before this time is seen as interrupting the death process and exposing the dead person to spiritual danger (Campbell et al, 1999). This comment and others that were similar, demonstrate that although some religious leaders have made the decision that acceptance of the brain stem death criterion is correct it does not mean to say that individuals will accept this when their beliefs lead them to a crisis of conscience.

A student said:

> As I am not religious and as a result of talking to relatives who were faced with the option to donate I found something out that I did not know before. Catholics believe in resurrection and therefore some feel that in order for this to happen when the body dies it must remain intact so that when the body rises again it will be complete.

In this situation the student realised that a deeply held religious conviction can strongly influence relatives' reactions to treatment decisions. When faced with

this scenario it can prove difficult as the student pointed out. Not only did she have to cope with the imminent death of the patient but also the feeling that a positive action that would benefit others could not take place. This was particularly poignant when I learnt that this student had a relative who was currently waiting for a transplant. The student finds it hard to come to terms with what Jonsen and Toulmin (1988) describe as the absolute demands of Christian ethics.

The student further commented:

> *I thought that these relatives should think about the situation from different angles. Surely there was more to this than a religious belief. How did I know the patient would have felt the same as they did?*

The rigid defence of moral truths which forms part of a religious belief demonstrates a different system of values that will inevitably cause differences of opinion as has been illustrated by the student above. In this situation it must be remembered that all moral beliefs are relative to an individual and as Kant (1724-1804) pointed out, in making the assertion that an act is right or wrong we are saying that it should be true for everyone.

A journal on medical ethics (Mitchell et al, 1993) reported that Protestant bishops had made the suggestion that brain death was an invention of the medical profession to suit their own purposes of organ donation and did not really represent death in the proper sense and in no way did it grant the respect which is owed to the dead person.

The researcher asked the students that had made comments about the definition of death if they would be willing to donate their organs if the situation occurred. Of the twenty three students who commented, nineteen said that they would be unwilling to donate because they were not entirely sure about

the circumstances surrounding the definition of death, and admitted being influenced by the media in relation to this, even though most had come across patients who were waiting for or needed transplant surgery of one type or another.

The following student comment sums up this feeling:

If I needed a transplant, of course deep down I would want to stay alive but I am sure I would always wonder if the donor had been really dead if you know what I mean

The definition of life offered by Spenser (1820-1903) is interesting:

The continuous adjustment of internal relations to external relations

(Singleton et al, 1995 p.75)

The researcher believes that the above quotation may lead the reader to question what Spenser actually meant by this definition of life. Today, the definition of life still suffers from similar confusion but no doubt for very different reasons. The most important question is what is meant by being alive. Singleton et al (1995) describe a theory, which attempts to conceptualise what it means to be alive. This theory is known as the 'Person View'. This view suggests that certain characteristics are necessary in order to give life its inherent value such as relationships, aspirations and dreams. Rachels (1986) who is a supporter of this view describes the possession of these characteristics necessary for being alive in the biographical sense rather than just in the biological sense. He believed that although it is necessary to be alive in the biological sense in order to have a biographical life, a biological life is not sufficient for a biographical life. Being alive in the biographical sense Rachels saw as the idea of being a person. He goes on to suggest that

consciousness, although necessary, is not sufficient for a biographical life but memory on the other hand is.

> Without the continuity that memory makes possible, a life, in any but the most rudimentary sense, is unattainable (p.53)

According to Rachels then, consciousness alone does not grant an individual personhood, only the addition of characteristics that can only be achieved after birth. Therefore, it would follow that an embryo cannot be considered as a person.

There are great difficulties associated with the decision about when life begins biologically, but equally difficult ones determining when an embryo becomes a person.

A student relates an experience whilst on clinical placement:

> *I was talking to a patient who had found out she was pregnant and wanted to have an abortion. I asked her how she felt about it and she said that she did not regard the embryo as a child yet and therefore undergoing an abortion early was ok. I could not understand her point of view because I would consider it as a child straight away.*

Here, the student finds it difficult to comprehend the patient's point of view in relation to the embryo. She felt that all life should be sacred but where, then, is the line to be drawn in the continuum from the individual cell to the individual after birth? I asked the student where she felt the distinction should lie and whether she was happy with the decision. She found that creating a demarcation line was problematic, reflecting the difficulties that have continually arisen over the centuries when attempts to define personhood have been debated. Glover (1977) pointed out that in law the unborn child has the right to claim damages for injury sustained in utero, but not against a right to life. Iglesias (1984) believed that there was no stage in human development when we cannot be regarded as people. The attributes that are present in the adult are there in potential form in the embryo and therefore they are no less of a person than the adult. According to Campbell et al (1999) there are three

major viewpoints on the moral status of the embryo, as a person, as a non-person and as a potential person. As a person the embryo is regarded as such from the time of fertilisation. However, the embryo cannot be compared to the adult and killing a six-week-old embryo cannot be compared with killing an adult. Does this then make the patient's decision correct?

The second viewpoint considers that an embryo should be considered as merely a thing until there is evidence of brain function. Holding this status the embryo has no rights and therefore places no moral obligations on society. Finally the status of the embryo can be that of a potential person whose rights increase with development but who has some rights in utero through virtue of its potentiality. A recent article related the story of a couple who, when trying to replace a daughter who had previously died, rejected the result of the in-vitro fertilisation when they found out that the embryo was male (Leonard, 2001). The implications arising from such a scenario are many, not least of which a child who will be denied his genetic inheritance, the knowledge of his natural parents and siblings just because he was of the male gender instead of the female gender.

The student continues:

> The girl that wanted to have an abortion said that she had heard of the foetus being used for experiments to help patients with brain disorders. She said her aunt had Parkinson's and this type of experimentation may help her. I wanted to ask if that justified her decision.

Embryo research entails the use of spare embryos produced as a result of in-vitro fertilisation. Foetal research on the other hand involves the aborted foetus either prior to, during or after removal. Foetal neural transplantation has been used since the 80's to attempt to alleviate conditions such as Parkinson's disease. It has been shown that implanted tissue can remain active in the brain for a long period of time and restore some function to the basal ganglia. (Kordower et al, 1995). The tissue for this type of intervention can only be

available through abortion and at the time of development of the technique

Gillam (1989) outlined four positions in relation to abortion. Two positions were

in support of abortion, one dismissing the moral wrongness of the procedure

and the other separating the decision to transplant from the decision to perform

the abortion. There were two positions against the procedure, one seeing

abortion as morally wrong and the other focusing on the early stage of

development that meant it could not be clinically applied.

A student continued:

> *As I said before I could not agree with the patient's decision. She was,
> in my opinion killing the foetus and I could not be a patient benefiting
> from any surgery using this material. If this treatment is successful
> some women may just have an abortion in order to provide the material.
> This need would lead society to condone abortion and some women
> who may even demand payment will abuse this.*

The student makes an important observation here that must be addressed in

the ever-increasing need to develop innovative treatments for the eradication of

disease. In subsequent discussion with her I learnt that her feelings regarding

abortion had become more intense in the light of developing technology that

made use of embryonic or foetal material.

> *I sometimes feel that the way people can manipulate a foetus today
> makes it seem that it is just viewed as a commodity rather than as an
> individual.*

Campbell (1999) makes the point that the position which, morally separates

abortion and foetal transplant, is the one that appears to reflect the views of

society. However, it has been criticised on the grounds of what Campbell calls

'moral complicity' because it is impossible to separate the issues surrounding

abortion from those surrounding transplantation. The expectations that have

been created by rapidly developing technology are leading to a situation where

there is a belief that a medical solution is available for every human problem. A lot of these medical solutions, like the ones illustrated above, have created their own unique set of ethical dilemmas which nurses are faced with on a daily basis, such decisions have far reaching effects on society.

The following chapter evaluates the modules on ethics and how they have influenced students' perceptions of moral dilemmas in practice and the development of their ethical decision-making skills in such situations.

CHAPTER SIX

ETHICS IN PRACTICE

The focus of the second part of the interview was directed towards students' evaluation of the ethics modules taught as part of the Project 2000 nursing curriculum. The students were invited to comment on the perceived worth of the theoretical preparation in relation to dealing with ethical problems that arose in practice. The students were encouraged to discuss a range of issues in relation to the above including: the development of their confidence when involved in discussions of ethical problems in the clinical environment, their ability to understand and rationalise decisions taken by patients, possible change of outlook with reference to particular ethical situations and ways in which they felt their learning would benefit them as they became qualified nurses. The first two issues will be examined in this chapter and the last two in the following chapter.

When interviewed the students were at different stages in their progression through the Project 2000 curriculum, although all had completed the Common Foundation Programme and were studying their chosen branch programmes outlined in Chapter One. This meant that they had studied the three ethics modules taught at pre - foundation and foundation level - Introduction to Law and Ethics in Nursing Practice, Justice and Rights in Nursing Practice and Introduction to Management and Duty of Care. All had also completed the module at advanced level on Leadership in Nursing Practice and some were in the process of undertaking the final ethics module at advanced level on Accountability and Responsibility in Nursing Practice.

As previously stated students were asked to explore various avenues in relation to their evaluation of the taught modules. The first area that will be explored, is the issue of the development of their confidence in their ability to take part in discussions of ethical problems that arose in practice and the consequent decisions taken.

One student observed:

> *I found that I was able to offer an opinion when I was asked which I could not have done previously. An example I could use was an incident concerning confidentiality. A patient divulged information to me, which he said he did not want his wife or the doctor to know. I remembered from college that confidentiality is not an absolute obligation and therefore there would have to be good reasons to keep it quiet. One of the exceptions to the rule of confidentiality is to do with justice and if the information is likely to affect some one else as it was in this case then it should be disclosed. I had to make a decision about what I would do. I told the patient that I might have to divulge what he had told me.*

In this situation it would be easy for the student to feel that he should keep the patient's confidence but when the information that is divulged is felt to be of such a nature that it will have serious consequences for others, then the student must feel that he has the confidence to refuse the request. This is often difficult for the novice who may suffer from a degree of lack of confidence due to inexperience. The above comment illustrates that knowledge which can be used to the advantage of the health care professional can serve to provide them with the conviction that their opinion is correct and therefore they must follow it through to its conclusion. The student felt that he was able to stand back and think through the consequences of any action taken. He thought that this was because he had been able to apply the knowledge that he had learnt as part of an exercise undertaken in the classroom situation as outlined below. The student continued:

> *I think what also helped me to act in the way that I did was the fact that I had to give a presentation in class to the other students and the things*

that could happen when a patient told you secret information had to be discussed. This was an exercise in problem solving where the problem was defined, the relevant principles identified, the options considered and what would be the outcomes of these, choosing one and then evaluating what the results were. Therefore I had been in this situation in my head already so to speak. My classmates asked me some awkward questions after the presentation so I did have to think about it quite hard!

Grace et al (1997) agree that this ability to apply knowledge and theory in the practice setting is vital and the student must be able to forge that link. The ability to think through a situation and apply a logical method to a solution enables the student to reflect on the process undertaken. Confidentiality is very important in health care relationships but exceptions to this principle are necessary. If these exceptions are obvious such as a court order, statutory requirements such as the Misuse of Drugs Act or the Road Traffic Act (Singleton et al, 1995) the public interest or at the patient's request, then a breach of this duty is less difficult. However, in circumstances where individuals' interests are affected the situation is a little different. The nurse must have the ability to understand that respect for the patient's autonomy cannot be justified when the action they propose will mean potential or actual harm to another individual or individuals, or themselves.

Most decisions that are taken during a normal shift in a health care setting are unlikely to be dramatic or life-changing, but that is not to say that they do not pose difficult dilemmas. In the situation outlined above the student was entering an unfamiliar situation and therefore the decision became more critical. As Thompson et al (2000) points out:

> Lack of appropriate knowledge or skills, unfamiliarity with established rules of practice or ignorance of likely outcomes may undermine the confidence of nurses and force them to examine why they chose to act in a particular way (p.257)

The problem-solving approach that the above student underwent during his theoretical instruction provided him with what he felt were the necessary skills which he was able to call upon at a time when he was unsure of which course of action was the correct one.

The development of confidence to tackle situations that can arise unexpectedly in practice can be illustrated in the following scenario.

Student:

> *I was looking after a patient who had been asked if he would join a drug trial. It was explained to him that he might be in a group that received the drug or in a group that would be given a placebo. He said he would only want to be included if he was sure he would get the drug so that he might benefit from its action. Although it was not possible to say which group he would be in a nurse who had been asked to seek consent from the researcher told him he would definitely be given the trial drug but this was not true. When I questioned her she said he may be given it anyway and the research was important for future patients*

In this situation the student felt that the patient's ability to act as an autonomous agent was being severely affected by the behaviour of her colleague. A respect for autonomy demands that the patient make an informed, voluntary decision about his participation in the research. It is only acceptable to use someone as a means to an end, in this case for the benefit of future patients, if they wish the same end result and give informed consent. Without this consent the patient is used as a means and violation of their autonomy occurs. In the above randomised controlled trial informed consent is vital before randomisation and participants must be aware that they may well receive the placebo. If the consent is valid the patient must receive accurate information and must not be coerced into participation. The participants can be protected from this type of influence from the researcher by the inclusion of a third party to seek consent, as was the case in the above. Campbell et al (1999) point out the following:

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Consent is important, not only because it signifies that the participants in the research have been given the opportunity to make their own assessment of the risks and benefits, but also because the consent process recognises that the research participant is a person..... with a set of personal values that must be respected. Research without consent constitutes an invasion of the personal integrity.... even if no physical harm is caused them (p.174)

In the above case the patient had given consent but only on the condition that he would be given the drug rather than the placebo. The consent could not be seen as valid as it was impossible to determine into which group he would be placed. The nurse on the other hand had not given the patient these facts and, therefore he was not making a truly informed decision about his participation in the research programme.

Student:

> *I said I did not agree and the patient had a right to know that he would be randomly selected to one group or the other. I attempted to explain why and found I was able to justify my case quite well. I had an argument on my hands though...my colleague argued that if the patient wants to benefit from the research he has a duty to assist in it. Eventually we did explain to the patient we could give no guarantees about receiving the drug and he still agreed to participate and said he was glad we had sat down to discuss both sides of the argument with him.*

The student also went on to explain how the recognition of the principle of autonomy had helped and supported her argument in the above situation.

Student

> *I had identified the main ethical principles in the first ethics module I did and realised how important the principle of autonomy was. This made me think about how patients are sometimes protected from information which others feel is either not necessary or would be harmful. I would be mad as hell if someone did that to me.*

Thompson et al (2000) believe that paternalism within the clinical setting can become officious if the respect for patients as individuals and their rights fail to be respected and their autonomy ignored.

The development of confidence in relation to the discussion of ethical situations in the clinical environment can often be daunting and the ability of the individual nurse to see her way through the complexities that these situations often entail leads them to feel that any confidence that they have developed can soon be lost when one of these particularly difficult situations arise, as the following case demonstrates.

Student:

> *Working in A and E during one shift a child was brought in who seemed to have scalded herself. The burn looked quite nasty and the child was very distressed. It was very difficult to offer her any comfort at all and I felt a little bit helpless in the situation. Her mother who was extremely upset and tended to be very protective towards her accompanied child. The mother was adamant that her daughter had pulled a hot drink from the kitchen surface. The staff on duty were a bit suspicious and there was talk that this may be a non-accidental injury. The mother was a single parent who had two other children that were quite young. I am a single mother with two young children and I know how difficult and frustrating it can be.*

If concerns are voiced in this situation the most likely course of events is for the child to be removed from the custody of the mother and the child protection team will take control of the situation. The role of this team is to make a decision that the child will not suffer if returned to the parent. In this situation the mother may be able to take part in any decisions taken but she cannot be in the position of making authorised decisions due to her perceived failure as a parent. This action is primarily to protect the child from harm and to make sure that everyone is acting in the child's best interests.

The student nurse must be aware of the divided loyalties and powerful feelings that can result from exposure to such a situation. In relation to her own experience she may identify with the parent and feel extremely sorry for her. The student realised that the mother was likely to be in need of care in her own right.

> *I felt so sorry for her because if she had lost her temper and caused the child damage it may have been a temporary loss of control that she bitterly regretted afterwards.*

It is often difficult to be able to weigh the interests of the parent with what is thought to be the best interests of the child. It became obvious that the student had great difficulty in accepting the decision that was taken in relation to the patient discussed and therefore felt that her confidence had been undermined and she had been unable to contribute to the discussion with the multi-disciplinary team.

Student:

> *I had great difficulty with this situation and my confidence took a knock. Everyone seemed to be in agreement and I was the odd one out. I didn't want to pretend so I said I disagreed - I think they all thought I lacked experience but it was not that, I just could not jump to such a conclusion so quickly.*

Conflict between moral values can exist, not only when an individual is faced with a moral dilemma but within society and between differing societies (Thompson et al, 2000). However, moral conflict can be healthy in that it acts to keep individuals and society vigilant to the numerous personal moral values that exist which may influence decisions taken. Conflict, on the other hand, can be destructive and undermine confidence and therefore it is important that through discussion and debate understanding develops which allows an appreciation of differing ethical viewpoints and their importance.

The student concluded:

> *I realise now why it was important to spend time during the modules recognising and accepting our own value systems and how they can play a part in practice. I never thought that it would be so difficult to come to terms with them in the real situation.*

An ethical framework is essential, the researcher believes, to allow students to talk about the values which they feel are most important to them, and the ones

with which they feel it would be hard to compromise. If they are able to gain an understanding of what may have influenced the formation of their ideals it will make it easier for them to deal with criticism if it arises.

