Title

Faithful to the good

Author

Liaschenko, Joan,

Publication Date

1994

FAITHFUL TO THE GOOD: MORALITY AND PHILOSOPHY IN NURSING PRACTICE

by

Joan Liaschenko

DISSERTATION

Submitted in partial satisfaction of the requirements for the degree of

DOCTOR OF PHILOSOPHY

in

Nursing

in the

GRADUATE DIVISION

of the

UNIVERSITY OF CALIFORNIA

San Francisco

[redacted]

Faithful to the Good[1]: Morality and Philosophy in Nursing Practice

Joan Liaschenko

---

[1] The phrase is borrowed from Wendell Berry's poem, *A Marriage, an Elegy*.

Dedication

To my parents, Esther and Edward Drabick
for starting me on the journey,

To the memory of my brother, Mark
for his lessons on life,

To the nurses in this study
for their ethical sensitivity
and the creative genius of their practice.

ACKNOWLEDGEMENTS

Many people have helped me in the initiation and completion of this project and I welcome the occasion to acknowledge their support. First, are the extraordinary women who comprised my committee: Dr. Anne J. Davis, Dr. Linda Chafetz, and Dr. Virginia Olesen. Their very pointed comments always challenged me to extend my intellectual horizons. In additional to their exceptional scholarship, their sense of humor and cultured perspectives on life have enriched my life; their support will continue to be felt for years to come. I especially thank Anne Davis for her commitment in support of my entrance to the School of Nursing and for her faithfulness to my personal and professional development.

I have learned much from Dr. Afaf Meleis and have been influenced by Dr. Patricia Benner although our paths have diverged. Dr. Patricia Underwood always seemed to be there to help with a variety of important matters. The staffs of the Department of Mental Health, Community, and Administrative Nursing, student affairs, the book store, and the inter-library loan section have been most accommodating to me over the years.

I have learned much from the coursework undertaken at the University of California, Berkeley campus. Dr. Martin Packard's class in the Logic of Inquiry serves as an ideal to emulate. I especially thank Professor Bernard Williams for the pleasure of his introduction to Aristotle. Even though his remarkable, subtle thinking frequently went beyond my philosophical capacities, I gained more than he can know. Dr. Leo van Munching was very helpful in bolstering me against my own hesitancy towards philosophy for which I am grateful.

Professor Walter Fisher of the University of Southern California has deeply influenced my interest in and knowledge of narrative rationality. I thank him for his willingness to engage in dialogue with me, for his review of the narrative portion of this work, and for the helpful articles he has sent

me.

Professor Nicholas Maxwell of University College, London has influenced my thinking regarding the role of academic inquiry in the contemporary world. I believe his book, *From Knowledge to Wisdom*, profoundly important and I appreciate his having engaged in conversation with me.

Financial support for this work was provided by the National Institute of Nursing Research, the National Institute of Mental Health, the P.E.O. Scholar's Award, the Century Club and the Graduate Division of the University of California, San Francisco. They have my heartfelt thanks for relieving some of the economic demands of doctoral education. Tess Joseph provided excellent transcription services and Belinda Young was very helpful with final editing.

I thank my parents and my sisters and brothers for understanding the importance of this work to me and for their encouragement.

Friends sustain and nurture me--they are a gift. I thank all those friends in Philadelphia who helped me initiate this project and shared in my enthusiasm, especially Séamus Cummins, Elizabeth Gavula, and the administrative nursing staff of Misericordia Hospital. Friends on this coast saw me through the completion of this work: Lynn Forsey, Ruth Nutting, Tanya Saul, Karen Schumacher, Brenda Simons, Dr. Siriorn Sindhu, Debbie Smith, Sara Weiss, and the nursing staff of the psychiatric division of the San Francisco Veterans Administration Hospital. A very special thank you is due David Langford for numerous computer consultations and invaluable discussions of methodology and to Theresa Drought and Dr. Stasia Fisher for critical library assistance and provocative, insightful conversation.

Without the support of nursing administration in various agencies, this project would not have been possible. I am grateful to Kathy White, Cathy Jenkins, Elizabeth Reasoner, Gail Gresham, and Nancy Barrett. I especially want to acknowledge the nurses who gave so thoughtfully of themselves to this endeavor. This is largely their story and I have tried to be faithful to it.

Finally I thank my husband, Geoffrey, for many things but mostly for his wonderful intellectual companionship.

Abstract

FAITHFUL TO THE GOOD: MORALITY AND PHILOSOPHY IN NURSING PRACTICE

Joan Liaschenko, RN, PhD

Practice has embedded within it a morality which is derived from the very activity of that practice. This study illustrates an actual morality of nursing practice across the three domains of ethical experience; virtue, duty, and cultural ethos. Stories of the concerns experienced in their practice were elicited from 9 psychiatric and 10 home care nurses. Each nurse was interviewed twice for an approximate total of three hours. Philosophically, these stories were considered to exhibit narrative rationality and they were analyzed by using techniques of narrative analysis.

In this research, nursing ethics is seen as comprised of the four aspects which constitute the moral work of practice: having a life, acting for, relationship, and testimony. For these nurses, helping patients to have a life lay at the moral heart of their practice. To have a life is to have a sense of agency, to occupy social and political space, to live a temporally structured existence, and to die. The work of nursing inevitably necessitated that these nurses act for their patients in several domains; physical, psychological, and integrity of the self. The potential for the abuse of power in such situations was offset by knowing the patient. This was made possible through the relationship between nurse and patient, specifically by listening and entering the patient's world. The significance of having a life lay in the distinction between the knowing of the person in her world and the knowing of the patient as an object of biomedical science. These epistemologies and the values which underlie them frequently collided head on in the everyday realities of health care. When this happened, nurses questioned the ends and means of medicine. Such challenges were always raised against the background of what a given intervention would mean for the patient in their world. Speaking morally, these nurses bear witness to

lives and give testimony. This study goes beyond principles and care to suggest a content for nursing ethics.

Anne J Davis

Anne J. Davis, RN, PhD, FAAN
Chair, Dissertation Committee

Table of Contents

Chapter

CHAPTER ONE

INTRODUCTION TO THE PROJECT

The work of nursing is directed towards "the other" in a particular condition of vulnerability and I take the meeting of this vulnerability to be the moral work of nursing. The heart of nursing ethics is a matter of how we practice, of how we make and sustain a commitment and carry out the work of nursing in the face of vulnerability--both the patient's and our own. Yet nursing has been slow in acquiring an account of ethics gleaned from practice. Another way of stating this is that much of what we hold to be ethical knowledge in nursing has come from some source other than our practice, most often analytic moral philosophy and bioethics. This is especially the case with ethics research in nursing, a significant portion of which has been conducted using Kohlberg's theory of moral reasoning. Utilizing these perspectives has resulted in three major consequences. First, while this has enabled nurses to talk the language of the dominant discourse in ethics, it has neither illuminated nor validated the ethical experience of practicing nurses. This is because ethical issues in health care are, for the most part, those identified by medicine or bioethicists. Moreover, bioethical discourse typically focuses on dilemmas thereby excluding ethical concerns and problems (Johnstone, 1989; McInerny, 1987; Mitchell, 1990). We, therefore, know little about the ethical concerns as experienced and labeled by nurses themselves. Second and following directly from this is that those ethical issues which have been studied in nursing practice have been limited, for the most part, to intensive care nurses; other areas of practice have been overlooked. This is because the intensive care unit is the most common stage for the plots of dramatic, warrior medicine (Hawkins, 1984; May, 1983; Stinson and Stinson, 1981). Third, we are without a language to express the concerns of experience and without validation we continue to be plagued by the self-doubt of inferiority which infects gendered labor (Ruddick and Daniels, 1977). But beyond self-doubt, such an absence contributes to the public silencing of nurses within the hegemony of the medically controlled health care system (Flynn, 1991; Johnstone, 1989).