> Ethics provides a framework within which we can give one another reasons why we believe these values and principles to be important, can offer and listen to reasonable criticism and can, on occasion, find ways of establishing public consensus about the rights and wrongs of particular conflicts. (Thompson et al 2000, p24)

The grounds on which paternalism can be applied can lead to situations in which a patient may be denied autonomous choice in health care decisions even though they appear capable of making that decision. This is known as strong paternalism and the situations in which it can arise are many and varied. The doctor can prescribe treatment without consultation with the patient or provide biased information, which results in the patient choosing the option that the doctor feels is in the best interests of the patient. Usually the justification for this behaviour is their superior knowledge and ability to predict outcomes. The principle of beneficence will override the respect for the patient's autonomy but should this be the case? If a patient is capable of being informed they are capable of weighing up the advantages and disadvantages of treatment and their decision may be in opposition to the doctors. Another point to bear in mind is whether medical judgements can or should be considered infallible. A judgement concerning quality of life and the moral consequences of that must ultimately lie with the patient. According to Rumbold (1999) paternalism is a complex concept and can be demonstrated in several ways - in attitudes, language and treatment decisions. Whatever form it takes it still involves overriding autonomy for what is considered to be the patient's own good.

The following situation outlines a case in which the competence of the patient can be considered uncertain but the overwhelming need to act in a paternalistic manner is extremely strong.

Student:

> *I was allocated to a ward where a young girl, she was 16, had been admitted with anorexia nervosa. She had suffered with this since she was 13 and had been in hospital before. When I talked to her she was certain that she would not be able to beat this disease and although she had gone through periods of eating a little more she had always reverted to her old habits. She said treatment was a waste of time and she only did it to keep her parents off her back.*

The difficulties presented by this type of scenario are considerable. The patient is young and seems to have her whole life in front of her and therefore doubts over her ability to foresee the long-term consequences of her actions must exist. The student, who was only a few years older than the patient herself found that she was able to identify with her and therefore she felt it was difficult to offer advice.

Student:

> *I have sometimes thought that I am a bit over weight and have gone on faddy diets. I didn't think it was so strange that the patient felt as she did. A lot of the staff could not understand what she was doing.*

Being able to identify with the patient as the student points out in the above comment can prove to be beneficial. The ability to be able to empathise with the patients who are being cared for can strengthen the nurse-patient relationship according to Creek (1997). The origin of this strength comes from the nurses' ability to be able to ' put themselves in someone else's shoes'. However this does not necessarily make the decision taken by the patient the right one.

Student:

> *Even though I could understand why the patient felt the way that she did, when I thought about it I could see that her actions were going to lead to her harming herself seriously. I don't think I would go that far.*

The choices that people make which others in similar circumstances may not make do not mean that they are unable to act autonomously. The individual(s) taking the action must justify infringement of this right. The overriding reason for taking paternalistic action is the argument that the patient will be better off but according to Veatch et al (1995) these judgements that the individuals will benefit from interventions by the health care team need careful assessment. It could be the case that even if patients are described as being better off it is not certain that the paternalistic action was justified. The degree of benefit must be weighed against the infringement of their freedom.

Student:

> *This girl was desperate to be able to stop her treatment and was so upset when she felt no one was listening to her. I told her I would listen and try to bring her point of view to the attention of the staff. I knew it was important to see both sides of the argument.*

The student here feels that communication between the patient and other members of the multi-disciplinary team has broken down. Thompson et al (2000) regard this situation as one in which there is failure to respect the patient as a person and therefore it is a threat to their autonomy. In this situation there will be tension between respect for the patient's rights and the health professionals duty of care. Any judgement that is made in this case will inevitably be highly subjective, therefore staff whose primary role it is to preserve life and increase its quality are maybe not in the best position to determine whether any intervention would justify infringing the patient's autonomy. Who should fulfil this role of decision maker is open to debate but the fact remains that an objective viewpoint may override the biases that are an inevitable part of working within the health care setting.

Student:

> *Before discussing ethics in the classroom setting and spending some time actually looking at what the various principles mean I would not have realised how important personal autonomy was. I suppose that my opinion previously was that treatment should be implemented because otherwise serious consequences would arise and I would not have stopped to think what this would mean to the individual concerned.*

Previous to her exposure to the clinical environment the student felt that in a situation such as this she would wish to prevent a young girl from taking a decision, which will inevitably cause her serious physical and psychological damage, if not death. Faced with this scenario in the light of her exposure to 'taught' ethics she has realised that protection of an individual's autonomy, which is threatened during illness, is as important as the potential treatment the patient may undergo. If there were overwhelming reasons, which everyone involved agreed with why intervention to prevent a course of action was necessary and this was balanced on the assessment of patient benefit and harm by an outside body it may still not justify overriding the patient's wishes. (Ramsey, 1978)

As the student concludes:

> *Autonomy is so important that I felt that I must try to defend this right. Having an understanding about something gives you the confidence to speak out even if you are not popular on occasions with colleagues. This role as the 'gatekeepers' of ethical practice must apply to everyone and not just to those who study ethics full time.*

The second area that students were asked to comment on, in the light of their experience of undertaking the ethics modules, was their perceived ability to accept and rationalise the decisions that patients and relatives took which may not agree with their personal viewpoint. This part of the interview provoked some interesting comments and situations described were varied.

This student focused on a particularly devastating illness:

> *The disease I would most fear getting is Alzheimer's. To lose all your mental capacities but still be physically able is terrifying. I would hate for my relatives to have to watch me deteriorate slowly and for me not know who they are. I would make a living will so that when I became so ill that I could not make a decision that my life would not be prolonged.*

This particular student did have very strong views about this disease and admitted that when she had had to care for an individual who had been diagnosed with this condition she had great difficulties when the patient expressed the view that she wished to continue her life for as long as possible even if she became incapable of human interaction.

Student:

> *I find it hard to understand how some one could wish to continue to live when they become unable to interact with the world around them. Surely this cannot constitute a quality existence. Before I studied ethics I would have had no hesitation in saying that in these circumstances it would not be unreasonable to consider euthanasia. Now I stop and think-what would this patient really want.*

In this situation the student has begun to focus on the right of the patient to self-determination and their right to be protected from involuntary euthanasia by others. Active euthanasia is a widely-debated subject especially in patients that suffer from advanced dementia. Palmer (1999) concludes that by allowing active euthanasia in conjunction with the request within a living will we reach the best compromise possible. He believes that patients cannot wish for a continuing life because they do not have any conception of what continuing life means. Several writers agree that the features that make life worth living are absent in advanced dementia. (Tadd,1998; Hendrick,2000). This lack of sense of self may negate the right of the individual to the allocation of resources because they will be of no benefit to them. Post (1990) however proposed that far from being individuals who lack any sort of potential and, for the relatives only memories of what used to be, there is a core that remains. The inability to predict how much of the cerebral cortex has undergone destruction means that

the extent of the ability of each individual to function is unknown. Post strongly believes that these people must be protected from active euthanasia if they have expressed this desire because they should be remembered for what they once achieved and as a sign of respect for whatever biological life is remaining. The provision of basic care, but not the use of life saving technologies, is the way forward together with the support necessary to protect the carers from the physical and emotional effects that this situation will inevitably create.

Most commonly the reasons for contemplating ending someone's life prematurely are related to mercy (Parkes,1998). A judgement is made that the quality of the individual's remaining life is so poor that they would be better off dead. It may also be the case that other peoples' lives would be better off if this decision were taken. As mentioned earlier the inability to interact would lead most reasonable people to not wish to continue where physically, socially and emotionally they are totally deprived.

The student continued:

> *Although I found it unbelievable that someone would wish to continue to live even if they had to rely on others to do everything for them I knew that it was necessary to view this from different angles. I just consider it a great burden to impose and it's not right to assume that relatives or carers would naturally take on that role.*

This is a most interesting observation by the student and is one that warrants further discussion. The automatic assumption, if it takes place, that relatives will be willing to accept the consequences of caring for a patient in this condition creates an ethical dilemma in its own right (Kerridge et al, 1998). This automatic assumption denies the relative their right to choose how they will conduct their lives and whether they wish to assume the duty of care.

The student continues:

> *I would like to think that I could accept that role as a relative without hesitation but I can't say for certain. I am finding that I do not think in such*

a concrete way as I did before studying ethics. I seem to be becoming an in-depth thinker if that's the right term to use!

It would appear from the above comment that the student is developing her ability to consider clinical situations she encounters from an ethical perspective. Student:

I can't justify making a decision about something if I have not considered all the avenues. That would be blinkered and irresponsible.

From this comment it can be proposed that the student is now beginning to comprehend the difficult process that ethical decision-making entails and therefore because of this she is developing the skills necessary to be able to make these decisions competently.

Student:

I realise now that there is nothing wrong with having my own opinions about things but I am learning to recognise that what I feel is best from my point of view may not be what the patient feels is best for them. Studying ethics, especially the appreciation of individual rights has shown me that there are alternative ways of looking at situations. It is easy to become very blinkered and feel affronted when someone doesn't agree with you.

The student, faced with the situation outlined above discovered what Socrates (469-399 BC) described as 'knowing thyself'. He argued that it is impossible to act as a moral agent unless one possessed insight and if one was to be in possession of such a virtue it was essential to admit ignorance. Aristotle (384-322 BC) suggested a system, which incorporated the acquisition of two kinds of skills namely intellectual virtues and moral virtues. The former involved the ability to make decisions while the second required the necessary characteristics to function as a moral agent. Thompson et al (2000) state that the relationship between these two skills within a moral agent and the balance between them is essential to produce an individual with the abilities necessary to competently deal with ethical problems.

A further scenario related by a student concerns proposed treatment which may prevent disease in the future, but which would be considered extremely radical in view of the age of the patient and the nature of the operation.

Student:

> *I was in contact with a family who had been referred to a plastic surgeon from a geneticist because there was an extremely high risk of breast cancer within the family history and several members of the family had died as a result of the disease. Two sisters, their mother, their cousin and a 13-year-old girl who was the daughter of one of the sisters attended the consultation. The mother of the two sisters had already been treated for cancer in one breast and they all wished to know more about prophylactic mastectomy and reconstruction. The mother of the 13 year old also asked if the surgeon would be prepared to perform a similar operation on her daughter, who, when questioned agreed with her mother.*

This kind of situation poses a dilemma because the parent and the surgeon wish to do the best for the child but the interpretation of what is in the best interests of the child may differ. In discussion with the student it became obvious that the mother was adamant that the surgery should take place and if it did not she would hold the health professionals responsible if her daughter did contract breast cancer. The student felt complete outrage at this and thought that the child should be made a ward of court preventing the mother from taking her elsewhere to seek the operation irrespective of the child's agreement to the procedure.

If the parent, child and the surgeon do not hold the same beliefs or values the ability to decide the matter of rights and responsibilities becomes complicated.

Student

> *I found out later that the surgeon had refused to agree to operate on the 13 year old because he said that the risks associated with such major surgery could not be outweighed by the risk that breast cancer may or may not develop. However he did offer regular checkups to monitor the child so that intervention could take place if necessary as soon as possible.*

A child giving consent to treatment under the age of 16 was established in law in 1986 (Hendrick, 2000).The 'Gillick test' set a standard of competence which meant that children must understand what is to be done to them, why the decision has been taken to treat them in this way and what consequences may follow the decision to either accept or reject treatment,. Hereafter the ability of a child to give consent below 16 if they are deemed to be competent became known as 'Gillick competence'. It allowed children the independent legal right to consent to treatment. However, in order to do this the child must achieve the above criteria outlined in the 'Gillick Test'. It is also important that the health professional, according to Brazier et al (1996), be satisfied that the child is intelligent enough and mature enough to understand what it means to be 'Gillick competent'. This may not always be certain and, as has been pointed out by Fortin (1998) the notion of understanding and maturity in relation to an adolescent must undermine the effectiveness of this concept.

In discussion with the student the researcher became aware that the surgeon had seen the child on her own and realised that she had very little understanding of the situation. The girl believed that it was inevitable that she would contract cancer because of her family history and therefore felt if she did not have the surgery death would be inevitable. When it was realised this was not the case the girl was most relieved and did not wish to pursue the course of action any further. The mother, when interviewed alone was desperate to protect her child from a life-threatening condition which she could not be sure would not arise in later life. She felt that to live with the uncertainty was unbearable and had therefore led her daughter to believe that cancer was a certainty rather than a possibility.

Student:

> *I found it very difficult to come to terms with this course of action by the mother because she was deliberately deceiving her child. What if the surgeon had taken a different course of action here? Saying that I had*

*been taught to stand back and consider situations. I was challenged but
when I did stand back and think about the issues at stake I came to the
conclusion that consideration of both points of view was essential in
order to adopt a rational approach to the situation. I was glad I had
been able to practice in class in a pretend scenario even though I forgot
that learning initially!*

Most people will, at some time pass judgement on other people's actions in a

particular situation because we all have an idea of what is the best course of

action that should be taken in that situation. Nurses are often faced with

exactly this situation, especially when they feel the other party is acting in a

manner, which may be deleterious to another. Thompson et al (2000) believe

that if we do this we will resist any attempt to try and rationalise or analyse why

this is happening. He goes on to suggest that we hide behind the terms

intuition or conscience, which may be a refusal to examine the reasons why we

have chosen to act in the way that we have. The student here reacted

intuitively when faced with the situation, wishing to take quite drastic action,

which would not have been appropriate. Later on she realised that there will be

situations in which the parent will be so frightened and upset by what is

happening or could happen to their child, that they will not make a good

decision in those circumstances.

For consent to be freely given it must be obtained without coercion. The

definition offered by Beauchamp et al (1994) states:

> a person acts voluntarily to a degree he or she wills the action without
> being under the control of another influence (p.163)

An interesting dilemma was posed in the questionnaire concerning the issue of

organ donation from a fourteen-year-old boy to his mother. The students were

asked to decide whether the child, as the only member of the family

compatible, be allowed to donate or not. Whether right or not, this situation

must inevitably place the child under a certain obligation and therefore under a

degree of influence. Seventy three percent of the students who responded thought that the boy should be allowed to donate. The researcher wondered whether there would be a link between ages in students who had responded to this question. The results of this analysis can be found in Appendix 6 (Test 4). There are situations, however, in which the patient is in conflict with the doctor and their family because of the course of action they have chosen to undertake. The following case illustrates such a situation and how the student involved could accept the patient's decision and understand why he had made the choice, but had difficulty with the reaction of the relatives to that decision. Student:

> *I was nursing a patient who had suffered a spinal injury. It was a high injury which meant that he had to be ventilated and was paralysed from the neck down. He was only young and was engaged to get married the following year. He had led a very active life and enjoyed a variety of sporting activities and was an outward-bound instructor. When he realized how limited his life would be he said he did not want to continue being ventilated.*

From the researcher's own experience it is very easy to assume that one will know how that person is feeling and what sort of thoughts are going through their mind. When and under what circumstances would it be acceptable for the patient to decline life-saving treatment? This particular patient faced a life, which was likely to be very different from the one he had envisaged, the plans that he had made may not now be achievable and he must therefore come to terms with his altered situation and find alternative avenues to follow. It is necessary to allow the patient to accept this and then the process of rehabilitation can begin and a positive outlook encouraged. However, initially, the patients are completely devastated and cannot see any remaining value to their lives. This feeling can persist for some time before they eventually begin the long road to acceptance of a new live. In some cases these feelings do not diminish and the patient's wish to discontinue their lives, which they feel are of

no value, persists. This decision is one that all members of the health care team find extremely difficult to accept as the patient who is informed and competent is refusing treatment or requesting cessation of treatment, which will save their lives. Jonsen et al (1998) state that refusal of care by a patient who is competent and fully informed should be respected even if that action will ultimately result in the patient's death.

Student:

> *Strange as it may seem I did not have any problems with the decision that the patient wished to take because I could not imagine living like that. The reaction of the patient's family I found harder to deal with. Obviously they were devastated and wanted everything done to prolong life. I felt that they should not put pressure on the patient to change his decision because they did not have to live his life.*

Respect for autonomy has been justified by many ethical theorists but the two major influences have come from J.S.Mill and I.Kant. The former philosopher believed that we have a right to do what we want unless we are shown to be harming others. Kant, on the other hand argued that the respect for individual autonomy must take into account the autonomy of all. He also believed that moral responsibility for actions could only be satisfied if the individual was free to decide how to act and did so out of respect for duty. Within health care patients exercise autonomy through consent.

> Consent in the context of modern medicine is an ethical doctrine about respect for persons and about power. It seeks to transfer some power to the patient in areas affecting their self-determination.
>
> (Kennedy,1991 p.178)

If patients are to be allowed to exercise their autonomy this must impose obligations on health care professionals to provide the elements necessary for the patient to give true consent. These include adequate information, truthfulness, opportunities for communication, lack of coercion and above all accepting the preferences of the patient.

In a situation such as this where the patient is competent, but wishes to take a decision the carers find impossible to comprehend, the need to act paternalistically is great.

The student continued:

> *I felt the family could not come up with a good enough reason why he should not take the action he wanted except that they wanted him to be around in their lives. Were they thinking of him or themselves?*

This is an interesting comment because it does raise the point that paternalistic actions are far more likely to be questioned than they ever have been before. Rumbold (1999) suggests that paternalism should be rejected completely as nursing enters the new millennium. When health care professionals or the family strongly believe they are acting in the patient's best interests, it is not sufficient to override the individual's autonomy.

The student who was faced with this situation felt that he was right to maintain his stance and try to support the patient through an extremely difficult period. In conversation it became apparent that he felt he was able to give the support necessary because it was part of his role as a professional and if he had gone against his conscience he would not have been fulfilling his responsibilities as an accountable practitioner.

He made this important point:

> *The last module I studied on ethics concentrated on personal accountability and responsibility and how it is important that, as a nurse I understand the implications both legal and professional. It is important to stand up and be counted and take a stance even though it does not please everyone. However when that stance is taken you have got to be able to justify it, knowledge gives you that power.*

This comment reveals the student's realisation that an understanding of the processes of ethical thinking is vital in being able to have the confidence to justify decisions taken in practice.

Student:

The opportunity to be able to discuss the impact of ethical situations and how any decisions taken in those situations will affect different parties is essential. I feel that the preparation I have had in the classroom has given me an excellent insight into potential ethical issues in practice that I would have been unaware of before.

In this chapter students have outlined situations that demonstrate how they have benefited from formal ethical teaching and how this has helped them to build confidence in practice when faced with moral decisions. The comments made by students also demonstrate their developing ability to be able to begin to rationalise decisions taken by patients, which may or may not agree with their own and appreciate ethical dilemmas from a variety of standpoints. One student summed up this development as follows:

As a group of students studying the ethics modules my friends and I have seen the changes in each other both in our personal outlook and in the way that we respond to situations we encounter in practice. It's often the case that we continue to discuss issues that have been raised in the classroom long after the session has finished.

The following chapter will focus on how their experience of undertaking the modules on ethics has altered the students' ethical outlook in practice and how their learning will equip them to function as qualified nurses.

CHAPTER SEVEN

PREPARATION FOR PRACTICE

As mentioned in chapter six the second two issues arising from the data generated during the second part of the interview will be discussed. These will focus on whether the students' outlook on ethical issues that can arise in practice had changed as a result of their learning and how they felt the modules had prepared them for their role as qualified nurses. In this chapter I will also address the first aim of the study in order to compare the student responses to ethical dilemmas. Before commencing clinical practice or undertaking the taught modules the students were asked to complete a questionnaire, which outlined several ethical dilemmas with possible courses of action that could be taken in each situation. The students were asked to respond to these situations by deciding which action they felt was most appropriate in the situation outlined. A few of these questions also invited the student to write a rationale for the option they had decided upon. The students were asked to make a photocopy of their answers to the questionnaire, which they were asked to retain. This was necessary in order that the students that were selected to be interviewed were able to refresh their memories as to the answers given in the questionnaire. During the interview process this would enable the students to reflect on their views at that time and compare them with their current views. Some of the results from the questionnaire given to all the students before commencement in clinical practice have been discussed in the relevant data chapters. In this chapter the responses from the students that were selected for interview will be discussed to determine whether there is any provisional evidence of a change in response to the ethical dilemmas. They

were asked how they felt their opinions had altered, if at all, due to their increased knowledge of ethics and exposure to the clinical environment.

The first question the students were asked to comment upon dealt with the issue of informed consent. The scenario outlined the case of a surgeon who performed additional surgery, which he deemed necessary, to which the patient had not consented. Eighty six percent of the 210 students who initially completed the questionnaire agreed that the surgeon had the right to perform additional surgery without gaining consent. Statistical tests were carried out in relation to this issue, the results of which can be found in Appendix 6 (Tests 5 and 6).

The researcher was surprised at the number of students who were in agreement that the surgeon should continue to operate without consent irrespective of gender or age. This appears to reflect a continuing belief that the principle of nonmaleficence as well as the principle of beneficence are still viewed as providing a basis for paternalistic treatment of patients (Beauchamp et al, 1994). According to Campbell et al (1999) the doctor is still seen as having a godlike authority and the faith in the doctor's ability to diagnose correctly and prescribe effective treatment is an important component in the healing process. In practice there are many difficulties in trying to achieve informed consent and because the partnership between the doctor and the patient is commonly unequal the patient does not have an independent choice. In the 1980's writers were making the point that the importance of consent must not be belittled but there are situations in which the recognised ability of the medical profession to make the right choices regarding treatment is still the most important factor. Pellegrino et al (1988) believe that there is a need for a profession that will act for 'the patient's good'.

The students that were interviewed were asked if their opinions had altered since their completion of the questionnaire with reference to informed consent. 23 out of the 30 students interviewed stated that their opinions had changed since their completion of the questionnaire. The students felt that this change was due to their direct involvement in the clinical environment and their classroom experiences. The comments made by students will be discussed below. The procedures designed for obtaining consent enable the patient to make as autonomous a choice as possible but they also have a role in protecting the patient from harm and ensuring that the medical personnel act responsibly towards the individual concerned. Katz (1986) viewed informed consent as no more than decision-making between the health care professional and the patient. Beauchamp et al (1994) do not agree with this viewpoint stating that although the idea of shared decision-making is an ideal to be pursued it does nothing to define informed consent or can certainly not replace it.

The following statement is taken from the case Mohr v Williams in which a surgeon operates without the appropriate consent.

> If a physician advises a patient to submit to a particular operation, and the patient weighs the dangers and risks incident to its performance, and finally consents, the patient thereby, in effect, enters into a contract authorising the physician to operate to the extent of the consent given, but no further.   (Beauchamp et al, 1994 p.261)

The views of the students that the author interviewed who had, in the questionnaire agreed that the surgeon had been correct to operate on the patient at the time of surgery, are now discussed. During the interview process it became apparent that opinions had changed quite dramatically as the following comments will show.

One student commented:

It was only when I looked at the subject of ethics that I realised how naive I had been because if the surgeon is allowed to take decisions while the patient is asleep then the giving of consent means nothing.

Another student said:

Although I thought that it was OK for the surgeon to decide to operate in the scenario outlined in the questionnaire, when I was in practice and the patients were signing the consent forms I found myself thinking about it and how patient autonomy had to be respected at all costs. This was especially true when one patient asked me what was meant, in the consent form by 'any other procedure which the surgeon felt was appropriate at the time'. I wondered how far that statement could be interpreted.

Another student commented:

Before you look at the subject of ethics in nursing and then go out into the clinical environment I guess you look to people with experience and believe that the decisions that they take are the right ones without really thinking about it too deeply.

One could propose that the comments made by the students above demonstrate that studying modules dedicated to ethics has led them to think more deeply about situations that they would have otherwise accepted without question. While in practice the students are constantly faced with questions from patients who are looking for reassurance or confirmation in relation to their management. This is clearly the case in the second comment above and the implications of that question have left the student pondering the possible consequences of the statement within the consent form.

Another situation that the students were asked to respond to concerned the issue of organ transplantation from a fourteen year old to his mother. Respondents were asked to decide whether the child should be allowed to donate or not with or without certain preconditions.

For a long time there has been acceptance that patients' relatives if suitable, can donate organs such as a kidney for altruistic reasons. As a volunteer it

may be something that they really wish to do. However, is this necessarily the case when the prospective donor is only fourteen years old? Could there be a degree of emotional exploitation because other family members are not an organ match? The right of children to make autonomous decisions stems from philosophies that promote the individual's freedom to make rational autonomous decisions. These ideas are based on the fundamental moral principle that the respect for persons is owed to children who are developing persons thereby having the potential to become the fully rational beings to which autonomy is granted more or less automatically (Ross-Friedman, 1998) In the case of children this autonomy is frequently questioned, even though it is accepted that children can take on a degree of responsibility.

John Stuart Mill (1806-1873) who was a great believer in the concept of autonomy, was doubtful whether children could possess this capacity.

> This doctrine is meant to apply only to human beings in the maturity of their facilities. We are not speaking of children, or young people below the age, which the law may fix as that of manhood or womanhood. Those must be protected against their own actions as well as against external injury (p.73)

Even though there is a widely held view that children are, on the whole more sophisticated in this present society and therefore should be given more ability to develop their decision-making capacities, they still lack a sense of self and experience which are necessary to be able to make autonomous choices. According to Campbell (1992) denying children the right to participate fully in decision-making is not inconsistent with their autonomy but is allowing them the opportunity to develop their potential as fully rational adults. If this is ignored then the child is faced with a choice that he or she is incapable of making and is, in effect, forcing them into a premature adulthood.

If the treatment that is proposed carries considerable risk then it may be appropriate to allow the child to express their wishes but not participate in autonomous decision-making. Children should not be put into a position where they are asked to make decisions that might be against their will but if they are to exercise autonomy they must be given the opportunity and permission to do so (Alderson et al, 1996).

Of the thirty students interviewed it was found that twenty-one would now respond differently than they had in the questionnaire. The following comments show that students had begun to reflect on their decisions in the light of clinical experience and ethics teaching.

A student commented:

> *I really didn't think about the consequences of this action, I just thought that if the boy wanted to donate and he was able to do that then it was ok - it seemed like the easy answer. I'm sure now that he could not have been aware of what that decision entailed, even adults do not always understand exactly what transplantation means and what consequences it will have.*

It can be argued that in thinking about the consequences of an action we are paying heed to the ethical components of that situation (Kerridge,1998). The student above now feels that he has begun to examine the issue of transplantation and what that will mean for the patient more carefully.

He further added:

> *It is becoming much clearer to me now that it is important to think through a situation in a logical fashion in order to make a responsible decision. I could see why using a model for ethical decision-making like the one we used in the classroom was a good idea. Even though you didn't realise it you begin to think in a more logical fashion. I seem to be developing the skill to be able to stand my ground and defend what I believe to be right. I don't jump to conclusions so quickly.*

From the above student's comments it could be deduced that the influence of formal ethical instruction is causing a change in the student's outlook and allowing him to reflect on his decision-making ability. In order to be able to act responsibly Downie (1971) has always argued that an individual must have the knowledge, freedom and power of self-determination to achieve the outcome that they would wish. The student above, it could be proposed is beginning to realise the importance of the above-mentioned abilities, which will provide him with a strong foundation on which he can continue to develop his decision-making skills.

The following student's comments illustrate the importance of adequate information and the absence of coercive influences, which may serve to persuade an individual to perform an action which may not otherwise take place.

Student:

> While I was in practice I looked after a young girl who was in kidney failure and had to attend for dialysis several days a week. Most times she attended her sister came with her. She was about 2 years younger than the patient who was 15 at that time. Often when I chatted with them the subject of donation came up and the patient said she couldn't wait until she could have a new kidney. On one occasion the sister was very upset and when I spoke to her she said that she should give one of her kidneys to give her sister a better life. She said everyone would expect that and she felt guilty that the disease had spared her.

The student continued:

> I realised when I had responded in the questionnaire I thought that a relative does have an obligation and therefore it would be wrong not to decide to donate whatever age within reason. Faced with the situation I described I would have serious doubts about children donating because this child was scared and upset because she felt great responsibility for her sister's illness.

According to Beauchamp et al (1994) understanding and lack of coercion can be satisfied to a greater or lesser extent both sitting on a broad continuum from fully present to completely absent. Children can exhibit varying degrees of

both understanding and independence on this continuum, which may not satisfy the ability to make an autonomous decision.

Student:

> Talking about organ donation issues in the classroom made me realise that it is important to be aware who should be allowed to make the ultimate sacrifice and accept the risks. The potential donors understanding, their motives and the voluntary nature of the offer are so important. I did not realise all these had to be taken into consideration. It is so easy not to think about things too deeply.

In discussion with this student I became aware that the situation that the student had described had had a profound effect on her and that she could not believe that her opinion could have altered so much after this experience. During the course of our conversation I realised how necessary she felt the formal instruction in ethics she was undertaking was to her.

Student:

> This type of knowledge is as important as knowing about different disease processes and how to care for patients who are suffering from them. I would never have said that before. If you don't mind me saying I thought it was going to be a bit of a waste of time.

Judging what course of action may be in the patient's best interests can cause conflict in the health care setting. Students were asked to decide who they felt would be the most appropriate person to make the decision about whether a baby should be given life-saving surgery - the parents or the doctors. In response to this scenario, of the thirty students interviewed, twenty-six of them commented that they found responding to this question very difficult. The reasons for this difficulty ranged from the position of students who had children of their own and therefore were responding to the question in their role as parents primarily rather than as their role as a nurse, and those who thought that the decision could not be taken by one party alone but were still not sure whether one party should have the ultimate responsibility. The problems that arise with neonates that are born with conditions that require surgery in order to

ensure survival, are considerable. Their quality of life is likely to be compromised and a refusal of any intervention to prolong life may be considered to be the most compassionate course of action.

One student commented:

> When I considered this question initially my reaction was- I don't want to be asked this! On the one hand I really thought that the doctors should be the ones to take the decision for this child because they would have a better idea of how the condition could be treated and what the child's future life would be like. They would also be in a better position to know what could be done for the child in the future. The other part of me as a parent wanted to have the choice exclusively.

I asked the student why her initial reaction was to avoid the question and it became evident that she felt that she did not have the ability to deal with situations in which she was unable to detach herself emotionally from the issues involved.

Student:

> As a nurse I am unable to hide my head in the sand and not face decisions that I may be presented with. When I came back to address this question later on I still found it difficult but at least I now had a support mechanism. By that I mean a developing understanding of the mechanics of ethical decision-making and how you can work through the feelings that you have and make some sense of them. Ignoring things when you don't understand them is really an admission of lack of knowledge.

From the above comment it would appear that this student views the development of her knowledge in ethics as her support mechanism, which will continue to provide that support for as long as she needs it. Socrates (469-399 BC) suggested that some-one could not be said to be a responsible moral agent unless they possess self-insight. He also suggested that people begin to be wise when they admit their own ignorance. (Rouse, 1984). The researcher therefore feels it can be argued that the comment made by the student above demonstrates how the development of moral education provides the knowledge base for the development of competent ethical decision-making.

Campbell et al (1999) make the point that the legal profession is reluctant to become involved in these types of situations and rely on the joint decision taken by the parents and the doctor. It is important to act in a way that will remove some of the responsibility and guilt, which parents will inevitably feel when faced with a life and death decision. They must be helped to come to terms with the decision that must be taken to either prolong life or let it run its natural course. The action must also consider the limits of the medical profession in relation to such decisions because they should not be allowed to play God when dealing with the lives of others. However, the wishes of both the parents and the doctors must be weighed against what is best for the child. If we believe, as the researcher does, that the parents can often see more clearly than the doctors what is best for their child there can be situations where the parents will be suffering such anguish that they will not be in a position to make the right decision.

When interviewed at a later date the student made the following comment:

> *After being exposed to clinical situations for some time where I came across parents who were faced with hard decisions and continuing to study ethics in school especially issues surrounding medical paternalism I feel that I am in a much stronger position to face up to difficult situations I come across. As nurses we encounter so many potentially problematic situations that the ability to draw on an ever-expanding knowledge store is so necessary. The way that we can use our experience in the classroom situation means that the support is always there and eventually we won't need to use it as much.*

The famous case of Baby Doe in America led to amendments to the Child Abuse and Treatment Act (1984). The parents of this child who was born with Downs Syndrome refused life saving surgery and the child died as a result. The act mentioned above defined as child abuse the withholding of medically-indicated treatment from children. The definition of the above referred to all treatment that was likely to correct life-threatening conditions. There were

however three conditions under which this course of action would be optional. One of these stated that the provision of any treatment would be futile and inhumane.

Another student made the following comment about this question:

> I thought that the parents should make the decision about their child but when we talked about the principle of non-maleficence in school it began to make me think that maybe there were reasons why this was not the right decision. The child has a right but no choice in this situation. I think that the parents cannot take this sort of decision alone but it must be a joint decision with the medical staff. This action will ensure that the best interests of the child are satisfied.

The student here has been able to reflect on the decision he made initially because his developing knowledge has led him to re-examine the situation and consider the child which he admitted he had not given much thought to previously.

Student:

> It is very easy to focus on only part of the problem when you are fairly ignorant of how to view it. I just thought about the parents and the medical people and ignored the recipient of the consequences of the decision completely!

Beauchamp et al (1994) say that the most appropriate standard in the cases of patients who will never achieve competence is that of best interests which is judged by the best estimate of what a reasonable person would consider to be the most beneficial of the available options.

The questions, which are raised when patients request help to die, raise many extremely complex issues. Euthanasia is translated from Greek to mean a good or happy death. However there have been a number of interpretations of this term depending upon whether it is described by advocates or opponents. The former have described it as mercy killing, which fulfils the individual's right to die whereas the latter see it as little more than murder. As mentioned earlier

in the text voluntary euthanasia can be described as an individual's decision given freely to end their lives. If they request help from an outside agency it is known as assisted suicide. Non-voluntary euthanasia is described as a decision taken because an individual is terminally ill and there is no hope of recovery but the person is unable to be consulted about the decision and finally involuntary euthanasia which involves ending life without any consultation although the individual has the capacity to decide. There is also a distinction made between active and passive means. The former implies that a positive action is taken to end life, while the latter suggests that death occurs through omission.

Students were presented with a scenario in which the patient who is suffering from terminal cancer asks her doctors to help her to end her life. They were then asked to respond to a series of statements about the ending of life. The first of the statements was as follows: 'It is everybody's right to take their own life'.

During the interviews the researcher found that a significant number of students who had responded positively to the above statement would now respond differently as a result of their experiences both inside the classroom and in clinical practice. Eighteen out of thirty stated that their views had changed. Their comments are discussed below.

If someone reaches the conclusion that the quality of their life is so poor that they feel that life is no longer worth living either because they are suffering intractable pain, the prospect of their inevitable deterioration is too much to bear or they feel that they will become a burden to their loved ones, then assisted suicide seems to provide the answer.

Student:

When presented with the statement about end of life in the questionnaire I was in agreement with it because I wouldn't want anyone making decisions for me. While in practice I nursed a man who had been diagnosed with a degenerative neurological condition for which there was no cure. He was returning to the ward for reassessment two years down the line. In conversation he had said that he had wanted to die when he had been diagnosed and was angry when the decision he had made wasn't acted upon. Now he said he was so grateful that no one had agreed with his wish at that time and how fulfiling his life now was.

Here the student is presented with a situation in which the patient had undergone a change of heart. This made the student consider how, in the light of experience beliefs may alter and situations can be viewed differently.