That the knowledge of nursing ethics has taken the course it has is understandable, for our knowledge reflects the conceptual tools and theoretical lenses available in our time of history. History, however, is not static and the traditional approaches to moral philosophy and bioethics depend on an epistemology which now is being questioned seriously, specifically the belief that there is an objective truth which yields knowledge true for all times and places. Bioethics has been criticized on a number of issues: as an instance of rule-following morality; for its equation with legality; its focus on the dramatic aspects of high-tech medicine; the emphasis on impartiality; and the failure to attend to the character of the persons involved. Feminist ethics, which also has been a firm critic of traditional philosophy, agrees with all of these criticisms but is concerned to emphasize how they effect the experience of women. From the re-looking at women's experience has arisen the concept of care. Nursing has found this affirming of its work and values but the concept is problematic and is not without controversy within both feminist theory and nursing.

Alternative approaches issuing from these critiques include practice accounts and narrative approaches to morality. These approaches are indicative of a shift from a formalistic to a more experiential perspective in moral philosophy and bioethics and they are marked by attention to specific practices and their aims, to the context of actions and intentions, and to the character of the actors. In addressing these aspects, the experiential approaches are closer to classical views on morality which are broader than those of modern views because they do not make distinctions between the moral and the non-moral. Kant, the major author of the preeminent modern view, restricted moral matters to that of duty and obligation, thereby abandoning any role in morality for many aspects of our psychologies and lives in general. In classical views, "nothing in human experience is without moral meaning, and the "the moral situation" is the life of each person in its entirety" (Norton, 1988, p. 183). Contemporary theorists argue for an expanded view which, in addition to duty, includes our aspirations as people and the social and political structure of our world.

With these critiques in mind, Annette Baier (1985a) addressed her colleagues in moral philosophy claiming that philosophers needed to attend to three things: what an actual morality looks like; what moralities have been in the past; and what future moralities can be. To this end, she argued that philosophers must turn to anthropology, sociology, psychology, and psychobiology to see what an actual morality is. They need turn to history for an understanding of how moralities have changed over time. Finally, they need turn to novels for a vision of what future moralities can be. The present study is a step towards the first of these goals. It illustrates an actual morality of nursing practice.

The Problem Statement

The present investigation sought to provide an account of an actual morality of nursing practice by examining two groups of nurses: home care nurses and psychiatric nurses. The reasons for selecting these two practice areas are the following: 1) the investigator's interest in both groups; 2) the investigator's knowledge of psychiatric practice and preliminary research on the moral concerns of psychiatric nurses (Liaschenko, 1989); 3) little research on ethical issues has been conducted with either psychiatric nurses (Carpenter, 1991; Garritson, 1988) or home care nurses (Aroskar, 1989; Haddad, 1992), although one study was found which compared both groups (Forchuk, 1991); 4) they occupy opposite positions in the current climate of health care change--the need for home care is escalating dramatically while provision of psychiatric services is shrinking continually; and, 5) both are low tech practice areas. At the outset of this project, it was envisioned that the two groups would be compared and contrasted but the methodology yielded findings so complex and rich as to make such a comparison both unnecessary and undesirable at this time.

The study's aim was to achieve an understanding of the ethical concerns of these nurses as elicited through narratives of practice across the three domains of ethical experience: virtue or character; duty or obligation; and cultural ethos. An important caveat is in order here. In contrast to much of the research in nursing ethics which utilized hypothetical case studies reflecting dilemmas, this investigation was concerned to understand the ethical concerns of nurses from the perspective of their actual practice and in their language. Accordingly, I was open to hearing all their concerns. An adequate analysis of cultural ethos, however, would demand a background literature of sociology and political and social philosophy as well as a different methodology, for example, ethnography. Ethical concerns reflecting cultural ethos, therefore, are not analyzed but simply listed.

Appreciation for narratives of practice forms the conceptual heart of this investigation. They illuminate the reasoning in this study in two ways. On one hand, narratives of practice emphasize the reasoning of a practice account of morality which views ethical concerns as arising from day-to-day practice. To put this another way, the ethical concerns originate in the work of practice and therefore an understanding of this work figures prominently in the study. A significant portion of the work of nursing, however, will prove to be narrative in nature. This is to say that much of the work of nursing is directed towards the illness rather than the disease of the patient and because illness has a narrative structure (Brody, 1987; Kestenbaum, 1982; Kleinman, 1988; G. Williams, 1984), clinical reasoning of a narrative nature is necessary to practice (Fleming, 1991a, 1991b; Kautzmann, 1993; Mattingly, 1991a, 1991b). In this way, the narratives reflect not only the means of data collection but also the very form of reasoning used by the nurses.

The Purpose of the Study

This inquiry affords a view of a morality of nursing practice from the perspectives of two groups of nurses. The broadly conceived and designed investigation cast a net wide enough to encompass a rich and valuable knowledge thereby yielding a beginning theory of a uniquely nursing ethics. I say uniquely nursing because the ethical concerns are identified and labeled by nurses from their practice and in their voice thus taking a small step in resisting the bioethical silencing of nurses.

Significance of the Study

It is believed that the present study represents a modest beginning in meeting some challenges posed by the National Institute for Nursing Research regarding bioethics research (Moritz, 1990). Some of those issues addressed by this study include: alternative theoretical approach, definition by nurses of ethical problems, emphasis on patient care situations, methodology, and study of non-hospital nurses. By attending to these aspects, the study contributes to the discipline's ethical knowledge of practice in the following three ways.

First, it reveals a nursing morality thereby yielding knowledge of the ethical dimensions of practice usually not seen in studies conducted from other theoretical perspectives and by differing methodologies. Morality, of course, is not an uncomplicated and straightforward notion; philosophical analysis has continued uninterrupted for thousands of years. Generally speaking, morals are and have been a matter of how we conduct ourselves (Angeles, 1981). In the present historical epoch, several contemporary accounts have rejected the Kantian perspective in which morality is a matter solely of duty in accordance with reason. These alternative conceptions, which are more similar to classical notions, argue for understandings of morality which include our motivations and self-evaluations as we navigate the contingencies of life within the political and economic organization of the late twentieth century. Thus, we have views of morality encompassing doing the best one can (McNaughton, 1988), the quality of our emotional dispositions (Wilson, 1987), *The Importance of What We Care About* (Frankfurt, 1988) and *Caring About Caring* (Baier, 1985b), and our ability to cope with *Moral Luck* (G. Williams, 1981). If Carson (1990) is right and we live by our loyalties and if Burrell and Hauerwas (1977) are right and morality is coping with the tragic, bioethics as it exists is not very helpful to nurses. This expanded view of morality permitted an exploration of the lived ethical experience of nurses and in keeping with a practice account it provided knowledge of the ways in which their ethical concerns arise from practice. The work of nursing was shown to be understood through the notions of *having a life*, *acting for*, *relationship* and *testimony*. With the possible exception of having a life, these are not new concepts for nursing. The study, however, is unusual in that it synthesizes these aspects of nursing work in novel ways which are suggestive of a philosophy of nursing practice and a theory of nursing ethics.

Although this study was not a linguistic analysis, the use of extensive narratives did reveal the moral language in the everyday practice of these nurses. The discourse was neither one of rights nor one of care and while it is true that words such as rights and care were spoken, their use was noticeably scarce. Others have reported similar results (Cooper, 1991; Sherblom, Shipps, and Sherblom, 1993). This is a curious finding given the continued debate between a principle-based ethics and an ethic of care within the discipline (Salsberry, 1992). While I am critical of principle-based ethics, I am suspect of and therefore mistrust our near obsession with an ethic of care. Whereas I believe the language of care speaks *to* nurses, I am not convinced it speaks *for* them. In this study, the language of advocacy was central. Sherblom, Shipps, and Sherblom (1993), using a slightly different methodology, reported similar findings. In their study of ethical decision making, nurses expressed both justice and care concerns. Nurses voiced integrated concerns, however, in the language of advocacy. The significance of the present investigation lies in recognizing a moral discourse supporting personal agency in the context of having a life; it is precisely these notions which anchor the respondents' ethical concerns and practice. Their moral discourse then is consistent with what they value. This is important given that two of the functions of moral languages are protection and evaluation (Frohock, 1986).