Student:

This certainly showed me that consideration of ethical decisions must be taken seriously and what I think that I believe at the moment can be subject to change. As I am learning how to think through the process of making an ethical decision patients also need to be aware of the things to bear in mind before they commit themselves to a particular course of action.

Jonsen et al (1998) point out that patient requests for a quick death are frequently made in situations when the patient is suffering extreme stress. The appropriate management and the correct multi-disciplinary team approach can often alleviate this.

Another comment by a student demonstrated how, if voluntary euthanasia becomes freely available, patients could feel that it is a 'way out' if they are led to believe that they are creating an extra burden on their families.

Student:

An old lady I talked to was really worried because she was couldn't go back to her house because she could no longer manage. Her daughter had agreed to take her mother to live with her but the old lady was extremely distressed because her daughter was expecting another baby and was on her own and she did not want to add to her troubles. She felt if she could no longer cope she shouldn't be here.

The student who related the above scenario had agreed that it was everyone's right to take his or her own life. He now told me that this situation had made him doubtful about that decision. When I asked him the reason he said that if we all had that right then surely that brought a duty with it which he felt the situation he had experienced demonstrated.

Student:

> It is very easy just to agree with something because you feel it should be the case. As I have learnt more about ethics my understanding of the implications of any decision that is taken can be more long reaching than we know. This old lady almost felt obliged not to be here any more because of her situation. The decisions that are taken now can influence the conduct of society for years to come. I am beginning to see how naive my outlook and how narrow.

This realisation that the student shows in this statement is paramount the researcher believes, to his ability and the ability of his peers to become responsible moral decision-makers in the future. The acceptance of the practice of voluntary euthanasia could lead to grave social consequences and what is sometimes known as the classical 'slippery slope' argument. This argument maintains that once voluntary euthanasia becomes accepted practice it could easily escalate into compulsory euthanasia (Hunt, 1997). Even though strict controls are initially in place they will gradually become relaxed and then euthanasia can easily be extended to people whom, through no fault of their own have found themselves a burden to their families. Attempts have been made to legalise euthanasia in the United Kingdom. Thompson et al (2000) outline two arguments against, one of which has been outlined above. They also draw attention to a survey conducted in Holland in 1991, where euthanasia is legalised, showing that along with 4000 cases of assisted euthanasia there were also 1000 cases without evidence of a request from the patient. Frey (1998) reminds us that even if we were in a position to legalise euthanasia it would not be possible to prevent abuse. Vulnerable individuals

could be forced into making decisions that they did not wish to because it would benefit others. Frey feels it is better not to take any risks at all and leave the issue well alone.

The student concludes:

> *When we studied issues concerning euthanasia in college we looked at rights and liberties. I realised the importance of rights and duties and how each had an influence on the other. I found out the difference between moral and legal rights and how no right is absolute. This made me think about the right to die and the implications this has on other people. I would think carefully now about whether I had a right to die.*

This student went on to say that he had thought that a right automatically meant that others must comply and he felt that this viewpoint was likely to put pressure on others, which was unacceptable. In the clinical situation the researcher has experienced this pressure when patients have demanded the right to die. She believes that most nurses feel that their role is about sustaining life, not assisting in hastening death. The British Medical Council (BMA, 1999) also gives guidance on the moral principles that should guide practice. These guidelines suggest that the primary goal of medical treatment is to benefit the patient by restoring and maintaining health. If this is not possible then palliative care should be employed.

There were students who disagreed with the statement about the right to life because they felt the Christian tradition forbade individuals having the right to take their own lives. However they encountered situations in practice, which led them to question this belief. The sanctity of life doctrine regards human life as valuable and it must be respected irrespective of its quality and this is the essence of The Human Rights Act (1998). Life is a gift from God and does not essentially belong to the person; only God has the right to take that life away. An intentional act to end life goes against God's will and therefore is morally wrong. Life, viewed like this must be preserved at all costs. However Hendrick

(2000) points out that some people who believe in this doctrine concede that there are some circumstances where taking life may be justified such as self-defence.

Student:

> *I did not believe that anyone has a right to take his or her own life because that was the way I was brought up. When I went into practice I came across patients who were suffering from illnesses, which they would not recover from. I found myself thinking that I would not want to continue to live in that state. It really made me think about the helplessness of the situation and whether life should be maintained at any cost.*

In discussion with the student she admitted that she did not believe that the beliefs that she held could be altered by any situations she encountered.

Student:

> *I think I was being extremely blasé in my outlook. I probably never considered coming across a situation, which was so profound, it would lead me to have to question what I believed in.*

The realisation that fundamental beliefs may be challenged in unfamiliar situations is one that nurse's may face. The student above found that one of her beliefs - that of the sanctity of life - was challenged in a way she did not consider possible. Keown (1997) challenges the doctrine of the sanctity of life claiming that it does not assert that life is an absolute good but that life-prolonging treatment is not always the priority and there are circumstances where death is permitted. Therefore it is the quality of life, which becomes important. How quality of life should be defined has never been universally agreed because of its subjective nature and the changing opinions of individuals as they age.

The student continues:

> *In college we had time to talk about the situations we came across in practice. I was able to talk about these patients with my classmates and tutors. This was a very good way to bring our feelings out and hear*

what others thought. It allowed me the opportunity to explore and question what I thought I believed in without a second thought but now was quite unsure because I had seen situations that I had never experienced before.

The student here values the ability to return to the classroom situation and express her thoughts and feelings in respect of a situation, which, on her own admission has left her with a degree of uncertainty in herself. It is important that students develop the ability to explore their own personal and professional values and be able to distinguish between them (Stone, 1998).

Truth-telling was another scenario the students were asked to respond to in relation to patient diagnosis. The withholding of information from a patient that a relative feels will have unacceptable detrimental effects on them is, as the researcher is aware, a common problem in clinical practice. During the interviews the students showed an overwhelming change of opinion in relation to this scenario. Twenty-seven out of thirty felt that their initial response to the question was incorrect. Historically, revealing the truth to patients did not figure in the doctor-patient relationship:

> Deception is completely moral when it is used for the benefit of the patient (Leslie, 1954 p.854)

Although health professionals are unlikely to concur with this statement it does not mean that withholding the truth does not occur. Truthfulness is a virtue thought to be necessary for a fruitful interaction between the patient and the doctor. Kant (1724-1804) believed that whatever the consequences, telling the truth was an absolute duty of will. Bok (1978) says:

> Truthfulness in statements that cannot be avoided is the formal duty of an individual to everyone, however great may be the disadvantage accruing to himself or to another (p.38)

The responsibility for this falls to both parties and must be expressed in the relationship between the two in their communication, not just the avoidance of lying but not creating false impressions either. Understandably there is still

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hesitation on the part of the doctor to impart a bad prognosis to the patient, whereas the families often know. However, Campbell et al (1999) highlight the fact that surveys have shown that, of those consulted, the majority would prefer to be told directly what their prognosis was likely to be rather than being kept in the dark about the true nature of their condition and therefore being unable to trust those around them. Many authors including Palmer (1999) believe that Kant's position is rather inflexible especially when applied to the health environment. He considers the duty to tell the truth as a prima facie duty which can be overridden by a more compelling prima facie duty. There may be occasions when it might be better not to disclose all the facts because the patient may not be able to cope with knowledge of the situation, but to aim to conceal the information in the long term is not acceptable. According to Singleton et al (1995) a general justification for not telling patients the truth about their diagnosis is that it will cause great suffering and would lessen the quality of life they have left. The best person to judge which course of action is most beneficial is debatable. Therapeutic privilege allows the doctor to withhold information from the patient if it is deemed in their best interests to do so. The obligation here to tell the truth cannot be regarded as an absolute duty because it will produce adverse rather than beneficial effects.

Student:

> When I completed the questionnaire I thought that the GP should go along with the daughter's request because her mother would find it difficult to accept. I would probably have acted in the same way. When I had been out in practice I changed my mind because I worked with a patient whose relatives tried to withhold the truth and he then had very little time to settle his affairs before he died. I knew he was desperately upset by this and it made his last days very traumatic when they should not have been.

Faced with this question the student, identifying with the patient's daughter agrees with the decision she takes. It is only when she is presented with a similar case in practice that she realises the trauma that a patient can suffer as

a result of this course of action. The refusal to disclose information to patients deprives them of the power to be able to make the decisions they feel necessary about their life. If relatives intervene to try and prevent a diagnosis being given it causes further complications. The question must be raised as to whether the family have the authority to waive any claim that the patient may have to know their diagnosis, the possible prognosis and any other information which may be relevant to the patient's welfare. The ability of the family members to assess the impact of the news must be considered and whether they would be better able to do this than the health care professional.

Student:

> *I really feel that the experience of this patient I have mentioned made me think seriously about not telling patients the complete truth. We talked about this a lot in college and when I heard other stories from my colleagues it made me more certain that patients must face up to the truth. The opportunity to study ethics in college allows us to thrash out various topics. What I believed before I went into practice and what I believe now is obviously different. If I weren't able to come back to college and discuss why I had changed my mind I'd be in a state of confusion I think. I now know that ethics is about understanding why we think as we do.*

In returning to college this student had the opportunity to share her experiences with her colleagues. It could be proposed that this process has helped her to reinforce her opinions and put her experiences within the clinical environment into perspective when she mentions 'allows us to thrash out various topics'. She admits that her beliefs have altered since she went to work in practice and this situation can, according to Krawsczyk (1997) leave nurses feeling vulnerable and lacking in confidence. The delivery of the modules is organised in such a way that the students study ethics throughout their training. Three of the modules are delivered during the common foundation programme and the remaining two during the respective branch programmes. Apart from the first trimester the students spend a certain amount of time in the practice setting.

In trimesters two and three this comprises 15 hours per week. In trimester four the students are in clinical practice full-time. As they enter their respective branch programmes in trimesters five, six and eight the students return to practice two days a week. Trimesters seven and nine comprise full-time clinical practice. The organisation of the programme in this way allows students the opportunity to reflect on the experiences they have encountered in practice and as the above student comments this is important in order to give the support necessary both from her peers and the teaching staff.

Several students commented upon the ethical issue of truth-telling during the course of the interviews. Students were concerned about the withholding of information from patients and the position in which this placed the student. They were unsure as to how they should handle such a situation and develop an appropriate course of action. When information is withheld from an individual he or she is deprived of the right to exercise free choice in his or her own affairs. This deliberate act interferes with the autonomous process of decision-making and the patient can be considered as being treated merely as 'means' rather than an 'end' in him or herself. However, if the patient lacks the ability to be truly autonomous then withholding the information or only telling the patient a partial truth is seen as acceptable. It can then be seen as morally right for the doctor to take on the responsibility of decision-making. His expertise should take precedence over impaired autonomy Palmer (1999). Withholding the truth can then be seen as the means of achieving a result, which will be beneficial to the patient, a model known as benevolent paternalism.

Student:

> *Nurses are often in situations where patients ask them what is*
> *happening. It is important to know that there are reasons why patients*
> *have a right to be told and we now know those reasons. We also need*
> *to appreciate when a patient should not be told everything. This is quite*
> *a powerful position to be in.*

The above comment highlights not only the patient's need to know but also when it is acceptable not to disclose information that may be judged inappropriate at the time.

Student:

> I think it is so easy to be put in a situation in which you are not sure what is the right thing to say. It may be that here isn't a right answer. For me personally this is a frightening situation and once you have said it you can't take it back. I was really grateful that I had discussed this issue in college and had worked through some scenarios in which we explored what could happen in these kinds of situations.

When I discussed this further with the student she said that she had recently been faced with a patient who did not know his diagnosis and how she had been able to recall such a situation she had worked through in the classroom. The student continued:

> I thought back to the role-play we engaged in and although I still found it scary I knew what action I could take and because of that I did not appear so unsure in front of the patient.

It is now accepted that health care rationing will be inevitable (Grimley-Evans, 1997) Firstly, the population is composed of an increasing number of elderly people and the cost of continuing care is expensive, and secondly the influence of sophisticated technological and pharmaceutical advances are resulting in the treatment of conditions which were previously untreatable. Ridley (1998) points out the health care system is so successful it automatically raises expectations, which causes a rise in demand which continues to increase. The principle that is used to justify the allocation of the health care resources is the principle of justice or more correctly distributive justice. A document published in 1995 entitled Promotion of the Rights of Patients in Europe stated:

> Everyone has the right to such protection of health as is afforded by appropriate measures for health prevention and health care, and to the opportunity to pursue his or her own highest attainable level of health.
> (p.16)

However, how attainable is a right to health care in the practical sense? The allocation of health care resources is taken at both the macro level where decisions are taken about how to allocate resources within the health care budget, and at the micro level when there are only a limited number of treatments available. Decisions taken at the macro level will obviously affect the micro allocation because these decisions will determine how much money will be given to different areas of health care.

Campbell et al (1999) echo the thoughts of several writers when they make the observation that health is not regarded as a matter of individual preference and purchasing power. If we fail to distribute it fairly then issues are raised in respect of human rights and social justice. Society has an obligation to provide an adequate standard of health care as outlined in the 1948 United Nations Declaration of Human Rights.

It has been acknowledged over the past few years that policies introduced into the health environment have caused a nurse's experience of everyday nursing to be characterised by tensions, which have been described as theory-practice gaps (Rolfe, 1996). Stronach et al (2000) outline reasons why these tensions now exist in clinical practice. The introduction of 'quasi-markets' in health care they feel, have led to an undermining of nurses in their day to day functioning in relation to accountability and professionalism. There appears to be an increasing gulf between the drive to encourage nurses to strive towards a forum in which they can employ the educational initiatives they have been taught and the current health care system which is based on increasing patient throughput and financial constraints. The aforementioned authors have investigated three research projects sponsored by the English National Board in order to highlight the problems that can occur when " these reports introduce forms of utopianism reinstating the theory-practice gaps they sought to close

down" (p.155). Among the points made are the political divisions which create the knowledge gaps, the separation between a technical and a dialogic culture, and the difficulties that student nurses experience during practice placements due to the 'market effect' of current work culture. Stronach et al (2000) while appreciating the important contribution these reports make towards nursing knowledge illustrate certain aspects of these reports, which, they believe, can lead to a form of 'Utopianism' mentioned earlier. The above authors point out what they feel to be the weakness inherent in the three research projects. The authors of the first report Eraut et al (1995) have to a certain extent, ignored the micro political obstacles, which will have an important effect on the nursing reforms that they recommend. Phillips et al (1994) the authors of the second report in advocating a politically-neutral organisational culture, have created an even wider gap between reality and utopia, and Miller et al (1994) authors of the final report mistakenly believe that students will be able to resist the pressures placed upon them by their ability to use the reflective process.

The following scenario in the questionnaire asked students to opt for the health strategies of either Trust A or B both of which make different decision strategies as to how their limited funds will be allocated. This is a dilemma which reflects the political problems inherent in current health care. One of the results of these strategies is that certain groups of patients in either Trust are disadvantaged in different ways. The respondents were also asked to give reasons why they had chosen the particular course of action. These types of choices are common for health authorities today and there is no ideal solution.

Student:

> *I thought that money should be spent on a smoking cessation programme rather than heart bypass surgery because less people would need surgery in the future. I now think that making such a decision is not as simple as I thought. Justice is something I hadn't considered before I studied ethics and I certainly wouldn't have been*

able to justify why I'd taken the decision I had. That's quite frightening really.

The essential aspects of justice have been brought together in the theory of justice put forward by Rawls in the early 1970's. Since that time several philosophers including Daniels (1985) have tried to construct an approach to the allocation of health care that acknowledges established theories of distributive justice. However it was not until Doyal (1995) that a concrete illustration of a health care structure that was morally acceptable was produced. Doyle describes the ability of individuals to flourish as necessary for full participation in social life and for this as good a state of health as possible is a prerequisite. It then follows that the allocation of health resources is a moral obligation and they must be distributed in order to give people what Butler (1999) describes as a 'fair crack of the whip' (p. 85)

Doyle outlines how this would work in practice. He suggests shortfalls being evenly distributed across the services, people being treated according to relative need, a system of randomisation if necessary, curtailing of ineffective services, public debate and consultation and finally no consideration given to individual lifestyles.

Student:

> *When I had to decide whether money should be spent on preventative measures or surgery I thought immediately preventative measures. In practice when I was faced with a relative who needed heart surgery it stopped me in my tracks because even though I knew they had smoked years ago but now didn't, it could have contributed to their illness. I had made my decision in the questionnaire without much consideration I now definitely had to reconsider. There was more to this than a simple decision.*

This student then went on to say:

> *In class we learnt about the meaning of equal opportunities and how we should share the resources with people that lack them for the good of all. We were also able to look at whether individual circumstances*

allow them to access what is rightfully theirs. This has massive implications, which I had never considered. Studying ethics has really opened my eyes and made me think at a much deeper level if you know what I mean.

It can be argued that the above comment demonstrates the importance of allowing students to explore the meanings behind ethical principles as these are applied in practice. The student not only is beginning to think about the principle of justice in relation to equal opportunities but also how the decisions taken at the time can affect what may happen to other patients in the future. The two types of justice outlined above are the ability to be fair, that is attempting to give everyone equal opportunities and the ability to be fair in terms of equity so that different groups of individuals have equality of outcomes. To attempt to satisfy these demands is a most complex task. However it must be remembered that health care professionals can play a major role within society in influencing the debate about how health care can be a priority. Campbell et al (1999) are most insistent that health care professionals who refuse to acknowledge this role are depriving the people whose health care needs are at stake of an important source of insight and critical demand for change. Thompson et al (2000) say that the more professionals who enter the debate the clearer the picture of the areas that are in crisis.