Finally, this study is significant because, as Davis (1981) first noted, nurses are desperate to talk about ethical issues they encounter in practice, issues which can lead to moral distress (Wilkinson, 1987/88) and moral outrage (Pike, 1991). I heard repeatedly from the nurses in this study how grateful they were for the opportunity to talk. Some nurses were surprised to find themselves telling narratives about events which occurred as long as 15 years ago--the concern still lingering. A few nurses cried. Others expressed the wish for a forum to continue the discussion. This does not appear in the findings chapter but perhaps it should as it points to the success of the collaborative relationship between investigator and participants so crucial to feminist research (DeVault, 1990; Fonow and Cook, 1991; Harding, 1987; Hall and Stevens, 1991; MacPherson, 1983; Oakley, 1981). Their wish to talk expresses far more, however. I believe their desire speaks to the cultural invisibility of nursing work and to the silencing of their voices in our "palaces of compulsive healing".[1] Was it Adrienne Rich who said that in a society where naming is power, silence is deadly? The significance of speaking the ethical concerns which frequent our practice simply cannot be over-emphasized--the consequences are momentous, for patients, for nurses, for society. Carolyn Heilbrun (1989) writes:

---

[1] The phrase is borrowed from John van den Berg.

> Power is the ability to take one's place in whatever discourse is essential to action and the right to have one's part matter (p. 18).

I want to conclude this introduction by illustrating some of these points by sharing a now famous case in bioethics (Burton, 1989). In 1973, a 25 year-old man and his father were viewing some property they were thinking of buying in East Texas. They had trouble starting their car so the older man peered under the hood while his son remained inside the car trying to start it. The automobile was parked over a leaking propane gas pipe and a spark from the engine started an inferno. The older man was killed instantly; the younger man engulfed in flames ran from the vehicle trying to find his father. He collapsed but never lost consciousness. When he was found by a farmer a short time later, he asked for a gun; he never stopped asking to be allowed to die. Dax Cowart spent roughly two and a half years in hospitals. Today he is a lawyer and still maintains he should have been allowed to die.

H. Tristram Engelhardt (quoted in Zaner, 1989) made the following impassioned plea for Dax Cowart and others:

> When the patient who is able to give free consent does not, the moral issue is over...In short, one must be willing, as a price for recognizing the freedom of others, to live with the consequences of that freedom: some persons will make choices that they would regret were they to live longer. But humans are not only free beings, but temporal beings, and the freedom that is actual is that of the present. Competent adults should be allowed to make tragic decisions, if nowhere else, at least concerning what quality of life justifies the pain and suffering of continued living. It is not medicine's responsibility to prevent tragedies by denying freedom, for that would be the greater tragedy (p. 46).

I agree wholeheartedly with Engelhardt's support of the patient's right to choose. His words are powerful and they need be taken very seriously. And yet, Engelhardt is mistaken in one point; once the patient refuses consent (or grants it), the moral issue is not over. Regardless of whether the patient consents to or refuses treatment, nurses (and physicians), themselves defenseless against the tragic contingencies of life, will be attending a person in a profound state of vulnerability. If Carson (1990) is right and we live by our loyalties, if Burrell and Hauerwas (1977) are right and morality is coping with the tragic, if Wilson (1987) is right and morality is the quality of our emotional dispositions, and if McNaughton (1988) is right and morality is doing the best we can, bioethics as it exists is not very helpful to nurses. Engelhardt is wrong because he assumes that the moral issue is over when the language of our dominant morality is exhausted. He fails to realize that the tragic is a moral category which demands a language. For Burrell and Hauerwas (1977), tragedy is the name we give to our striving to do what is best in a finite and vulnerable world. They claim that our culture is one that is loosing the sense of the tragic and so we try to compensate with technology.

As nurses, we struggle to articulate the ethical concerns in our practice but find we are discounted or trivialized or sentimentalized. This has been damaging to individual nurses, the discipline of nursing, and patients. It is time for change. We need a moral language that will preserve a sense of the tragic reminding us all that each of us is vulnerable to the contingencies of human life. We need a language that will enable us to sustain our patients and each other; that will serve as the vehicle for our ethical reflection; that will give voice to our ethical concerns. The necessity of meeting this challenge is captured eloquently and passionately in the words of nurse and writer Sally Tisdale (1986),

> We address our discomfort with the public wringing of hands called medical ethics. As a concept it is doomed to futility, too small to contain the problem it hopes to solve. Ethics is the study of conduct and behavior, the study of response, antiphony, echo. Given a certain situation, given A and B in this relation, what should be done? It is cerebral, and those who hope to find more than temporary guidance in it are kidding themselves. We haven't thought deeply enough about our creations. We haven't *felt* deeply enough; we agonize by committee. We trail behind our far-flung machines and tinkering using ethics like a map to figure out how to get from one place to another. We have extended ourselves and our measurements. We see and hear beyond our given range, probe endlessly in the dark interiors,

> congratulate ourselves on progress. But when the beam comes sliding over and it's *us* underneath--you, me, suddenly a fish out of water - we're speechless. It is as though we don't know anything at all (p. 430, emphasis is Tisdale's).

The remainder of this work is structured in the following way. Chapter two contains a brief summary of the major critiques of bioethics. The next chapter presents a review of select nursing literature. Chapter four reveals the findings and chapter five concludes with a summary and discussion.

CHAPTER TWO

CRITIQUE OF BIOETHICS

Introduction

In the United States, bioethics largely has been the province of philosophers, specifically moral philosophers (Weisz, 1990). The reasons for the infusion of philosophy into medicine are complex (Rothman, 1991) and the relationship has not been a smooth one (Zaner, 1988). The result, however, has been that moral theory as developed and understood by moral philosophers in the Anglo-American tradition has been "applied" or mapped onto ethical problems in the medical arena. An ethical theory, like most theories are formal propositional statements giving some systematized account of our beliefs and some notion of what ought to be done. They contain two kinds of terms, terms about desirable states of affairs which philosophers have referred to as "the good" and terms about what one ought to do, known as "the right".

Burrell and Hauerwas (1977) refer to this prevailing view as the standard account, while Hoffmaster (1990) calls it positivist morality because of its similarity to positivist conceptions of science. In these standard accounts, "morality consists of rules and principles, which, because they are normative, can be articulated and defended only on the basis of rational arguments directed at what ought to be the case" (Hoffmaster, p. 241). Positivist morality is primarily concerned with justification or rational argumentation. The specific content of justification will depend on the moral theory from which the derived actions are being justified; the two principal theories being deontological (largely the makings of Kant) and consequential, the prototypical theory being utilitarianism (largely the makings of John Stuart Mill). The view of positivist morality is that the whole of morality can be exhaustively expressed in a set of propositions about what ought to be the case. All judgements about the situation in question are derived from the principles and rules of the theory. Medicine, because it has traditionally been concerned with the physician-patient relationship, has primarily adopted a deontological position, the principles being autonomy, nonmaleficence, beneficence, and justice (Beauchamp and Childress, 1983). Consequentialist ethics in medicine arise largely in the context of discussions regarding the allocation of resources.

Both philosophical moral theory (Pincoffs, 1986; Wallace, 1988; Williams, 1985) and bioethics (Carson, 1990; Fox and Swazey, 1984; Hoffmaster, 1990; Zaner, 1988) have been subjected to increasing rigorous critique. The overwhelming conclusion of all these critiques is that both philosophical moral theory and bioethics have failed to capture much of what is important in our ethical lives. In fact, bioethics as it exists now is deemed so inadequate that Siegler (Zaner, 1988) has proposed that the term bioethics be dropped in favor of the term clinical ethics which would more readily reflect the realities of practice.

Feminist ethics is another source of criticism of bioethics and the male-biased moral philosophy which underlies it. There are several reasons for the ever-expanding number and cogency of their arguments (Addelson, 1987; Baier, 1985c, 1986, 1987a, 1987b; Bell, 1989; Benhabib, 1987; Code, 1988; Flynn, 1991; Friedman, 1987; Gilligan, 1982, 1987; Held, 1984, 1987; Holmes, 1989; Kittay and Meyers, 1987; Lauritzen, 1989; Overall, 1989; Purdy, 1989; Sherwin, 1989; Sichel, 1989; Sommers, 1987; Stocker, 1987; Tronto, 1989; Walker, 1989; Warren, 1989; Wendell, 1989). First, women comprise the largest number of health care workers and feminist ethics takes as its starting point the experience of women. Second, their analysis of gender demonstrates how this experience is essentially one of domination and oppression, themselves moral categories. Third, in their commitment to make a better world, they are concerned with the vulnerable in all situations of domination; thus, children, the sick, the elderly, the disabled, all of whom fall under the auspices of the health care system, merit particular attention (Holmes, 1989). Furthermore, these situations of domination include racism and classism which are deeply affected by the structure of health care in this country.

I agree with these critiques and claim that bioethics as understood and practiced today is highly inadequate for addressing the demands and realities of nursing practice. In the remainder of this paper, I want to lay out some of the major points of these critiques and discuss alternative views more in keeping with the realities of nursing practice. Although there is significant overlap among all the authors, I treat feminist ethics as a separate group because of the key concept of care which organizes much of their thinking.

Points of Criticism

Rule-following Morality

The first point concerns the fact that traditional moral theory concerns itself almost exclusively with problems which Pincoffs (1986) has referred to as quandary ethics. Within the traditional view of moral theory, it is thought that there is an essence of morality which is taken as rule following (Pincoffs, 1986; Wallace, 1988). This essence is based on "true classical first principles" (Schneewind, 1983, p. 114) which make possible genuine moral knowledge through the process of deductive reasoning. There are four characteristics of these classical first principles: they must be context-free, admit to no exceptions, be substantive, and foundational (Schneewind, 1983, p. 113-114). All other principles and rules are derivative of these first principles. Problems arise when there is a conflict of principles or rules. Correct moral problem solving involves "getting the moral facts" of the situation and applying the appropriate principle to them thereby rendering the right decision (Hoffmaster, 1990). In this view, morality is reduced to decision theory and "the better moral decision maker turns out to be the better moral philosopher" (Hoffmaster, 1990, p. 242). Hoffmaster, strongly maintains that this decision tree view of morality is not a reflection of our actual moral lives. Rather, he insists that "moral decision making is essentially a matter of finding an approach that allows one to cope with the nature of the problem" (p. 253). Carson (1990) agrees in noting that "the trouble with the applied action-guide model of bioethics is that it is largely out of touch with the way people live, which is by their loyalties" (p. 53). One can see how morality has a very different understanding when viewed as coping and as living by our loyalties in contrast to merely decision making.

Furthermore, traditional moral theory assumes that the facts "present" themselves in a straightforward and unambiguous way; it fails to recognize that moral facts are interpreted. For example, an issue of patient autonomy or nursing beneficence requires an interpretation; we must say what counts as a violation of patient autonomy or as an instance of nurse beneficence. There are no "brute" moral data just as there are no "brute" scientific data (Taylor, 1987).

Because moral facts are seen as presenting themselves in a straightforward manner, judgement is viewed as unnecessary. Judgement is unacknowledged in two ways. First, the traditional view fails to address the role of salience in moral considerations. Some aspects of an issue are more important or relevant than others; what is salient in one instance may not be so in another. Attending to salience is a matter of judgement which arises within the context of a practice (Benner, 1984; Dreyfus, 1987; Rubin, 1990; Sherman, 1989; Wallace, 1988; Wiggins, 1978), yet the traditional view gives no account of this. Judgement is unacknowledged in a second way; since the only quality that counts for our being moral agents is that we are rational beings, moral agents are interchangeable. Judgement is a crucial element of our ethical experience and some judgements are better than others because some persons are better at judging than others. Who is judging can be as crucial as what is being judged. Alternative views to traditional moral theory, however, are concerned with both of these aspects of judgement; for example, feminist moral philosopher Held (1984) states,

> ...we ought to begin with the point of view of a sincere moral agent with experience of the problems in question, not the point of an ideal observer removed from our actual reality (p. 3).

Legality

A second point of criticism is that bioethics is conflated with legality (Fox and Swazey, 1984). Fox (1990) notes that we are a people united "under law" rather than leaders. The American legal system is a highly rationalistic one which was built on the idea of the sovereignty of the individual. This primacy of the individual was forged politically in our history at the time of transition to the modern period which ushered in sovereign national states organized around a particular language and culture (Toulmin, 1990). The years 1600 to 1650 are usually associated with the beginning of the transformation of feudal obligation to national loyalty (Toulmin, 1990). The concept of the rights of the individual was central to the discourse of how the relationship of the individual to the state was to be conceived and maintained. An excellent example of certain aspects of this discourse is Spinoza's *A Theologico-Political Treatise* (1670/1951).

Such a commitment to the sovereignty of the individual as opposed to the power of the state is predicated upon the view of the individual as a rational, autonomous, self-interested being capable of striking and keeping a bargain. The concept of rights applies to health care as well, and for many complex social and political reasons, bioethics and law are seen far too often as equivalent.

This is intimately related to a criticism made by Carson (1990) who argues that bioethics operates on a Hobbesian view of the universe. From this perspective, a person is a self-interested, autonomous agent who is held in check only by appeals to moral obligation (Kirmayer, 1989). Gauthier's (1986) *Morals By Agreement* is a contemporary account of just such a view in which morality is conceived as a bargain, whereby self-interested, rational, autonomous agents agree to certain rules thereby maximizing the self-interest potential of all parties. Following these rules (seen as moral rules) ensures the right action which will enable each party to maximize his gains and minimize his losses. But of course, the experiences both of the practitioners of health care and its recipients do not reflect that of self-interested, autonomous agents. Because this bargain can take place only among equals, large numbers of our society are excluded. The result is that we are left with a view of morality so impoverished that our moral discourse cannot address adequately the issues of modern life and certainly not those of health care.

Technology

A third point of criticism is that bioethical issues tend to be limited to the immediate and direct result of the increased possibilities offered by rapid scientific and technological advances (these are Pincoffs' quandaries). In other words, bioethics becomes a discourse merely on when to use or not to use our seemingly limitless technology. With the near exclusive focus on technology, we can ignore the larger social context in which many of our health problems are embedded--a context which includes abject poverty, domestic violence, homelessness, racism, sexism, and the hopelessness and despair which come from knowing that one can never really belong to the larger culture--a hopelessness and despair that can chip away at any meaning or significance that one's life holds. Fox (1990) points out that nowhere is this more evident than in neonatal intensive care units where debates are on-going about the justification of treating premature infants with severe medical problems. However, there is no recognition of the reality that the vast majority of these babies are born to poor, disadvantaged, usually single and teen-aged, most often non-white mothers (p. 208). Such an exclusive focus on such a limited aspect of our reality is a failure that must be addressed if bioethics is to contribute anything of substance to a public conversation on the goods of human life.

Such criticism parallels that of the specific domain of philosophical moral theory. Bernard Williams (1985) has noted that our ethical experience is richer and more complex than is conveyed by our ethical theories; our ethical experience has to do with our psychologies, our prejudices, our political institutions and the differing power relationships resulting from those institutions. In short, our ethical experience is embedded in a larger cultural context. Similarly, Yearley (1990) notes that the ethical world is comprised of obligations, virtues and character, and a form of life or "ethos of a culture" (p. 8-9). Williams (1985) makes a distinction between what he calls the morality system which has to do with duty and obligation and the rest of ethical experience. The morality system for Williams is that part of our ethical experience dealing with duty and obligation. Williams wants to claim that this is not the only, nor perhaps even the most important part of our ethical experience. Williams has called the traditional emphasis by moral philosophers on the notion of the right and the good, thin ethical concepts, that is, concepts with little substantive content. In contrast, he maintains that our ethical experience is understood by concepts such as courage, loyalty, honesty, deception, cruelty, and so forth, which he calls "thick ethical concepts". This term, originally coined by Gilbert Ryle, was taken up by Clifford Geertz (*The Interpretation of Cultures*, 1973). According to Geertz, "thick descriptions" are a way of gaining access to what is meaningful in a culture. They have four characteristics: (1) they are interpreted; (2) social discourse is what is interpreted; (3) they make interpretation possible by transforming the fluidity of social discourse into terms that are fixed for later examination; and, (4) they deal with the local and particular rather than the large and profound (Carson, 1990). Williams (1985) uses the term "thick" in a philosophical sense to discuss the distinctions between is and ought, fact and value. He argues that thick descriptions of our ethical concepts unite fact and value. In his words:

> "The way these notions are applied is determined by what the world is like (for instance, by how someone has behaved), and yet, at the same time, their application usually involves a certain valuation of the situation, of persons, or actions" (p. 129).