> In facing up to the ethical responsibilities of dealing with groups of patients.... management and administration, public health and research...nurses should grapple with the tensions between autonomy and the common good, between respect for the rights of individuals and social justice (p.160)

During the interview the respondents were asked how they felt studying ethics had helped prepare them for their role as a qualified nurse. Nursing literature increasingly focuses on the endeavours of the nursing profession to become a profession (Joudrey et al, 1999). It has been observed from the 1960's that the

study of ethics pertaining to the specific occupation is one of the major characteristics defining a profession (Goode, 1960). The importance of teaching not only the application of ethics in practice but also the correct attitude is encompassed in the following statement:

> The novice enters the school with a set of values, which may change during the socialisation process to reflect the values the profession holds in high esteem (Du Toit, 1995 p.165)

The transition that students must make to become a qualified nurse cannot be over estimated. The pressures that the institution imposes are not the only consideration. The student must learn to handle conflicts that can arise when individual values do not agree with the values held by other colleagues or the institution itself. The ability to handle these situations is vital to allow the student to make as easy a transition as possible from their student status to that of a qualified nurse with all the accompanying responsibilities that brings. From the researcher's experience it is the inability to deal with patient and relative reactions to a variety of situations, from the terminally ill individual to the patient who has been waiting for an outpatient appointment too long. Although students will naturally respond to these situations they may not have the experience to think and react in an appropriate manner. The most common way in which the student nurse learns to adopt appropriate responses is to emulate the actions of experienced nurses around them (Benner, 1984). The researcher can remember the shock felt when she first encountered a colostomy and how matter of fact the nurse she was working with regarded it. Even though these feelings were overwhelming it did not seem acceptable to display such feelings and adopting the same attitude as one's seniors was the preferred course of action. There are advantages and disadvantages to this approach, which have been outlined by Thompson et al (2000). Learners can see an easy way to come to terms with what they encounter and how to cope

in such situations, but on the other hand they put at risk their initial sensitivity, a time when their personal morals dominated. They adopt the professional approach and it is likely that conflict can arise between what the student may wish to do and what they actually do in their role as a nurse.

Employees that work in any large organisation will fulfil certain roles. This is necessary because the general public will expect people who are working in those particular roles to exhibit the behaviours that they see as typical of that particular job (Holly, 1993). Therefore a nurse will be expected to stick to the rules that govern that role, and individualism will take second place. In the researcher's personal experience this can give rise to confrontational situations because there is an inability to fulfil a stereotype or compromise personal beliefs. Adopting a role does not mean that nurses must relinquish their values but they must learn to deal with situations when these values conflict with that professional role (Wade, 1999). It is these ethical situations that the student must be prepared to face.

As one student put it:

> I think that in the present climate it is essential that nurses understand and appreciate the massive role that ethics play in health care. Without the knowledge we walk into a minefield and don't even realise it.

Student:

> I felt that a lot of patients did not have much control over what happened to them when they were admitted to a ward. It seemed to me that the most intimate parts of their lives became common knowledge and that was considered normal.

A student, when first exposed to the clinical environment can often put themselves in the position of the patient more easily than the experienced nurse.

Student:

> *I find it quite easy to talk to patients and it is easy to become quite involved with their situation. I feel so sorry for some of their situations. The qualified nurses seem to deal with this a lot better and often say that I have to learn not to let things affect me so much because I will find that I will find it hard to get through the day!*

This ability to empathise with the patient is desirable but will not alter the situation because the student is frequently not in a position to influence the way the patient is being treated. When students qualify, this situation changes, and as a staff nurse they are able to direct care but their response to the patient may differ from their reaction as a student. It is often not from a personal level but from a more impersonal professional level.

As one student commented:

> *It will not be long now until I qualify and it is interesting how you become immune to unpleasant experiences. If you don't of course you wouldn't cope. Take a fungating wound - its still unpleasant but no longer can you appreciate just how awful it is for the patient because you don't experience that revulsion as you did when you first saw something like that for the first few times.*

The ability of nurses to distance themselves from difficult situations is, the researcher feels, necessary to some degree. As Thompson et al (2000) agree the student nurse values the feeling of security that goes with acting in a professional capacity when faced with difficult situations. To stand up and be counted for the expression of personal beliefs takes courage and an individual needs to be sure if they are in such a situation they feel that their moral judgements are sound.

> It takes a good deal of personal conviction and moral strength to speak out about things you believe to be wrong, or to stand firm on a matter of principle in the face of disapproval from the profession and the health care system. (Thompson, 2000 p. 34)

In the course of the interviews conducted with students it became apparent that the importance of the ethical preparation could not be overemphasised. As students continued their training the responsibilities, both personal and professional in the current health care climate were firmly etched in their minds. There was overwhelming agreement that the teaching of ethics was vital to ensure not only a smooth transition from student to staff nurse but to allow them the freedom to be able to make decisions in practice and defend those decisions when challenged.

Student

> *If I am to carry such onerous responsibilities for patient's well being then I know that I must possess the knowledge and skills to act as an advocate in the proper sense of the word. Nursing in 2001 is a challenge and therefore we must be prepared to meet it. Student to staff nurse occurs overnight.*

Student:

> *There were so many things that we discussed in class and acted out that I came across in practice. When I started I thought it was little more than a paper exercise to fill the curriculum. I don't think that now, it is one of the most important things we did because it was real and all nurses have to be a part of that.*

The first comment mentions advocacy and the student talks about using this in the 'true' sense of the word. When I questioned him about this he explained that he felt that nurses were the professionals in the best position to act as the patient's advocate. Thompson et al (2000) make the point that patient advocacy, the ability to be able to defend the rights of the vulnerable who are often unable to assert their rights, is necessary to satisfy the ethical principle of beneficence. This student also highlights the suddenness of the change from a student to a qualified professional. The nature of this change demonstrates the importance of adequate preparation to enable the student to make the transition and feel confident to meet the challenges that lie ahead.

The second comment displays great honesty from the student! It also makes a most important point. In discussion with her it became apparent that although she initially believed that ethics was a subject that did not bear any great significance as part of her training programme she found that it had increased in importance as she became exposed to clinical situations. This increasing relevance, the researcher believes, will create a lasting appreciation of the importance of ethics in health care and will provide her with knowledge that will remain intimately connected with everyday nursing practice. These two comments appear to demonstrate that the students are acutely aware of the importance of possessing a comprehensive knowledge base which will equip them to function as qualified nurses who are able to meet the demands which today's health service imposes on its employees. The ability to transfer their knowledge from classroom to practice is a vital part of their ability to develop into responsible practitioners.

CHAPTER EIGHT

CONCLUSION

In order to conclude this thesis it is necessary to consider several issues. Firstly, whether student nurses have begun to explore and develop their own personal freedom, accountability and responsibility, which are inherent within the concept of "agency", discussed in the introductory chapter. Secondly, whether the students feel that the inclusion of ethics in the curriculum has played an important role in preparing them for the process of moral decision-making and their role as a qualified nurse. Therefore the researcher must revisit the aims of the study and discuss to what extent these have been achieved and what conclusions can be drawn from the data collected. It is also important to address the limitations of the study that would have an influence on the impact of the thesis.

The first issue to consider is that of the concept of personal freedom, accountability and responsibility inherent in the concept of "agency". To become 'an agent' as described by Harre (1983) is to feel that one is in the possession of the ultimate power of decision and action. He argues that the possession of this characteristic must be the ideal position for the nurse faced with an ethical dilemma. Kant (1724-1804) asserted that there were three fundamental beliefs; these were a belief in God, a belief in freedom and a belief in immortality. He viewed freedom as one of the foundations of ethics and necessary for giving people moral responsibility for their actions. Downie (1971) suggested that the freedom that was necessary for moral action was that of self-determination, through which we need to be able to understand our own limitations and the constraints put upon us by our environment. We also

need to be able to reflect on past experiences, visualize the likely outcomes of our actions, choose the appropriate resources and understand what the probable causes of a situation might be.

Freedom, as defined by Husted et al (1995), is self-directedness, meaning the agent's capacity and consequent right to take independent actions based on the evaluation of the situation. Freedom is an essential part of what the authors have called the Symphonological Bioethical Theory, a system of interpersonal ethics based on the terms and presuppositions of an agreement.

In the health care setting this agreement establishes the nature of the relationship between the patient and the professional, and recognises the role of the health care professional as the agent of the patient (see Appendix 7).

Scruton (1994) describes responsibility as one of the most important features of life because without it we would be unable to manage the intricacies of human relationships. Today the meaning of the term responsibility is more complex according to Giddens (1999). Leaving aside the idea of legal responsibility and focusing on moral responsibility Giddens describes this as the judgement and decision-taking in matters of right and wrong. It is based on the individual's freedom to be able to use their judgement as they see fit. It follows therefore, that if personal freedom cannot be exercised, then the individual does not possess full moral responsibility. For a nurse her personal responsibility is not only to herself but also to her patients, colleagues, the profession and society at large. (Rumbold,1999)

Thompson et al (2000) outline six criteria that an individual should possess if they are to be designated a responsible person. Among these are the ability to

acknowledge a moral obligation and the capability to act as an independent moral agent. They agree with Rumbold (1999) that a nurse should possess personal, fiduciary, professional and civic responsibilities. Personal responsibility is defined as responsibility for actions taken with appropriate knowledge of the obligations inherent in that responsibility; fiduciary responsibility is that arising from the trust both the patient and society place in the nurse; professional responsibility or accountability is that vested in nurses by their governing bodies who are society's representatives, and civic responsibility is that which relates to membership of a public institution using public money.

> To be a nurse requires the willing assumption of ethical responsibility in every dimension of practice...the nurse enters a partnership of human experience where sharing moments of time ...some trivial and some dramatic...leaves it's mark forever on each participant. The willingness to enter with a patient that predicament which he cannot face alone is an expression of moral responsibility; the quality of moral commitment is a measure of the nurse's excellence. (Levine, M E 1998 p.54)

This statement, in the researcher's opinion, demonstrates the importance of the role of the nurse and how her ability to accept and handle moral responsibility competently is an essential part of his or her professional duty.

The relevance of moral development to ethical decision-making is generally accepted in the literature (Benjamin et al, 1987;Guillett et al, 1996;Stone,1998) and these authors agree that in order for moral development to take place students must be in a position during their training to enhance personal freedom and become aware of their responsibilities and accountability. The themes that were drawn from the data will be discussed below. The researcher would wish to propose that that comments made by students show that they are demonstrating development of freedom, responsibility and accountability within clinical practice in relation to ethical situations they have encountered.

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One of the themes drawn from the data gathered focused on the complexities of the ethical situations that students were faced with. According to Holly (1993) the understanding of the impact of an ethical dilemma is essential in order that nurses can develop an awareness of their responsibilities when involved in these situations. The researcher would wish to propose that the ability of students to recognise the inherent complexities in these situations demonstrates that this understanding is beginning to emerge.

The following are comments from two students:

> I thought that a decision to withdraw active treatment from a patient who was extremely ill would be really easy. Surely the Consultant in charge of the case would be able to instruct everyone involved ceasing treatment, as he knew best. All the differing opinions from so many people made it an almost impossible task. The relatives were violently opposed to the cessation of treatment and therefore there was a stalemate situation or so it seemed to me. (p.89)

> I witnessed the admission of a woman who had caused an accident because she was over the limit. At the same time the occupants of the car she hit were also admitted and one of them was quite badly injured. I felt very angry towards the woman who had caused the accident and felt that she didn't deserve treatment.

> I wondered how I would react to seeing the woman who had caused the accident. Part of me knew that I would have to appear professional and ignore it all but when she asked how the occupants of the other car were I had to leave. Luckily there was a qualified nurse with me so I didn't have to face that situation. (p.105)

In discussion with the students regarding the above comments I discovered that they were becoming aware of the numerous standpoints that can create complications in any ethical decision. The growing awareness of the students to the many facets that make up an ethical dilemma can be illustrated by the following comment. Students recounted a number of different instances, one of which is outlined below, which serves to illustrate that due to the nature of ethical problems, taking a decision quickly can ultimately lead to a course of action which could be detrimental to the patient.

I looked after a young boy who had been trapped in a shed when it had caught fire. He was very badly burned and there was not much of his body that had escaped injury. His genitals had been destroyed and the medical opinion was that the boy's quality of life would be so poor and his level of disability so great that maybe it would be better not to actively treat him.

I thought that it was very wrong to impose personal opinions onto a young boy who may well have a full and worthwhile existence. This was a decision taken quickly and I felt there was much more to discuss. Who are we to say that treatment will or will not be given in a particular situation. Are health care professionals there to do that? Could I be in that position one day? My life may not be considered worth fighting for.
(p.120)

The students also began to become aware of their role within the health care team and how personal responsibilities are affected by the dynamics of the group. They found that they were beginning to be able to question actions taken by other members of the team.

When there is a meeting on the ward to discuss the patient's care no one seems to agree about anything. There is sometimes confusion about the way forward.

I was involved in the care of a patient who was unable to make a decision for himself; the team members had different views as to who should take responsibility. Little communication took place except between staff from the same disciplines that complained about members of another discipline. I felt sorry for the patient who got no action - right or wrong (p.92)

This girl was desperate to be able to stop her treatment and was so upset when she felt no one was listening to her. I told her I would listen and try to bring her point of view to the attention of the staff. I knew it was important to see both sides of the argument (p.147)

Fiduciary responsibility as mentioned earlier refers to the consequences or results of an action, which includes acts and omissions. If a nurse is working as part of a team and another member of that team is found to be negligent then the moral responsibility may still be hers. Although the traditional role of nurses has not been to question decisions taken in practice this has been

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changing over the last few years but it is still acknowledged by many nurses that challenging decisions in clinical practice is a risky business. Thompson et al (2000) observe that there are certain issues that nurses are most concerned about in relation to responsibility. These tend to be related to their sphere of personal responsibility when giving patient care or in the management role rather than issues that are beyond their control. They highlight areas such as truth telling and confidentiality as well as conflicts with doctors or relatives. The comments made by several students seem to bear this out.

> *The patient I had previously been talking to happened to mention the fact that she had not told the doctor something, which she felt, would be relevant to her condition. She said that she felt that the doctor would blame her for her present situation. I was not sure what I should do. If I said anything I would be breaking her trust in me (p.100)*

> *It turned out later on that week that the relatives had become very upset when they found out that the patient had been told his prognosis by the doctor. They demanded to know why this had happened. The doctor told them that the patient had asked directly and therefore he had told him. I was pleased that this had happened because the patient was more at ease. I also felt that if the patient was not told I would be partly responsible for that as I was looking after him (p.110)*

The comments below serve to illustrate how the students are starting to question the decisions that are taken in practice about patient care and treatment either by health professionals or relatives.

> *Before you look at the subject of ethics in nursing and then go out into the clinical environment I guess you look to people with experience and believe that the decisions that they take are the right ones without really thinking about it too deeply (p.162)*

> *I felt the family could not come up with a good enough reason why he should not take the action he wanted except that they wanted him to be around in their lives. Were they thinking of him or themselves?(p.157)*

I would argue that this type of questioning is evidence that the students are beginning to exercise their freedom and their awareness of their moral responsibilities. If these situations arise, the nurse's responsibilities will be a direct result of the decisions of others. It follows therefore, as Randall et al

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(1991) point out, that ethical dilemmas that exist in practice, which may initially

have been the responsibility of another member of the health care team, will

still be the responsibility of the nurse but in a different way. However, it is

apparent from comments made, that the students recognise that as nurses

they do have power over the patients they come into contact with, which

increases with experience.

> *Nurses are often in situations where patients ask them what is*
> *happening. It is important to know that there are reasons why patients*
> *have a right to be told and we now know those reasons. We also need*
> *to appreciate when a patient should not be told everything. This is quite*
> *a powerful position to be in (p.178)*

In the researcher's experience this power can be exerted in areas such as

observations, both physical and psychological, and the day-to-day

management of the ward routine. These are the areas in which nurses are

morally responsible for their patients and they can often be forgotten when

more dramatic ethical problems occur. The ability of nurses to be able to

develop their moral reasoning skills is essential if they are to become

professionals who can make competent ethical judgements.

In 1987 Benjamin and Curtis made the following observation:

> Traditionally, nurses have been discouraged from developing and
> acting on their own ethical judgements. Although the institutions of
> nursing and medicine developed separately until the late eighteenth
> century, the increasing importance of the hospital in health care brought
> nursing under the dual command of physicians and hospital
> administrators (p.39)

Accountability and responsibility are often discussed together as they have

been here, but some writers regard accountability as different from the concept

of responsibility. Accountability is about justifying one's actions. Dimond

(1995) distinguish three types of accountability: legal, professional and moral.

A nurse may act in such a manner as to compromise her professional

accountability but she may have satisfied her moral accountability to a patient. It follows therefore, that always acting in a professionally-correct way can mean that actions are not morally right. The process of accountability is summed up in the UKCC (1996) Professional Guidelines as:

> Weighing up the interests of patients and clients in complex situations, using professional knowledge, judgement and skills to make a decision.

Accountability follows from the responsibility that society places on the nurse in her role as a member of a profession. It is often the case when talking to nurses that they feel responsibility for their patients in relation to the care they are giving but they will also feel responsible or accountable to them as well. Therefore if things go wrong blame can be apportioned although not often attached to the individual but to the profession as a whole. Comments made by the students showed clearly in several instances that they were quite aware of the potential conflict that can occur when moral and professional accountability comes into conflict. The wish to maintain patient confidentiality and the need to impart that information to a third party was one example given.