Thick ethical concepts are compatible with virtue theorists exactly because of the richness of description which includes both moral agents and context. Pincoffs (1986), for example, argues that if we want to know what counts as a moral problem, we must explore the common, moral language used in ordinary, daily life to describe people. People are cruel or kind, forgiving or vengeful, dishonest or truthful, selfish or altruistic, and so forth. Pincoffs finds this a rich language for assessments, "a language that is mostly relegated by contemporary theories to the region of 'virtue and vice', a region that is then set aside, never to be returned to" (p. 43). In a similar vein, Casey (1990) notes that the concept of virtue is intimately related to emotions and thus enables people to make sense of their experience. Furthermore, virtues are best understood by a rich description of their context.

Impartiality

A fourth point of criticism is that the standard account aims at a moral stance which is impartial and disinterested. The demand of this moral requirement is to ensure that self-interest does not assume any relative weight greater than the interest of any other rational person. Such demands are considered universal to apply to all persons, at all times, in all situations. In this case, the impartial assumes priority over the particular circumstances. The critique of impartiality is a major point addressed frequently in feminist discourse and Benhabib's (1987) work is especially cogent.

Absence of Character

Finally, there is the criticism that the standard account makes morality a matter of passive rule-following (Wallace, 1988). When our moral lives are construed in such a way, notions of salience and judgement are not important. In some sense, the moral agent ceases to have agency at all; they are simply 'following the rules'. One implication of this is that the standard account leaves little room for self-evaluation and attention to what we might call character. Character has been out of favor for quite some time but in the alternative views I will discuss, character is making a comeback. In these views, character is embodied practices. Thus understood, character reminds us that moral agents are not merely interchangeable rational beings but persons embedded within a social context who have a history and a moral standard against which they judge themselves. The revival of interest in virtue ethics has also served to highlight the role of character in our moral lives. The language of virtue unites the person to the act; it signifies how someone "moves through life" (Pincoffs, 1986, p. 77). As Pincoffs notes, we are the author of our moral lives and "there are matters of moral biography and autobiography which cannot be ignored" (p. 128).

This leads directly to our understanding of what it means to be a person; all ethical theories have such implicit assumptions. The assumptions of personhood in virtue theories are compatible with Taylor's (1985) idea of a person as a self-interpreting being capable of qualitative distinctions about which he can make evaluative judgements. Of course, such a capacity has implications for our understanding of the idea of responsibility which for Taylor (1985) is "bound up with the capacity to evaluate desires" (p. 28). But as noted above, persons are brought into and develop within a given moral community; virtues are taught and learned in a social context. The value of a virtue ethics is that it opens doors to renew our societal discourse about what it means to be a member of a moral community. Virtue extends the moral conception of our society because virtue is relevant even when rights and obligations are not. This is especially important for those persons in society charged with providing health care. Virtue, because it concerns character and how we live, can not be excluded from any moral framework for a practice discipline. Any ethics that does not give adequate attention to character is deficient.

Feminist Ethics

In general, feminist ethics is in agreement with the criticisms outlined above. Of course, what makes a feminist ethics feminist is the study of moral theorizing with respect to gender. A feminist approach is defined by taking as its starting point the experience of women, by acknowledging that this experience is characterized by oppression and domination, and by its open commitment to changing the practices of this oppression and domination (Bell, 1993; Lengermann and Niebrugge-Brantley, 1988; Purdy, 1989). When one examines moral concerns within the context of women's lives, what emerges is the key concept of care. That is, much of the central experience of women's lives involves the work of caring for others whether the others be children (Ruddick, 1989), the sick (Reverby, 1987), or students (Noddings, 1984). Sara Ruddick has named this work caring labor while Susan Reverby calls it women's work.

At the outset I must clarify that my use of the term feminist ethics is not meant to imply that there is a single, non-disputed version of moral theorizing that constitutes feminist ethics. Certainly that is not the case since there is considerable disagreement about the role various concepts should hold in a feminist ethics. The fact that gender remains the central organizing concern in a feminist ethics, however, requires that the concept of care be addressed; what care does do is to bring emotion and particularity to the center of feminist moral theorizing.

Any fruitful discussion of the place of care in feminist ethics must begin with the work of Carol Gilligan. With the publication of *In A Different Voice*, Gilligan (1982) responded to the work of Kohlberg, thereby beginning a dialogue which is successfully challenging the hegemony of male-biased psychology and moral theory. Kohlberg derived his theory of moral development from research on eighty-four boys who were studied over a twenty year period. Gilligan took issue with Kohlberg's failure to include girls and women in his research. In her studies of women's development, Gilligan examined the relationship of the developing self to the other within the context of moral concerns and her findings did not support the traditional view of women as inferior to men in moral reasoning as suggested by Kohlberg's work.

Kohlberg clearly extended the work of Piaget; it is worth giving a brief summary of some of Piaget's central concepts because they are part of the same epistemological tradition which also includes the moral theories now being called into question. It is not insignificant that Piaget saw himself as taking the central questions of epistemology and making them scientifically researchable (Gruber and Voneche, 1977). These questions of what we know and how we know were examined from the rationalist position, as Piaget was vehemently opposed to empiricism. He rejected the idea that knowledge was the result of elementary sense data built upon over time but whose identity remained essentially unchanged. For Piaget, thought is the transformation of internal mental structures through interaction with the environment. These structures are "not things or beliefs, but coherent sets of mental operations which can be applied to things or beliefs or to anything else in the individual's psychological space" (Gruber and Voneche, p. xxxi). The key concepts essential to the idea of structure are those of wholeness, transformation, and self-regulation (Gruber and Voneche, p. 768).

Structures change from one stage to another and stages for Piaget are characterized by four criteria. First, there is a necessary order of sequence, that is, one must follow the other. Second, there is an organizational coherence to the child's conduct at any given stage; a stage is not characterized by the dominance of one property. Third, each stage serves to integrate the structures from the previous stage which were necessary and preparatory for the current stage. Fourth, the progression of stage sequence is universal (Langer, 1969, p. 8).

Just as Piaget took the Kantian categories of space, time, motion, number, and causality for his epistemological starting point in studying child development, so also did he take the Kantian moral categories of autonomy, respect, freedom, obligation, duty, laws and rules as the basis of his research in moral development (Gruber and Voneche; Kant 1785/1959). These are taken to be the 'natural' categories of morality, exactly those items necessary to the formation and maintenance of the social contract. It is no accident that in their anthology of Piaget's writings, Gruber and Voneche entitle this section, "Moral Judgement: Children Invent the Social Contract" (p. 159). Piaget's moral stages reflect this understanding of morality. The first two stages are rooted in emotional attachments to parental figures where moral behavior is considered as ritualized and imitative respectively. It is not until the third stage when the child begins to be free of such emotional entanglements that they are able to approach genuinely cooperative behavior. For Piaget, however, this stage is only the prelude to real morality which consists in the understanding of how rules for behavior are constructed, understood, and used. Thus, the fourth, fifth, and sixth stages are concerned with this progressive development of the rules necessary to maintain a bargain between equal and autonomous moral agents. Such an understanding of morality makes it quite clear to see how morality is conflated with legality. Indeed, legal sense refers to the use of rules which for Piaget is morality; he states, "the most superficial observation is sufficient to show that in the main the legal sense is far less developed in little girls than in boys" (Piaget, 1965, p. 77). Piaget illustrates this point by comparing childhood games noting the intrinsic inferiority of the game of marelle (hop-scotch) preferred by girls to the game of marbles preferred by boys: he states that the game of marelle "in itself is very simple and never presents the splendid codification and complicated jurisprudence of the game of marbles" (Piaget, 1965, p. 77).

Kohlberg's studies confirmed the earlier work of Piaget in pronouncing the moral inferiority of women because they tended to be 'fixated' at the level of concern and cooperative activity. Gilligan

(1982) challenged this interpretation in terms of both the understanding of the idea of morality and the development of the self. In her studies, the essence of morality is seen as sustaining the connections which are essential to all life while responsibility is the recognition of these sustaining connections (p. 59).

Baier (1985c) argues that what women want in a moral theory is exactly what Gilligan has begun--attention to the sustaining of relationships necessary to human life. She develops this further by suggesting that the most fruitful key concept might not be care but rather trust (1986). Yet this trust is not limited to the trust of the makers of a social contract. In her masterful contrast of the moralities of Hume and Kant, Baier (1987a) highlights the importance of a morality based in human affection (Hume, 1777/1989) and the implications of such an understanding for a morality between non-autonomous, non-equal parties. She wonders if perhaps feminists have overlooked the relevance of Hume for understanding morality from a feminist perspective. Although Schott (1988) does not compare Hume and Kant, her analysis of why Kant has been so successful in Western civilization would suggest that Hume is far too concerned with emotions, traditionally thought to be a downfall of women.

This concern with and attention to emotions is a critical feature of much of feminist theory in general (Boddington, 1988; Code, 1988; Jaggar, 1989; Olesen, 1990). Jaggar points out that our values are rooted in our emotional lives and argues for the importance of this for our knowledge as well as our morality. It seems that a recognition of the role of emotions in our lives puts people back at the center of philosophical inquiry; this centrality of particular people and their context is pivotal to feminist theory even if there is acknowledgement that such a position cannot account for all human relationships (Purdy, 1989; Stocker, 1987; Tronto, 1989). According to Walker (1989), "current philosophical practice still largely views ethics as the search for moral knowledge, and moral knowledge as comprising universal moral formulae and the theoretical justification of these" (p. 15). Yet Benhabib (1987) offers a cogent demonstration of how the universal, abstract other in the Kantian and Rawlsian positions is not a person at all, thereby rendering such positions incoherent. Thus Walker (1989) calls for "an alternative moral epistemology, a very different way of identifying and appreciating the forms of intelligence which define responsible moral consideration" (p. 16). The central features of such an alternative epistemology include the understanding of particular peoples in particular contexts where context is taken to be a given relationship with a specific history, identity, and emotional definition (p. 18) and which are united by narratives. Also essential to Walker's alternative epistemology is "the ability to communicate among persons involved or affected" (p. 18).

Communication. Communication is relevant to ethics in two respects. First, it directly captures what is considered primary in ethical discourse. For example, in a very important study, Flynn (1991) showed how the biomedical model of discourse of hospital ethics committees completely separates the person under discussion from the narrative that is or was his or her life. Instead of focusing on the particularities and thus the reality of the person, they are likely to engage in abstract discussions of when a person is 'dead enough' to remove from life support. This is a pathetic trivialization and misconstrual of human life and to avoid it, we must listen to how people understand the narratives of their own lives.

This is exactly Code's (1988) point when in arguing for a narrative understanding and against "'malestream epistemology'", she poignantly asks, "what has become of the people whose knowledge it [malestream epistemology] allegedly analyzes and explains" (p. 200). She goes on to say:

> reflection upon epistemological and moral matters which is responsibly attuned to such narratives might be able to retain a kind of contact with human lives that is often lost in formalistic and abstract theoretical structures (p. 200).

As Flynn (1991) demonstrates, contemporary bioethical discourse reflects these limits of the traditional epistemological and ethical approaches in defining what counts as a moral problem. Warren (1989) agrees noting that a major problem of contemporary bioethics is the near exclusive focus on the dramatic, crisis issues of health care in contrast to what she calls housekeeping issues. Whereas crisis issues are important, are final, involve a narrow range of possible actions, and are amenable to the standard moral principles, housekeeping issues are viewed as trivial, ongoing, involve a wide range of possible actions, and are only partially amenable to standard moral principles. Furthermore, a feminist ethics would expand what counts as a moral problem because it would include the inequalities of power and status as moral categories (Bell, 1989; Overall, 1989; Warren, 1989). It is Warren's claim that the most important ethical issues are the ones no one really wants to confront. In this regard, it is deeply significant that in her experience of teaching bioethics, she would ask what moral concern in health care people most wanted to avoid--the answer:

> the hospital's own hierarchical social structure. In particular, should the dramatically unequal power distribution between physicians and nurses (social workers, etc.) be maintained? (p. 86).

Sherwin's (1989) strident criticism suggests that the essence of medical ethics is to legitimate existing institutional practice. She claims,

> the institution of medicine is usually accepted as given in discussions of medical ethics, and the debate has focused on certain practices within that structure: for example, truth-telling, obtaining consent, preserving confidentially, the limits of paternalism, allocation of resources, dealing with incurable illness, and matters of reproduction. The effect is to provide an ethical legitimization of the institution overall, with acceptance of its general structure and patterns. With the occasional exception of certain discussions of resource allocation, it would appear from much of the medical ethics literature that all that is needed to make medical interactions ethically acceptable is a bit of fine-tuning in specific problem cases (p. 63).

The second relevant aspect of communication concerns the nature of philosophical discourse in general and ethical discourse in particular. Warren (1989) is particularly vocal on this point, arguing that a feminist ethics would be concerned not only with what is considered a moral problem but also with "how discussions in moral philosophy are conducted" (p. 82). According to her, these discussions should focus on diversity, relationships, and the basing of theory on ordinary experience which are undercut too often by the 'Ethics Game' where the goal is not to come to terms with an issue but to demonstrate academic finesse and to one-up your opponent. In the 'Ethics Game', "moral theories and arguments are used as weapons" (p. 83). Warren calls this the "Gladiator Theory of Truth" which distorts truth and crushes creativity. Moulton (1983) also notes the adversarial nature of contemporary philosophy while Walker (1989) reminds us that the effect of such antics is to distract us from concrete, real world problems. In her words,

> this kind of moral epistemology [alternative epistemology] reminds us that styles of moral thinking are not primarily philosophical brain-teasers, data begging for the maximally elegant theoretical construction, but are ways of answering to *other people* in terms of some responsibilities that are commonly recognized or recognizable in some community (p. 23, emphasis is Walker's).

Thus, a feminist ethics would stress the importance of joint, cooperative work in seeking solutions to a wide range of ethical concerns understood as involving concrete people in the context of relationships.

Alternative Approaches

Practice

Two approaches which begin to meet the above critiques of the traditional philosophical view of morality are a practice account and a narrative approach. Several scholars are working in these areas (Benner, 1991; MacIntyre, 1984; Ruddick, 1989; Taylor, 1989; Wallace, 1988). For this investigation

I draw largely on the work of Wallace (1988) who refers to his account as a contextualist morality. Wallace developed his account from the work of John Dewey, specifically, *Human Nature and Conduct*. In this view, morality is seen as a body of practical knowledge which has the following characteristics: 1) the knowledge (and morality) is obtained by dealing with concrete problems, not abstract and hypothetical ones and, as such, is the product of experience; 2) the resultant knowledge is shared with contemporaries and transmitted to succeeding generations; 3) this knowledge affects large domains of human life; and, 4) it is dynamic. Practices are organized social activities which meet a social need, for example, caring for children, teaching, caring for the sick, law, etc. Each of these involves practical knowledge or skill; but when we learn a skill we also learn to notice certain things and, therefore, moral considerations are embedded in all our practices. As we saw, this is in contrast to most theories of moral philosophy which "regard moral considerations as phenomena external to human beings, most often as rules or principles whose source and authority are problematic" (Wallace, p. 54). According to Wallace, the practice conception sees moral considerations as:

> internal to individuals--internal in the sense that the locus of these considerations is taken to be the learned dispositions of individuals. Moral considerations are items of practical knowledge which, in individuals, take the form of character traits--complex learned dispositions consisting of know-how, skills, concerns, values, and commitments (p. 55).