> *I was in a dilemma, do I keep the patient's confidence or do I tell the doctor who has a right to know the truth if he is going to administer the correct care? If something goes wrong then I would be held to account (p.101)*

It is important if nurses are to enhance their moral development that they are aware of how ethical dilemmas that are dealt with in practice, can affect society at large. (Singleton et al, 1995). A moral consensus is inherent in all societies and this is necessary for the normal functioning. It will change over time and develop as the society develops. There will always be ethical issues that have the potential to alter our moral environment, which a society will either accept or reject. Recently a decision has been taken by the British Government to ban scientists from continuing to experiment with human cloning techniques

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(Holmes, 2001). Individuals or groups of like-minded people may rebel and try to change certain moral convictions held by others such as the pro-abortion lobby. Society will change and adapt to alterations in moral thinking as long as these ideas do not 'fly in the face' of the basic assumptions of human nature. However it is important to consider the evidence from the media that strongly suggests there is now a much wider variety of moral opinions and a greater tolerance of behaviours than there has been in the past. It is now far more acceptable to express beliefs that may only be acceptable to a minority and for these beliefs to become part of the moral fibre of society. As mentioned in Chapter one we are in the midst of a technological revolution in health care, which is gathering pace, and as a result the values that others hold can be many and varied. If this is the case then it must become more difficult to maintain what Beauchamp et al (1994) describe as the traditional moral viewpoint.

Thompson et al (2000) use paternalism as an example of a value that no longer holds credence with the general public.

> This shift is associated with greater respect for the value of self-determination (or autonomy) and the related ideal of human rights - especially the rights of women and minorities. Also involved in this change is an emphasis on the individual which favours such values as self-expression rather than self-sacrifice, tolerance rather than conformity, and flexibility rather than strict obedience to moral rules.
> (p.13)

One of the major themes that has arisen from the data collected from the students is the influence that particular ethical situations in practice have on society at large. Among the comments that were made ones about the patient's right to choice in relation to smoking before surgery, the right to determine end of life decisions and the right to know why decisions about the allocation of scarce resources have been taken in the way that they have.

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The patient needed surgery as a direct result of his smoking habit. The surgeon eventually refused to operate and the patient was sent to enroll in a smoke-stop clinic. If he stopped smoking then he could come back to be reassessed for the surgery to take place (p.114)

I was working on a ward where there was a patient who had been suffering from cancer for several years. He had undergone a lot of treatment, some of which was very unpleasant with dreadful side effects he told me. I asked him why he was in hospital this time and he said the doctors wanted to try a new form of treatment on him to assess the effects although they could not say whether it would benefit him or not. His family was very keen for him to have it but he was not. He did not want any more medical interventions. He said he felt like a child who had to be looked after all the time and it was not living (p.97)

An elderly man on the ward I was on was suffering from renal failure that he had had for a long time. His condition was deteriorating which was why he had ended up on the ward. He needed renal dialysis but there was a shortage of beds for this treatment and the doctors said that he was being considered together with a younger man who had a young family. It turned out that the younger man received his dialysis first. I had never thought about patients not being able to have the treatment necessary before. I took it for granted (p.122)

These comments made by the students reflect the issues that Thompson et al (2000) mention as the ones attracting current contemporary concern within the clinical environment.

The variety of moral values that now exist will inevitably cause conflict not only between individuals but also between different cultures. In the multi-cultural society of Britain the health service may well see an increasing number of conflicts arising about whose moral values should have priority. A comment made by one student, the researcher felt, was appropriate to include in this concluding chapter.

I am a Muslim and I must admit I was not sure how I would approach patients in the hospital environment. There were the same fears as I am sure all new nurses have going into a strange environment but for me it was more than that. Having been brought up as a Muslim I have different moral values I suppose and therefore I am bound to view situations differently. Is this fair to patients who are not from my background?

Hinman (1998) discusses what he calls The Identity Argument in which he outlines two premises. In the first he advocates that what is morally right depends on one's identity as a moral agent. In the second he argues that one's race, ethnicity or culture is central to one's identity as a moral agent and therefore what is perceived as morally right depends to some extent on the individual's race, ethnicity or culture.

It is widely acknowledged that a major hurdle to ethical decision-making today is the variety of values that are held by individuals and these must be taken into account when a decision is contemplated in order to avoid the conflict that may follow (Husted, 1995; Diamantides, 2000; Butler, 1999).

The second issue to address is the value of the ethics modules in the development of the student's decision-making skills and their preparation for qualification. There are a variety of educational methods that have been used to teach ethics to nurses which have ranged from formal instruction on the classical theories to student-led classes in which the personal clinical experiences are used as a basis for discussion. Holt et al (1999) question whether educationalists are really teaching ethics and feel that a distinction needs to be made between what is meant by moral guidance and what is meant by teaching ethics. The authors argue that moral guidance on how to act is more suitable for the *primary school* classroom *and instruction on the* critical evaluation of the beliefs and arguments behind ethical issues is more appropriate to students of higher education. The researcher would agree to a certain extent with this philosophical approach but, as the authors point out, an understanding of the construction of rational argument is essential to the student's ability to master this approach.

Work undertaken by Emmett in 1966 identified four factors that she felt must be taken into consideration in ethical decision-making. These were the specifics of the situation, the roles of the participants, the applicable ethical rules and the organisation to which we are accountable. Authors including Downie (1971) realised that all these factors must be taken into consideration. Martin [writing in] (2000) highlighted the importance of personal commitments and ideals which he believes will motivate, guide and give meaning to the work that nurses do.

A study was undertaken in Korea in 1999 by Han et al to evaluate student nurses' participation in ethical decision-making after undertaking a course in ethics and this suggested that the students were able to identify moral issues and could apply principles to particular situations.

The students who were the subjects of this study undertook the ethics modules at various points during their nurse training. They were exposed to a variety of teaching and learning methods, which have been outlined in chapter three. These included a case study approach, where students were asked to comment on an ethical dilemma and make a judgement about the moral worth of the decision taken, and story telling as a means of allowing them to begin to comprehend the complexity of ethical situations. This less-formal approach was balanced by a basic theoretical foundation in philosophical ethical theory. Holt et al (1999) states:

> There is a valuable and effective role for practical case-study material based on students' personal experiences, in other suitably adapted actual case material, or in wholly fictitious (though plausible) examples. These need to be addressed within a framework of analysis, which helps to make the issues manageable, by novices (p.249)

Thompson et al (2000) outline four approaches to teaching ethics in the professions which they classify under the following models. These differing approaches aim to develop the skills necessary to enable an individual to make a responsible ethical decision. The first of these is the moral instruction school that focuses on instruction-based codes of ethics and rules. The second is known as the ventilatory school which emphasizes not just the rational approach mentioned above, but also how an individual feels about an ethical dilemma, the third is the critical thinking school which, while recognising the importance of the rational aspects of ethical decision-making also emphasizes the need to ground that decision in the demands and circumstances of the specific situation. The final approach known as the situation-based ethics school focuses on an individual's ability to attend to the specific situation and attempt to address that situation in the most appropriate way relevant at that point in time. The authors above recommend that when teaching ethics it is necessary to use a combination of the teaching methods taken from the different models.

> Taken together they are capable of illuminating different aspects of our moral experience and helping us to learn the different kinds of insight and skills that are relevant to responsible decision-making. (p.262)

Comments made by the students who took part in the this study about the value of the ethics teaching they received, demonstrated that their confidence had developed considerably in that they felt able to offer opinions as a valued member of the health care team and on occasion stand up for what they felt to be right though other members of the team did not always agree.

> *I found that I was able to offer an opinion when I was asked which I could not have done previously. An example I could use was an incident concerning confidentiality. A patient divulged information to me, which he said he did not want his wife or the doctor to know. I remembered from college that confidentiality is not an absolute*

obligation and therefore there would have to be good reasons to keep it quiet. One of the exceptions to the rule of confidentiality is to do with justice and if the information is likely to affect some one else as it was in this case then it should be disclosed. I had to make a decision about what I would do. I told the patient that I might have to divulge what he had told me (p.139)

I said I did not agree and the patient had a right to know that he would be randomly selected to one group or the other. I attempted to explain why and found I was able to justify my case quite well. I had an argument on my hands though...my colleague argued that if the patient wants to benefit from the research he has a duty to assist in it. Eventually we did explain to the patient we could give no guarantees about receiving the drug and he still agreed to participate and said he was glad we had sat down to discuss both sides of the argument with him (p.142)

Further comments from students showed that the use of a framework for ethical decision-making allowed them to work through a particular problem in a clear and logical manner so that they were able to explain to a colleague why certain actions should be taken.

It is becoming much clearer to me now that it is important to think through a situation in a logical fashion in order to make a responsible decision. I could see why using a model for ethical decision-making like the one we used in the classroom was a good idea. Even though you didn't realise it you begin to think in a more logical fashion. I seem to be developing the skill to be able to stand my ground and defend what I believe to be right. I don't jump to conclusions so quickly (p.164)

Understanding and being able to rationalise decisions taken by patients can lead to difficulties for the student nurse who finds it hard to come to terms with an ethical decision that they sometimes are unable to comprehend. The ability to stand back and view both sides of the argument and be able to understand why individuals think as they do is a vital skill for nurses. Students' comments illustrate that they are beginning to recognise the fact that situations should be seen from both sides so that a balanced view can emerge.

I can't justify making a decision about something if I have not considered all the avenues. That would be blinkered and irresponsible. (p.150)

I found it very difficult to come to terms with this course of action by the mother because she was deliberately deceiving her child. What if the surgeon had taken a different course of action here? Saying that I had been taught to stand back and consider situations. I was challenged but when I did stand back and think about the issues at stake I came to the conclusion that consideration of both points of view was essential in order to adopt a rational approach to the situation. I was glad I had been able to practice in class in a pretend scenario even though I forgot that learning initially! (p.154)

Student comments regarding the perceived worth of the ethical teaching in preparation for their role as a qualified nurse were positive and students felt that the modules were an essential part of their professional development.

I think what also helped me to act in the way that I did was the fact that I had to give a presentation in class to the other students and the things that could happen when a patient told you secret information had to be discussed. This was an exercise in problem solving where the problem was defined, the relevant principles identified, the options considered and what would be the outcomes of these, choosing one and then evaluating what the results were. Therefore I had been in this situation in my head already so to speak. My classmates asked me some awkward questions after the presentation so I did have to think about it quite hard! (p.140)

A study conducted by Valamaki et al (1999) showed that in order to produce qualified nurses who have autonomy and authority it is important to ensure that students develop self-determination. The findings from Valamaki's study indicated that self-determination was important for students and that they were willing to exercise this during their training. Therefore the ability to offer students more freedom of choice and the opportunities to make their own decisions during the education process will help to improve their skills and *ability for learning.*

At this point it is necessary to revisit the aims of the study and discuss to what extent these have been achieved and what implications the conclusions drawn will have on the future education of nurses and their subsequent clinical practice. The study set out to address three aims. The first two will be

discussed together and the third separately. The first aim attempted to analyse the opinions of student nurses about ethical issues before they were exposed to clinical practice and before they commenced studying ethics in college. I wished to explore how students would react when presented with hypothetical ethical scenarios. The second aim attempted to examine their opinions in relation to the aforementioned scenarios after exposure to clinical practice and also ethical situations, which they encountered as part of their daily work. When commencing this study I felt a certain degree of trepidation due to the potentially sensitive nature of the material but also excitement and curiosity as to the data that would be generated. The students provided a wealth of information, which allowed me the opportunity to examine and establish relationships from the data. Students who completed the questionnaire before exposure to clinical practice responded to ethical scenarios as described in chapter seven. After time spent in practice the responses that the students gave when interviewed about the same scenarios were very different. Their outlook had changed quite dramatically. Comments indicated that this was due to their interaction with patients whose dilemmas were not dissimilar to the scenarios. This led them to question the decisions they would now take presented with the same scenarios contained in the questionnaire. It became clear to the researcher when examining the data that there was a strong relationship between the students' experience in clinical practice and their re-examination of the questionnaire scenarios.

> *Before you look at the subject of ethics in nursing and then go out into the clinical environment I guess you look to people with experience and believe that the decisions that they take are the right ones without really thinking about it too deeply (p.162)*

> *I realised when I had responded in the questionnaire I thought that a relative does have an obligation and therefore it would be wrong not to decide to donate whatever age within reason. Faced with the situation I described I would have serious doubts about children donating because*

this child was scared and upset because she felt great responsibility for her sisters illness (p.165)

When presented with the statement about end of life in the questionnaire I was in agreement with it because I wouldn't want anyone making decisions for me. While in practice I nursed a man who had been diagnosed with a degenerative neurological condition for which there was no cure. He was returning to the ward for reassessment two years down the line. In conversation he had said that he had wanted to die when he had been diagnosed and was angry when the decision he had made wasn't acted upon. Now he said he was so grateful that no one had agreed with his wish at that time and how fulfiling his life now was (p.171)

Students felt that their initial reactions to the ethical situations presented in the questionnaire were a result of a spontaneous reaction without any reasoning behind the choice.

In the light of the data collected from this group of students it can, the researcher believes, be proposed that the exposure of students to what can be called 'real life' ethics alters their outlook in relation to decisions that the students take and the choices that they may make.

The third aim sought to analyse student opinion about the value of the ethics modules that they were undertaking throughout their training and how they felt these contributed to enabling them to deal more effectively with ethical situations in the practice setting. Again the researcher was presented with a large amount of data, which allowed her to conduct analysis and establish relationships. Students often commented that the classroom learning experiences with which they were involved proved to an invaluable tool on which they were able to draw when in clinical practice.

I realise now that there is nothing wrong with having my own opinions about things but I am learning to recognise that what I feel is best from my point of view may not be what the patient feels is best for them. Studying ethics, especially the appreciation of individual rights has shown me that there are alternative ways of looking at situations. It is easy to become very blinkered and feel affronted when someone doesn't agree with you (p.151)

This type of knowledge is as important as knowing about different disease processes and how to care for patients who are suffering from them. I would never have said that before. If you don't mind me saying I thought it was going to be a bit of a waste of time (p.166)

I really feel that the experience of this patient I have mentioned made me think seriously about not telling patients the complete truth. We talked about this a lot in college and when I heard other stories from my colleagues it made me more certain that patients must face up to the truth. The opportunity to study ethics in college allows us to thrash out various topics. What I believed before I went into practice and what I believe now is obviously different. If I weren't able to come back to college and discuss why I had changed my mind I'd be in a state of confusion I think. I now know that ethics is about understanding why we think as we do (p.177)

I thought back to the role-play we engaged in and although I still found it scary I knew what action I could take and because of that I did not appear so unsure in front of the patient (p.179)

The students were able to reflect on these experiences and used the learning as a reference point from which they could defend arguments and logically think through the implications of any decision, which was taken, and how such a decision had been arrived at. The researcher would therefore propose that the learning that took place began to instill in the students the necessary awareness of the many facets that comprise even the simplest situation, which contains an ethical component. The knowledge, which they had begun to accumulate, had provided them with the basis of informed ethical decision-making skills.

It is important to acknowledge the limitations inherent in this piece of work, as these will have an influence on the impact of the study. The sample comprised a group of students who were all studying at the same educational institution. Therefore this made them a discrete group and it is accepted that the larger the sample the more representative of the larger population it is and the sampling error will decrease as the sample size increases. (Crookes et al, 1998). The homogeneity of the group selected will also have an influence on the sample

size and the students chosen were all embarking on their nurse training within the same educational institution. Therefore it could be argued that a small sample size is sufficient. (Roberts et al, 1989). It must be acknowledged that a degree of sampling bias is present in all sampling strategies; the important issue however is whether or not the bias is enough to negate the conclusions drawn from the study. Within this study the researcher can identify several issues, which could lead to bias within the chosen sample. The particular population used consisted of four cohorts of students. However this represented only a small number of the total number of students who were entering for training over the period of time of the study. The conclusions drawn from the study could therefore only represent the opinions of this group of students and if the researcher had chosen to undertake the same study at a later date the study may have suggested different results. One also must be cautious about making claims about other institutions that train nurses. If the same area were investigated elsewhere in order to generalise from this work, its applicability to the new setting would need to be established. The students that were chosen to be interviewed were chosen by a process of random sampling. Using this method it must be acknowledged that students varied in several aspects including age, gender and previous experience. These variables could influence the reaction of students to the ethical issues they encountered and also their perceived value of the teaching input.

During the interviews that took place as part of the data collection process potential sources of bias occurred which merit discussion. My role both as a researcher and a lecturer was perhaps at times difficult for the students. The interviews were primarily conducted within the university setting and in this environment the students could have felt that I was primarily in a position of authority. They would see me more in the role of the lecturer rather than the researcher. In conversations I had with the interviewees I was aware that some

of the students were not being completely honest in their answers or they were providing me with the type of answer that they felt that I wanted to hear. The nature of the material that was under discussion during these sessions was, at times highly sensitive and, as a researcher, I had to be aware of the effect this would have on the student as well as recognising that some elements of the descriptions that were related to me would be difficult to include in the study. Between the students who were interviewed there were differences in the amounts of information volunteered. Therefore judgements had to be made about when it was legitimate to draw conclusions.

My dual role while conducting this study could have been responsible for behaviour changes that took place in the classroom. As previously mentioned I participated in several of the lectures given over the period of the study. The students were aware of my identity and, because of this, it is difficult to ascertain whether the students' learning experiences, and hence their perception regarding the value of the modules, would have been different if I had chosen not to participate.

The principal reason behind the choice of this study was to try to explore the impact of ethical dilemmas on a group of student nurses and how this could affect their practice. The study has also attempted to evaluate a series of modules on ethics that were introduced for the first time in the nursing curriculum with these groups of students. Taking account of the limitations discussed above, I have been able examine and analyse the opinions of the students both before and after their exposure to the clinical environment with some interesting insights from their point of view as new recruits into the health environment. The evaluation of the ethics modules again revealed some interesting data. However, the evaluation will only be as good as the present group of students and in the researcher's experience different groups of students can evaluate educational programmes in very different ways.

Notwithstanding, this, I believe the conclusions that can be drawn from the data generated is that the students felt that a grounding in ethics was an essential part of their nurse training and would continue to be of value throughout their nursing careers. The researcher feels that the importance of the teaching of ethics cannot be denied in the light of the comments made by students throughout this study.