Related to this idea of moral considerations as internal to the practice is the understanding that a standard for judging the rightness or wrongness of a practice cannot be independent of the practice. Wallace states that for Dewey, "any standard of right and wrong, including moral standards, emerges from human life and activity" (p. 75). Standards are not by-products of practices, they are implicit in them. Furthermore, these standards cannot be decontextualized and made exhaustively explicit.

The second characteristic of this view of morality is that moral knowledge is shared and passed on to the next generation. Moral learning is the result of acquiring the practices devised by others over time to deal with concrete, real life problems. This is absolutely crucial because "on this view, learning how to do things, learning to value things, and learning to be critical are internally related to one another" (Wallace, p. 55-6). When we learn things we are not merely learning a technique removed from an understanding of the role and value those things play in our lives.

The third characteristic of this view of morality is that our practical knowledge applies to several domains of human life. Wallace contrasts the practical knowledge of a moral nature with the practical knowledge of a more technical nature. For example, the practical knowledge of certain kinds of tool use would be limited to a few practices where such tools were relevant. In contrast, the practical knowledge of the institution of property or the concepts of courage or freedom will be relevant to a wide variety of practices.

The fourth characteristic is that a practice conception of morality is dynamic in the following way. Because human life is so complex, new situations will arise which pose problems for our existing practices. Ultimately, solutions are sought in the meanings various practices hold for us. We attempt to adapt these existing practices to the new situations and as we work out a solution, not only the situation but the practice and associated relevant considerations are changed as well. In this way,

> the good aimed at is a complex of intricately related things whose structure is dictated by a set of circumstances that limits possibilities, a context that includes a world and a way of life (Wallace, p. 72).

As mentioned, a part of moral learning is learning to be critical. For Wallace, this aspect relates to the ability to be creative in dealing with the demands of a new situation; in his words,

> to be critical, in an important sense of this term, is to be good at seeing how what one already knows can be changed so that it can be brought to bear upon unprecedented situations (p. 58).

The notion of character is important to contextualist morality because it is in part a motivational component and is also the locus of the virtues which in turn have motivational components. For Dewey (Gouinlock, 1976), character is integrated practices embodied in an individual. As stated above, when we learn something we also learn to value relevant considerations, and to be critical. This process sensitizes us to certain concerns and commitments; in fact, it could be said that we are cultivating and exercising our capacity to care. According to Williams (1981), life would be meaningless without caring and for the feminists, it would be impossible as well. Caring about something necessarily involves feelings of a positive kind which serve to sustain our actions over time. These actions over time can be thought of as a concern. Furthermore, what we learn in our practical and moral education is a tradition for dealing with specific problems of living as well as the ability to be critical which is oriented towards the inevitability of change. Sociologist Robert Bellah and his colleagues (1985) have called such traditions communities of memories.

An appeal to character is an appeal to both our emotional lives and to the notion of self-evaluation. According to Toulmin (1990), the major problem arising from modernity was the separation of reason and emotion. Emotions are not trusted in morality because they are thought to be self-interested, self-directed, and temporary. Kant (1785/1959), the major architect of morality as a requirement of all rational beings, claimed that the only act that can properly be called moral is the one done from the right motive and the right motive is only and always duty. An act can never be called moral if done only from emotional motives. It is important to note that Kant's philosophical position was in direct response to David Hume (1777/1989) who, as Baier (1987a) ably demonstrated, argued forcefully that morality is a matter of moral sentiments. While Hume understood morality as originating in our emotional lives, specifically, in our families (Baier, 1987a), Kant sought to remove every element of contingency from the moral universe (Williams, 1973). For Kant, morality was a matter of universal law and therefore a requirement for everyone who claims to be rational.

It seems clear that Hume is by far the better psychologist. In spite of this, this view has never achieved the popularity of Kant's position largely because we live in a culture where rationality and control are what is seen as important to human life. In her critique of the Kantian paradigm, Schott (1988) argues that Western civilization's long history of aversion to the body which began in ancient Greece reached its pinnacle with Kant's philosophical search for pure, objective knowledge. Schott's analysis is a feminist one and she claims that this quest for pure knowledge is not unrelated to the fact that it is primarily women who have been associated with the body through birth, care of the sick and dying, and care of the body after death. A pure knowledge would somehow allow us to bypass the contingency associated with the inherent drama of the life cycle. It is possible to see the modern health care system in Schott's analysis: women still provide the majority of direct care to the body and the pure and objective goal of knowledge still is seen as ever-increasing control over the mysteries of the body, especially those associated with birth and death. Emotions in this system are intrusive and interrupt the technical efficiency necessary for such control.

Fortunately, there is renewed interest among mainstream, Western philosophers in the emotions and the role they play in our moral lives (Fingarette, 1979; Moravcsik, 1982; Morris, 1976; Rorty, 1980; Solomon, 1990; G. Taylor, 1985; Williams, 1973). Indeed, the feminists have argued for the centrality of emotions in the production of knowledge itself (Alcoff & Potter, 1993; Code, 1991; Griffiths, 1988; Jaggar, 1989; Midgley, 1990). Finally, emotions are particularly relevant to the virtue theorists since virtues are concerned with how we evaluate ourselves and how we are seen by others. Virtues, according to Casey (1990), enable us to make sense of human experience. We understand terms like honesty, integrity, courage, commitment, patience. These are what Williams (1985) has called thick ethical concepts; for Williams it is these terms and not the thin concepts of our ethical theories which give content to our ethical discourse.

Narrative

The second alternative to the standard account of morality is that of narrative (Brody, 1987; Burrell and Hauerwas, 1977; Gilligan 1982, 1987; Walker, 1989). Narrative will be discussed further in chapter three; here I mean only to introduce the subject. Understanding our moral lives as narratives is useful for several reasons. First, human life exists and is understood in narrative form, that is, there is a temporal ordering of beginning, middle, and end (DeConcini, 1990; Richardson, 1990a). Narrative understanding provides a logic of good reasons (Fisher, 1987) which is to say that actions can be understood within a framework which unites character, context, intentions, meanings, and actions. According to Burrell and Hauerwas (1977), these actions form patterns which are stable but flexible over time, thus lending an internal coherence to our lives. However, there is flexibility in that while the story line or plot, the "what happens next," is not arbitrary, neither is it predictable.

Through narratives, personal meanings are connected to those of the larger culture. While the type of personal narratives are limited by the culture, narratives can also expand and change a culture (Howard, 1991). In this way, narratives are ways of learning not only ideals but also skills in using moral notions. This approach seems farfetched in a culture which emphasizes formal, rational learning; yet we do understand our ethical experience, like all experience, in story form. That narrative discourse is a language rich in description, a language which places the person in the context of his or her life is what is most important for our ethical lives. Zaner (1988) demonstrated the limits of a formalistic, abstract, principle based ethics in evaluating the philosophers in a medical center project. After philosophers had come into medical settings and had been teaching residents, Zaner noted that residents could articulate ethical principles and see how their decisions were based on them. Yet, not once was medical care altered or moral outlook changed because of this articulation and understanding of ethical principles. Toulmin (1981) had a similar experience on a national committee where he observed that while there was general agreement among members about what to do in a given situation, there was no agreement when it came to justifying their choices in accordance with ethical principles.

This shows that a procedural ethics or mere techniques of right action are not sufficient in helping us come to terms with the complexities of our moral lives. It would seem that narrative as a language form offers the potential of a rich description of our ethical concerns as they are lived in practice. Such a language should be rich in emotion, a language which illuminates and extends the network of human connectedness, a language which will help support and sustain our moral coping through tragedy. Character and virtue would assume a larger place in such a language as virtues are:

> linked capacities to attend, describe, inquire relevantly, feel appropriately, and respond reliably to situations of a certain kind (Walker, 1992, p. 33).

They are, "the range of skills that enable a person to cope with luck, to deal with the contingencies and vagaries of the particular situations" (Rorty, 1988, p. 147). We would realize that some of us cope better than others, yet coping is a skill and can be learned. I use learned in a broad sense of being nurtured and socialized to appreciate certain values and living accordingly. In this view, we would learn by doing directly, by hearing, telling, and participating in stories, and by watching others. Such a language would enable us to continually reflect on our practice; our ends and our means would be illuminated more clearly. But we need time to cultivate and live this language. Ethical discourse must become an everyday occurrence and not be limited merely to occasional rounds or conferences.