> *I think that in the present climate it is essential that nurses understand and appreciate the massive role that ethics play in health care. Without the knowledge we walk into a minefield and don't even realise it (p.186)*

> *The opportunity to be able to discuss the impact of ethical situations and how any decisions taken in those situations will affect different parties is essential. I feel that the preparation I have had in the classroom has given me an excellent insight into potential ethical issues in practice that I would have been unaware of before (p.166)*

> *When we studied issues concerning euthanasia in college we looked at rights and liberties. I realised the importance of rights and duties and how each had an influence on the other. I found out the difference between moral and legal rights and how no right is absolute. This made me think about the right to die and the implications this has on other people. I would think carefully now about whether I had a right to die.*
> *(p.173)*

There are implications for both the educational and nursing fields that arise from this study. The effect of the realities of ethical situations that arise in clinical practice can be readily seen from the comments within this study. Those who carry the educational responsibility for tomorrow's nurses must be ever vigilant to the consequences of a rapidly-changing, technologically-sophisticated health arena, which is continually pushing back the boundaries of the possible against a background of financial constraints. This will inevitably give rise to more and more complex ethical problems in which nurses are predominately at the forefront. Bearing this in mind a question that can be asked is whether it is possible to adequately prepare nurses to be ethically competent? What does the teaching of ethics equip a student with and if

anything does this preparedness ensure that they cope with ethical dilemmas more effectively? Educationalists must realise that the way that a student views his or her benefits from ethics teaching will change constantly. Therefore what is taught as part of basic training, although it may appear to be effective at the time, will not provide the student with the ability to deal with future situations as their sphere of responsibility changes. Therefore it is important that education in ethics continues long after qualification in order that the initial grounding these students have received will be built upon to continue to influence the nature of practice and produce a practitioner who reflects the characteristics of a professional (Rafferty, 1996).

The developments and changes that are taking place in nursing, not least of which is a profession trying to redefine its own boundaries in the light of its place within a multi-disciplinary team, will change the scope of nursing ethics. Nurses are taking on more extensive clinical roles and with them greater responsibilities for health care decisions. This is likely to mean that these nurses will require assistance in order to meet these challenges. Among these, I suggest, will be a deeper relationship with society generally, a closer interaction with the media and the political arena. However it must not be forgotten that the everyday moral problems, which are inherent in nursing care and treatment, must be addressed by the majority of nurses.

The role of nursing in the 21st century will inevitably undergo change in response to a health service, which is continuing to experience dramatic developments. Nursing is now a profession in its own right with a university-based education and a developing research base for practice (Bandman et al, 1995). It would appear that nursing in Britain is seeking to emulate the American model where patient management is the role of nurse specialists and specialisms are medically orientated. It is interesting that thirteen years ago Dingwall et al (1988) made the following comment:

> If we ask who will be standing beside the patient's bed in the year 2000,it is difficult to resist the conclusion that it will still be the handy woman class in the new guise of support workers (p.56)

Nursing is a young academic discipline, which is producing nurses who have a sense of identity and increasing confidence. Ellenchild-Pinch et al (2000) draw our attention to the fact that in a discipline such as nursing, that has a strong clinical focus, bioethical teaching is essential. They feel that students achieve the skills in identifying ethical issues and dealing with them during their educational experiences. They do this by having the opportunity to be heard, to have freedom of choice and to relate their learning closely to clinical practice. In the future the development of ethics teaching will, the researcher believes, encompass new technology and students will use web-based discussion software programmes and on-line conferencing. This will allow students greater freedom to interact with a larger group. Blake (1997) highlighted the fact that nurses need more opportunity for ethical reflection and this need continues throughout their nursing careers. This system could become available, not just as part of a recognised course in ethics, but as a point of access for all members of the health care team who feel the need to discuss ethical issues and share views and resources. In this way they can become exposed to a variety of different perspectives, which may help to clarify issues that are being questioned.

Nursing, in attaining professional status, demands the possession of a code of professional ethics and the evidence that it can be applied, monitored and evaluated in the clinical environment.

It is hoped that this research may have contributed to the debate in professional ethics in nursing, by highlighting some features of ethical decision-making in nursing. Some of these features are as follows:

1. Nurses need increasingly to be aware of the characteristics of a situation requiring ethical judgements, and to be sensitive to the complexity of such situations.

2. Ethical dilemmas are often in practice resolved by teams of health workers who all contribute a viewpoint.

3. Nurses are regularly in situations where they face ethical dilemmas, e.g. whether to inform a patient in full, about their clinical condition.

4. Nurses may often face a conflict between their moral judgement on an issue, and a competing professional responsibility.

5. Nurses are often involved in ethical issues which have implications for wider society, e.g. whether patients who continue to damage their own health through smoking, should have any limitations put on their treatment.

6. Formal tuition in ethical decision-making appears to give nurses confidence in their opinions, and also helps them to address an ethical dilemma logically.

7. Tuition also helps nurses to realise that there are often many different ways of viewing the same ethical issue.

Therefore to conclude this thesis the researcher wishes to revisit a comment made by a student that she feels sums up the importance of ethical preparation for clinical practice.

> *This role as the 'gate keepers' of ethical practice must apply to everyone and not just to those who study ethics full time.*

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APPENDICES

Introduction to Law and Ethics in Nursing Practice

APPENDIX 1

Module Code	HPA 209
Scheme	Human & Health Sciences Undergraduate Scheme
Schools involved in delivery	Human & Health Sciences
Name of Pathway	Dip. HE Nursing Studies
Module Tutors	C Quashie, D Machin, V Wilbourne, S Shaw, B Spencer, P Cranmer, F Goonoo
Module Status	Dedicated
Module Type	Compulsory
Module Rating	Pre-Foundation 10 Credits
Learning Methods	Lectures, tutorials, seminars and directed studies - 24 hr Unsupervised activities - 51 hr
Pre-Requisites	None
Recommended Prior Learning	None
Co-Requisite	None
Professional Body Requirement	Compulsory for Dip HE Nursing Studies UKCC Rule 18 (a) Statutory Instrument
Barred Combinations	None
Module Grading	None

Module Aims

This module introduces the students to the ethical and legal principles which guide the development of accountable professional practice in health care.

Module Synopsis

It lays the foundation for the student's development of awareness of ethical and legal issues as components of health care practice. It also introduces the student to the structures within which health care is provided and an appreciation of the role professional standards play in guiding conduct expected of health care practitioners.

Outline Syllabus

Ethical duties, moral goodness
Beneficence and non-malificence
Consequentialism - law
                                - moral
Professionalism
Code of Conduct
NHS organisation
Misuse of Drugs Act

Learning Outcomes

On completion of the module the student will be able to:

Knowledge Outcomes

1.   Identify how ethical principles can guide the care of people with health care
        needs.
2.   Describe how legal processes inform professional practice in health care
3.   Identify how the professional Code of Conduct guides the nurse
4.   ·Describe how health carers organised in order to meet the needs of society

Ability Outcomes

1.   Identify specific examples of health care structures and the special need that
        they meet.

Assessment Strategy

Evidence

Students written response to a series of 'sentence completion tests'.

Assessment Criteria

1.   Five sentences will require responses which recognises ethical principle
        (Knowledge Outcome 1).
2.   A further five of the sentences to be completed will involve identification of a
        legal basis for professional practice in health care (Knowledge Outcome 2).
3.   Five other sentences will require completion with items from the UKCC Code
        of Professional Conduct.
4.   Another five sentences will be required to identify the structure in which
        health care is provided (Knowledge Outcome 4, Ability Outcome 1).

Assessment Weightings

Pass/Refer/Fail

Learning Strategy

Lectures/debates
Discussions/seminars
Tutorials
Directed study
Reading

Indicative Reading

Cooke & Aughton (1990) *The Common Law Obligations* Pan Books
Dimmond B (1995) *Legal Aspects of Nursing* 2nd Edition Prentice Hall, London
Haralambos M (1994) *Sociology: Themes and Perspectives* Bell & Hyman
Jonsen A R & Siegler M & Winslade W J (1998) *Clinical Ethics* McGraw-Hill
Tchudin V (1994) *Deciding Ethically* Bailliere Tindall
UKCC (1992) *Guide for students of Nursing & Midwifery* Portland Place, London

Justice and Rights in Nursing Practice

Module Code	HFA 209
Scheme	Human & Health Sciences Undergraduate Scheme
Schools involved in delivery	Human & Health Sciences
Name of Pathway	Dip. HE Nursing Studies
Module Tutors	C Quashie, D Machin, V Wilbourn, S Shaw, B Spencer, P Cranmer, F Goonoo
Module Status	Dedicated
Module Type	Compulsory
Module Rating	10 FoundationCredits
Learning Methods	Lectures, tutorials, seminars and directed studies - 24 hr Unsupervised activities - 51 hr
Pre-Requisites	None
Recommended Prior Learning	None
Co-Requisite	None
Professional Body Requirement	Compulsory for Dip HE Nursing Studies UKCC Rule 18 (a) Statutory Instrument
Barred Combinations	None
Module Grading	None

Module Aims

This module aims to enable the student to develop an understanding of the ethical principles of justice and rights. It also introduces the student to elementary understanding of trespass and characteristics of care organisation.

Module Synopsis

It extends understanding of ethical, legal and structural issues in the context of an individual and organisational approach to care. It also introduces the concept of confidentiality in health care practice.

Outline Syllabus

Justice as fairness, as equality
Rights theory
Truth telling
Consent
Confidentiality
Offences against the person
Concept of organisations, types and functions eg centralised, decentralised

Learning Outcomes

On completion of the module the student will be able to:

Knowledge Outcomes

1.   Describe the principles of justice and 5rights and how these apply to individuals in health care practice.
2.   Examine truth as an ethical issue in health care practice
3.   Explain "trespass to the person" and how it relates to consent during interventions with the client.
4.   Describe the characteristics or organisations and relate these to health care in different health care settings.

Ability Outcomes

1.   Examine confidentiality in relation to patient information and how this guides practice in different care settings.

Assessment Strategy

Evidence

Oral presentation (10 minutes) on a teacher selected situation.

a)   The content of the presentation will require discussion of justice and the rights of the individuals (Knowledge Outcome 1 & 3).

b)   The material will require students to demonstrate recognition of truth as a moral issue and how individual rights might be acknowledged within the health care organisation (Knowledge Outcomes 2, 3 and 4)

c)   The discussion will, as part of the issues, consider the respect of confidence in the handling of care information (Ability Outcome 1)

Assessment Criteria

General criteria for oral presentation at Foundation level will apply (see Appendix 14)

Assessment Weighting

Pass/Fail

Learning Strategy

Lectures/debates
Discussions/seminars
Tutorials
Directed study
Reading

Indicative Reading

Armstrong, P & Dawson C (1989) People in Organisations. Elm Publication
Dimmond B (1995) Legal Aspects of Nursing, 2nd Edition. Prentice Hall
Gillam, R (1985) Philosophical Medical Ethics, John Viley & Sons, Chichester
Holliday, I (1995) The NHS Transformed, Baseline Books
Jonsen, A R, Siegler, M & Winslade, W J (1998) Clinical Ethics, McGraw-Hill
Tchudin, V (1994) Deciding Ethically, Bailliere Tindall

Introduction to Management and Duty of Care

Module Code	HFA 217
Scheme	Human & Health Sciences Undergraduate Scheme
Schools involved in delivery	Human & Health Sciences
Name of Pathway	Dip. HE Nursing Studies
Module Tutors	C Quashie, V Wilbourn, S Shaw, B Spencer, P Cramner, F Goonoo
Module Status	Dedicated
Module Type	Compulsory
Module Rating	Foundation 10 Credits
Learning Methods	Lectures, tutorials, seminars and directed studies - 24 hr Unsupervised activities - 51 hr
Pre-Requisites	None
Recommended Prior Learning	None
Co-Requisites	None
Professional Body Requirement	Compulsory for Dip HE Nursing Studies UKCC Rule 18 (a) Statutory Instrument
Barred Combinations	None
Module Grading	Not Graded

Module Aims

This module aims to extend the student's understanding of a moral and legal 'duty of care' and the role that they play in the delivery of care. It also introduces the student to concepts of management and associated schools of thought.

Module Synopsis

It will enable the students to recognise their own value systems and begin to learn to take decisions with understanding of ethical principles and obligation in law.

The module also introduces the student to management to enable them to identify its effect in clinical practice.

Outline syllabus

Ethical decision making - paternalism
- liberalism
Moral duty to care
Negligence - duty of care

Management schools of thought eg human relations and administrative management.

Learning Outcomes

On completion of the module the student will be able to:

Knowledge Outcomes

1.   Discuss how ethical principles can be utilised to influence decisions made about people in different care environments.
2.   Discuss how the principles of moral duty to care can inform decisions people make.
3.   Explain how an understanding of negligence should inform actions practitioners take when delivering care.
4.   Describe different concepts of management thinking and how these apply to the care of people in health care settings.

Assessment Strategy

Evidence

Oral presentation of negotiated client management, ethical issue.

a) Content of the presentation will include references to the effects ethics can have on decision making in particular care environments. (Knowledge Outcome 1).

b) The presentation will include discussion in ethical decision making and negligence in health care practice. (Knowledge Outcome 2, & 3).

c) Information presented will require the student to identify management ideas that form the framework within which care is delivered to the clients in their current clinical placement. (Knowledge Outcome 4).

Assessment Criteria

General criteria for oral presentation at Foundation level will apply (see Appendix 14).

Assessment Weightings

Pass/Refer/Fail

Learning Strategy

Lectures / debates
Discussions / seminars
Tutorials
Directed study
Reading

Indicative Reading

Callahan J C (ed) (1988) *Ethical Issues in Professional Life* Oxford University Press
Dimmond B (1995) *Legal Aspects of Nursing* 2nd Edition Prentice Hall
Gillon R (1984) *Philosophical Medical Ethics* John Wiley & Sons, Chichester
Jonsen A R & Siegler M & Winslade W J (1998) *Clinical Ethics* McGraw-Hill
LaMonica E (1994) *Management in Health Care* McMillan
Mullins L (1996) *Management and Organisational Behaviour* Pitman
Tchudin V (1994) *Deciding Ethically* Bailliere Tindall

Leadership in Nursing Practice

Module Code	**HAA 219**
Scheme	Human & Health Sciences Undergraduate Scheme
Schools involved in delivery	Human & Health Sciences
Name of Pathway	Dip. HE Nursing Studies
Module Tutors	C Quashie, B Spencer, P Cramner, F Goonoo
Module Status	Dedicated
Module Type	Compulsory
Module Rating	10 Credits A
Learning Methods	Lectures, tutorials, seminars and directed studies - 24 hr Unsupervised activities - 51 hr
Pre-Requisites	Completion of CFP
Recommended Prior Learning	None
Co-Requisites	None
Professional Body Requirement	Compulsory for Dip HE Nursing Studies UKCC Rule 18 (a) Statutory Instrument
Barred Combinations	None
Module Grading	Graded

Module Aims

This module aims to develop the student's knowledge and skills to understand and apply the principles of work organisation, leadership and change in care setting whilst recognising the relationship that exists between the nurse employee and the employer

Module Synopsis

It aims to help the student understand how the nurse contributes as a member of the health care team and the nurses role in organising reading and managing change.

The module also helps the student to define legal and professional frameworks in which nurses take responsibilities as employees.

Outline syllabus

Teams and Leadership styles.
Leadership Roles, Expectations and Situations
Power and authority in professional practice.
Work design
Type of work.
Skill mix.
Employment contract
Change and Change Management

Learning Outcomes

On completion of the module the student will be able to:-

Knowledge Outcomes

1. Appraise the role of leadership in health care settings and use principals derived from this to facilitate and supervise individuals and work teams.
2. Explain different characteristics of work and apply these to achieve a balanced mix of clinical skills
3. Evaluate the legal relationship that exists between the nurse, the employer and the duties it imposes on both parties.
4. Evaluate a theory of change as it affects task, people and technology and explain   the role the nurse in managing change.

Assessment Strategy
Evidence

Essay - 2000 words. An essay which discusses and element of care which demonstrates how the contractual obligation of the leader in the ward situation enabled change to be managed.

a)   The material will require students to explain ideas behind the mixing of skills to enable clinical functions to be effectively accomplished. (Knowledge Outcome 1).

b)   The work will also require the student to examine how clinical care is facilitated by team leaders. (Knowledge Outcome).

c)   Discussion will be expected of the legal duties imposed on nurses and their employers during the delivery of care to clients. (Knowledge Outcomes 3 & 4).

d)   The essay will also require the student to discuss a process and management of change in a clinical setting.

Assessment Criteria

General criteria for written assessment at advanced level will apply (see Appendix 15)

Assessment Weighting

100%

Learning Strategy

Lectures/debates
Discussions/seminars
Tutorials
Directed study
Reading

Indicative Reading

Beauchamp, T.L (1994) Principals of Biomedical Ethics (4th ed), Oxford University Press, New York
Dimmond, B (1995) Legal Aspects of Nursing. (2nd ed). Prentice Hall
Dimmond, B (1997) Legal Aspects of Care in the Community. Macmillan
Haralambos, M (1994) Sociology: Themes and Perspectives. Bell & Hyman
Hunt, J W (1992) Managing People at Work. McGraw-Hill
Mullins, L (1996) Management and Organisational Behaviour. Pitman

Accountability and Responsibility in Nursing Practice

Module Code	HAA 223
Scheme	Human & Health Sciences Undergraduate Scheme
Schools involved in delivery	Human & Health Sciences
Name of Pathway	Dip. HE Nursing Studies
Module Tutors	C Quashie, B Spencer, P Cranmer, F Goonoo
Module Status	Dedicated
Module Type	Compulsory
Module Rating	10 Credits A
Learning Methods	Lectures, tutorials, seminars and directed studies - 24 hr Unsupervised activities - 51 hr
Pre-Requisites	Completion of CFP
Recommended Prior Learning	None
Co-Requisites	None
Professional Body Requirement	Compulsory for Dip HE Nursing Studies UKCC Rule 18 (a) Statutory Instrument
Barred Combinations	None
Module Grading	Graded

Module Aims

The module aims to consolidate student's understanding of accountable nursing intervention and the responsibility nurses owe to themselves as employees and for their own continuing life-long professional development.

Module Synopsis

The module focuses students on the legal relationships that exist between nurses, patients, employers and the UKCC. It also develops in the student an appreciation of

the need to maintain care standards and sensitivity to changes in social and health care policy that impact on their personal practice..

Outline syllabus

Concept of formal accountability
Domains of formal accountability
Criminal Liability
Civil Liability
Employee Responsibility
Professional Accountability
Clinical Supervision and Peer review
PREPP/Scope of Practice
Concepts of clinical quality and standard settings

Learning Outcomes

On completion of the module the student will be able to:-

Knowledge Outcomes

1. Explain the framework of formal accountability to which a nurse is subject..

2. Discuss the patient's main sources of legal liability on nurses during interventions with clients.

3. Explore the relationship that exists between the nurses as employees and their employers.

4. Explain how nurses ensure that their practice accords with the requirement of the UKCC.

5. Appraise personal practice and take appropriate action to develop and maintain professional standards

Assessment Strategy

Evidence

Oral presentation (15 minutes) of negotiated nursing situation

a) The student will discuss aspects of formal accountability in nursing (Knowledge Outcome 1).

b) Explain how legal liability as an issue was dealt with (Knowledge Outcome 2).

c) Aspects of the presentation will focus on employment as the basis of the nurses clinical practice. (Knowledge Outcome 3).

d) The discussion will require students to identify the role of UKCC in the maintenance of professional conduct (Knowledge Outcome 4).

e) Issue of personal professional standards and development emanating from reflection on the material presented (Knowledge Outcome 5).

Assessment Criteria

General criteria for oral presentation at advanced level will apply (see Appendix 15).

Assessment Weighting

100%

Learning Strategy

Lectures/debates
Discussions/seminars
Tutorials
Directed study
Reading

Indicative Reading

Dimmond, B (1995) Legal Aspects of Nursing. (2nd ed). Prentice Hall
ENB (1995) Creating Life Long Learners; ENB, London
Hunt, J.W. (1992) Managing People at Work; McGraw-Hill
Kennedy, I. & Grubb, A. (1994) Medical Law, Cases and Materials, Butterworth
Mullins, L. (1996) Management and Organisational Behaviour; Pitman
DoH (1992) The Patient's Charter; HMSO
Sales, D (1996) Quality Assurance in Nursing. Macmillan
UKCC (1989) Exercising Accountability: UKCC, London.
UKCC (1992) The Scope of Professional Practice; UKCC, London
UKCC (1992a) Code of Conduct for Nurse, Midwife and Health Visitor (3rd ed) UKCC, London
UKCC (1992b) Code of Professional Conduct, UKCC, London

Interrelationships in the clinical framework

Protective responsibility (virtue)

Respect (act)		Respect (virtue) Relationship (virtue)

Obligations	Consequences		Interpretation and valuation

Ethical decision

The ethical decision-making

Ethical framework	Personal experience	Organisation

Ethical perception

Ethical reasoning

Technical information	Ethical decision

Consideration of practical possibilities

Final decision

Implementation through organisation (with the possibility that the action may be changed)

Holm S (1997)

The DECIDE model for ethical decision-making

D – Define the problem(s)
What are the key facts of the case? Who is involved? What are their rights, your duties? What is the main ethical problem to be addressed?

E – Ethical review
What ethical principles have a bearing on the case and which principle or principles should be given priority in making your decision?

C – Consider the options
What options do you have in the situation? What alternative courses of action? What help, means and methods do you need to use?

I – Investigate outcomes
Given each available option, what consequences are likely to follow from each course of action open to you? Which is the most ethical thing to do?

D – Decide on action
Having chosen the best available option, determine a specific action plan, set clear objectives and then act decisively and effectively.

E – Evaluate results
Having initiated a course of action, monitor how things progress, and when concluded, assess carefully whether or not you achieve your goals.

Thompson et al (2000)

ETHICAL DILEMMAS IN PRACTICE

The following questionnaire aims to investigate the attitudes of student nurses to possible ethical dilemmas which may arise in clinical practice.

It will form part of a research project which the author is undertaking as part of the Doctorate in Education. The data gathered will be used together with other data to ascertain the changing attitudes of nursing students to ethical problems which they may encounter during their practice.

The questionnaire is anonymous in order to protect the anonymity of the participants.

Please read the following instructions before completing the questionnaire:

1. Tick one box only per question.

2. Please make comments or give reasons for your choice where requested.

QUESTIONNAIRE

1   Are you:

        Male   ☐

        Female   ☐

2   Are you aged:

        Over 50 years   ☐

        41-50 years   ☐

        31-40 years   ☐

        21-30 years   ☐

        Under 21 years   ☐

3   Before commencing your nurse training were you:

        At school   ☐

        At college   ☐

        In employment   ☐

        Unemployed   ☐

        If employed please state nature of employment:

4   Educational qualifications:

        None   ☐

        CSE's   ☐

        'O' levels   ☐

        'A' levels   ☐

        Degree   ☐

        Other   ☐
        (please specify):

5   In which of the following categories of ethnic grouping would you choose to place
        yourself:

        White   ☐   Chinese   ☐

        Black   ☐   Indian   ☐

        Caribbean   ☐   Pakistani   ☐

        Black African   ☐   Bangladeshi   ☐

        Asian   ☐   Other   ☐

6   What is your belief system, if any?
        Please state:

        Christian   ☐

        Muslim   ☐

        Hindu   ☐

        Sikh   ☐

        Buddhist   ☐

        Atheist   ☐

        Agnostic   ☐

        Other   ☐
            Please state:

The following questions outline ethical dilemmas which may arise in clinical practice. Please read them carefully and respond.

7 Mr X is admitted to hospital for an operation on his left leg, for which consent was obtained. During the operation the surgeon found that the right leg also needed surgery which he duly performed. The surgeon was correct to take this course of action even though the patient had only consented for surgery on his left leg.

Please indicate whether you agree/disagree that the surgeon was correct to operate on the right leg without consent.

Strongly agree	Agree	Not sure	Disagree	Strongly disagree
☐	☐	☐	☐	☐

8 Mrs Y has been suffering from progressive kidney failure for the last 3 years and requires frequent visits to hospital for dialysis. Her doctor has recommended a kidney transplant because he feels she will not survive more than 6 months on her current treatment. Her husband, brother and sister have been tested and found to be unsuitable matches, however, her 14 year old son has roved to be compatible and wishes to donate a kidney to his mother.

Tick the option you prefer most, should he:

a) Be allowed to donate because he is suitable match and available immediately ☐

b) Not be allowed to donate because he is only 14 years old and may not appreciate the risks involved. ☐

c) Only be allowed to donate if no other suitable match can be found in time. ☐

d) Not be allowed to donate even if no other suitable match can be found in time. ☐

e) Only be allowed to donate with the consent of his mother ☐

9   Baby B was born with a condition known as spina bifida which requires immediate surgery in order for survival. The parents who have an older child aged 5 years wished to refuse the surgery maintaining that survival is not in the baby's best interests as he would be unable to walk and would be incontinent. The surgeons wish to perform surgery in order to ensure survival.

Should: .

a) The parents be allowed to take this decision about their baby given   ☐
   that they will be the main carers during the infant's life with another
   child who may be disadvantaged due to the demands made by a
   handicapped sibling. They will also be the ones in the best position
   to judge their child's quality of life.

b) The physicians/surgeons be allowed to take this decision given that   ☐
   they will be acting in the best interests of the child and therefore
   upholding Baby B's right to an operation which would save his life
   even though he would be left severely physically handicapped.

or

c) Describe in detail an alternative option:

_____

_____

_____

_____

_____

_____

_____

10   Miss C, a 42 year old teacher has been diagnosed with terminal bladder cancer 2 years ago. Since that time she had been in increasing pain and now, due to the cancer spreading to her spine she is unable to get out of bed or even sit up without being in great pain and discomfort. She has expressed a wish several times for doctors to assist her to end her life but they are reluctant to agree.

Please indicate your opinion about the following statements by placing a tick in <u>one</u> of the boxes for each of the following questions:

		Strongly Agree	Agree	Not sure	Disagree	Strongly Disagree
1	It is everybody's right to take their own life.					
2	It is morally wrong to end life on purpose.					
3	No-one should be obliged to participate in assisted suicide.					
4	Health professionals should do everything they can to keep patients alive for as long as possible.					
5	Health professionals have a duty to fulfil the patients wishes even if this includes assisted suicide.					
6	Assisting in suicide can be seen as letting die and not killing.					

11   Due to financial constraints Trust A have decided to opt for a policy of preventing heart disease through a programme of health education rather than treating individuals who need heart bypass surgery or heart transplants. They believe spending money on the prevention of smoking will result in less people suffering from heart disease in the future and therefore less demand on surgical services shortening waiting lists for other types of surgery.

With the same financial constraints Trust B have decided to continue to treat patients who need heart bypass and transplant surgery as they believe each person has a right to be treated irrespective of their behaviour ie smoking which may have contributed to their present condition. However, this will mean that patients awaiting other types of surgery may have to wait longer for their operations with which Trust policy do you agree? Please give reasons for your choice.

_____

_____

_____

_____

_____

_____

12   Mr D has suffered from progressive liver disease for 15 years due to alcohol abuse. He now requires a liver transplant in order to survive. The surgeon has informed Mr D that he will only operate if he gives up alcohol completely otherwise the new liver will be damaged. Mr D has reduced his alcohol intake considerably but has been unable to give up completely.

With which statement do you mostly agree, should:

a) The surgeon continue to refuse surgery until alcohol consumption has ceased completely however long it takes.   ☐

b) The surgeon operate because Mr D has reduced his alcohol intake.   ☐

c) The surgeon not take Mr D's alcohol intake into consideration and operate regardless.   ☐

d) The surgeon wait to see if Mr D can give up alcohol completely within 6 months risking the possibility that he might die from advanced liver disease in that time.   ☐

13   Mrs M accompanies her 62 year old mother Mrs S to the General Practitioner because she has been suffering recent memory loss and Mrs M suspects that her mother may be suffering from Alzheimer's disease which causes slow deterioration of mental functions, increasing confusion and disorientation and eventually death. In private Mrs M pleads with the GP not to tell her mother if the test is positive because she feels it will destroy any reasonable life she has left.

On confirmation of the diagnosis the GP sees Mrs S and when she asks about her diagnosis the GP tells her that she is as fit as she was 10 years ago and her memory loss is just a result of advancing years.

Was the GP correct to act in this way?

Yes   ☐

No   ☐

Unsure   ☐

Please give reasons for your choice:

_____

_____

_____

_____

_____

_____

_____

14   Mr and Mrs R have a daughter aged 7 who suffers from leukaemia and will need a bone marrow transplant in the near future to cure her disease. Mrs R and other family

members are tested but are not suitable donors. Mr R is also tested and found to be compatible but he asks the doctor in confidence to tell his wife and relatives that he is also incompatible as he is too scared to undergo surgery to remove his bone marrow but does not want his relatives to know this.

In relation to the above case please indicate your opinion about the following statements.

		Strongly Agree	Agree	Not sure	Disagree	Strongly Disagree
1	Information given in confidence should never be disclosed whatever the circumstances.					
2	Information given in confidence should be disclosed if there is the probability of harm to someone else.					
3	It should be the health professionals decision to decide to disclose confidential information if he/she feels it is appropriate.					
4	Confidentiality equals trust.					
5	The general public expect health professionals to maintain their confidentiality.					

Thank you for tasking the time and trouble to complete this questionnaire. On completion could you please return it by hand to either your cohort tutor or Pat Bowers, Room 3-32 Harold Wilson Building, University of Huddersfield.

INTERVIEW SCHEDULE

The following summarises the main topics covered in the ethics modules:

- Ethical Principles
- Moral Goodness
- Justice and Rights
- Consent/Confidentiality
- Duty of Care
- Paternalism
- Leadership
- Change Management
- Accountability
- Responsibility

The Ethical issues outlineD in the questionnaire covered the following topics:

- **Informed consent**

  A surgeon operating without prior consent when finding a further problem at the time of surgery

- **Organ Donation**

  The issues surrounding a child donating a kidney to his mother as the only compatible relation and his wish to donate

- **Clinical Paternalism verses parental choice**

  Surgeon's decision to operate on a baby with spina bifida when the parents do not wish any intervention.

- **Euthanasia**

  A patient diagnosed with bladder cancer who is now in the terminal stages of the disease and wish to end their life.

- **Allocation of Scarce Resources**

  Allocation of trust funds in relation to patients who need expensive surgical interventions.

- **Patient's Rights**

  Patient lifestyle influencing their disease process and whether this should dictate how their treatment progresses.

- **Truth-telling**

  How the amount of information given to a patient about their diagnosis can be influenced by relatives who feel that it is not appropriate to tell the patient the whole truth.

- **Confidentiality**

  Information given in confidence to a doctor which the individuals feels should not be divulged even if this compromises professional duty.

a) In the light of the ethics modules you have studied do you have any comments on any ethical issue which has arisen in the course of your practice?

b) Do you feel that your responses to the ethical dilemmas outlined in the questionnaire have altered since your exposure to the clinical environment?

c) Do you feel your studies in ethics has helped prepare you for your role as a qualified nurse? If so, how?

STATISTICS

Test one

A test of association was performed between age and the student response to a statement about the right of each individual to take their own life.

The age range was divided as follows:

Under 21, 21-30, 31-50 and over 50.

This test showed that there was no significant difference between the various age groups.

Chi-square = 9.681, df = 6, p > 0.05

A study undertaken in 1990 by Blanchard found that older people were more accepting of death and did not believe that it was their right to decide when it should end. Another explanation of these results may be the fact that the majority of students were aged between twenty-one and thirty, and a much smaller number were aged forty or more. This may have made it more difficult to demonstrate an actual association.

Test Two

A test of association was also performed between gender and the student response to the statement regarding he right of each individual to take their own life. This showed that there was no significant difference between males and females.

Chi-square = 9.681, df = 6, p > 0.05

These results are interesting because from previous experience of questioning students in relation to this issue the researcher has found that attitudes appear to differ between males and females. In discussion with students in the past it became apparent that males seem to be in favour of euthanasia both for themselves if the occasion arose and also for members of their family to prevent unnecessary suffering. Females felt that they may have responsibilities to others and this would lead them to consider whether they had the right to decide about their death.

Test Three

A test of association was performed between age and the response to the question regarding a decision between the policies of two health authorities: one that had chosen to invest in preventative measures in relation to smoking and the other that had chosen to continue to treat patients irrespective of their previous behaviour. This test showed that there was no significant relationship between age and the student's response.

Chi-square = .822, df = 3, p > 0.05

Documents such as ' Our Healthier Nation ' (1998) set ambitious targets for the prevention of disease and premature death but unfortunately there has been little impact on the incidence of teenage smoking. Butler (1999) points out that generally, young people realise that education about health will have its

advantages in older age and will lead to a diminished need to access health care in later years.

Test Four

A test of association was performed between student age and the agreement to transplant. The age ranges have been outlined in Test One. This showed that there was no significant difference between age and the agreement to transplant. Chi-square = 8.520, df = 9, p = > 0.05

The researcher thought that the students that were likely to be parents would be in the older age groups and therefore be more defensive of the parental decision regarding donation.

Test Five

A test of association was performed between gender and the need to consent before further surgery. This test showed that there was no significant difference between males and females.

Chi-square = .406, df = 2, p = > 0.05

The researcher thought that there would be a difference between the sexes in response to this question as she has, in discussion with other students found this to be the case.
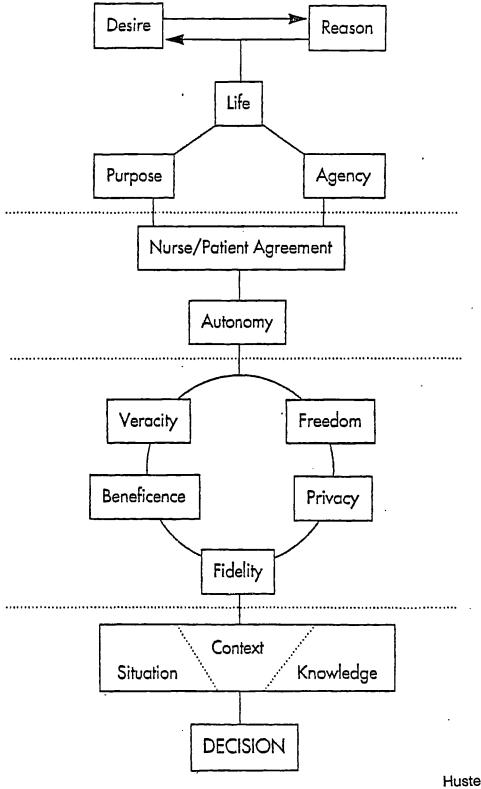
Test Six

A test of association was performed between age and the need to obtain consent for further surgery. This also showed that there was no significant difference

between the younger and older age groups.

Chi-square = 3.267, df = 9, p = > 0.05

The researcher thought that the students in the latter two age groups would have been more likely to have come into contact with the Health Service, either as a patient or as a relative of a patient. If this had been the case these individuals would have been more likely to have experienced the issue of informed consent.

HUSTED'S BIOETHICAL DECISION-MAKING MODEL II