Virtue, Duty, and Cultural Ethos

This section provides some background considerations for viewing the three components of our ethical experience. I have devoted more space to virtue theory because it has informed more of my thinking. The reason for this is twofold. First, virtue ethics is more closely associated with the idea of a practice than is a principle based ethics. Whereas a virtue ethics is concerned with the excellence of activities necessary for common human life, a principle-based ethics is held to reflect a universal and abstract moral truth which is then applied to practical situations. Second, motivation, judgement, and salience are critical aspects of virtue ethics and I am particularly interested in these as they relate to nurses and their practice. In contrast, principle-based ethics disavows the role of ordinary human motivation and eschews human psychology in general. I believe that it is precisely the attention to these factors which illuminates the ethical experience of the nurses in this study.

Virtue

History of the Concept

As a concept, virtue has a long and venerable history extending back to the ancient civilizations of Confucius and the early Greek philosophers.[1] Like all moral concepts it has changed over time and most present-day conceptions of virtue would be unrecognizable to the ancients, and perhaps, most unrecognizable to Aristotle. At its most basic, this change from ancient to modern might be expressed as a change from virtue understood as what one is to the modern idea of virtue as what one does (R. Taylor, 1985). Yet even within the Hellenistic world, there was no single conception of virtue. The Stoics, for example, believed that virtue was a matter of personal excellence but this excellence was considered to be the perfection of reason. Their conception of reason excluded any idea that feelings

---

[1] The classical view I discuss is Aristotle's *Nicomachean Ethics*.

might serve to guide action. For Aristotle, on the other hand, virtue was a matter of feelings (or desires) in accordance with reason. The kinds of things that we desire are of central import for Aristotle. His conception of ethics has been called by contemporary scholars as "The Rationality of Emotion" (Norman, 1983) and "The Organization of Desire" (Lear, 1988).

As mentioned earlier, our ethical experience is comprised of virtue, duty, and cultural ethos. For Aristotle, however, ethics was a matter solely of virtue and a form of life. Virtue for Aristotle was human excellence in activity leading to human flourishing. In his *Nicomachean Ethics*, Aristotle is concerned with two questions: what is the best life for man to live and what form of social organization will make that life possible. Indeed, the *Politics* is his sequel to the *Nicomachean Ethics*. It is not that the Greeks did not have a conception of duty or obligation. On the contrary, they had a very strong idea of duty but duty was not understood to be moral duty. Duties were actions understood as permissible or forbidden by law, custom, or tradition. In this way, there were duties associated with being a citizen, parent, statesman, and so forth.

For Aristotle, a life in accordance with virtue was a life of happiness and thus, virtues were an end in themselves. Happiness was a matter of human flourishing and not the pleasurable feeling state that we mean today. The virtues that Aristotle explicitly talks about are courage, temperance, liberality, magnificence, friendship (more broadly, good relations with others across a wide spectrum of situations), continence or temperance, and modesty (Aristotle, 1989; MacIntyre, 1966). With the transition from Hellenistic to Roman and, subsequently, Christian world views, these virtues changed. The majority of Aristotle's texts were lost to the Western world until their re-introduction by Judaic and Arabic scholars in the twelfth century. Yet there were scholars from the early Roman empire who were familiar with many of the Greek schools of philosophy. In particular, Cicero and Macrobius wrote about virtues and listed prudence, temperance, fortitude and justice as the four virtues (Evans, 1993). With the advent of Christianity, St. Paul bequeathed to the world, the decidedly Christian virtues of faith, hope, and charity. Augustine, in late Antiquity, formulated significant changes to Aristotle's understanding of virtue. One was that faith was the supreme virtue for it was faith that endowed all the other virtues with moral worth in the first place (Abelson, 1966). Another major change was that virtue was no longer an end in itself; rather, the purpose of the virtuous life was submission to the will of God.

During the middle ages, there were intense intellectual discussions on the nature of virtue and happiness but the separation between philosophy and theology had not yet occurred (Evans, 1993). As a result, the virtues maintained their decidedly Christian slant. One consequence of this was a shift from the paradigmatic virtue of pride in ancient ethics to the paradigmatic virtue of humility in Christian ethics (MacIntyre, 1966; R. Taylor, 1985). The implications of this turn are connected to views about human nature, man's place in the universe, and views in an afterlife which promised rewards and punishments. With the recovery of the complete texts of Aristotle through the translation of Judaic and Arabic scholars, Aquinas, following his teacher, Albert the Great, re-introduced Aristotle's conception of virtue to the Western world, albeit with modifications consistent with his Christian beliefs. Thus, with the change in world views, the idea of virtue as human excellence aimed at human flourishing gave way to the idea of virtue as submission to the will of God. From the Christian perspective, human flourishing in this world was not the end, but rather, rewards in the next world. To point out the significant difference in the two views, Evans (1993) states that for Christians, "the law of charity makes it imperative for the individual to give up his own claims to the common good" (p. 113). While Aristotle thought charity important, such an idea would have been incomprehensible to him. Another example of this difference can be found in attitudes towards sexuality. As a contemporary translator of Aquinas'

Treatise on the Virtues puts it, virtue, in modern times, "has been largely confined, in the minds of many,...to restraint or even abstinence in regard to matters pertaining to sex" (trans, Oesterle, 1984, p. xiii). Such a position most likely resulted from an emphasis on the virtue of temperance in relation to pleasures of the senses. Although Oesterle attributes this to an "extremely rigid moral tradition" extending back to the Puritans, there is scholarship showing repudiation of sensual pleasure for a variety of reasons dating back to earliest Christianity and beyond (Brown, 1988; Noble, 1992; Pagels, 1988; Schott, 1988).

In his book, *Ethics, Faith, and Reason*, Taylor (1985) argued that the mixture of the ancient philosophical with the Christian theological tradition which achieves its apex in Kant, has had important consequences for Western thought. The ancient understanding of ethics as a matter of what kind of person one could be is what Taylor has termed an ethics of aspiration. With the introduction of Christianity, however, came the idea of a divine lawgiver which transformed the ethics of aspiration into an ethics of duty. What was considered right or wrong action and thus permissible or forbidden by standards of excellence and other social conventions was changed into morally right or wrong as given by God. If an action is morally right, then one is morally obligated to perform it; if an action if morally wrong then one is morally obligated to refrain from performing it. In both cases, the authority rests with God and not in any way with social conventions. Taylor claims that although modern Western philosophy has dropped the idea of God, and thus a divine lawgiver, it has maintained the notion of a moral right and wrong. From the tradition of the ancient Greeks, it kept the ideas of reason and nature but rejected those of human excellence and human flourishing. It is Kant who so masterfully unites the two traditions by maintaining the idea of a lawgiver but substituting reason for God. Kant, like the Stoics, makes a profound separation between reason and feeling; moral virtue is a good will, or duty, and can come only from reason. So with the advent of modern philosophy and this profound shift in meaning, attention to virtue faded into the background as the discipline became more concerned with justifying claims to rationality. I will return to Kant in the section on duty but, for now, I simply want to point out that from Kant onwards, there has been a near exclusive focus on duty until the second half of this century. The publication of G.E.M. Anscombe's seminal paper, "Modern Moral Philosophy" in 1958 and Georg von Wright's *Varieties of Goodness* in 1963 successfully challenged modern philosophy's neglect of virtue. This is now a rich contemporary literature on virtue (see, among others, Foot, 1978; French, Uehling, & Wettstein, 1988; McDowell, 1979). As I discuss in the final chapter, I think that the idea of virtue has a powerful contribution to make to nursing ethics. In the meantime, I turn now to Aristotle with an overview of his virtue ethics.

Aristotle's Virtue Ethics

This section is a very brief overview of Aristotle's virtue ethics. As mentioned, Aristotle has fundamentally different concerns than those that have occupied most of Western moral philosophy since Christianity. The latter have been occupied primarily with the concepts of moral right and wrong and their justification. Aristotle, on the other hand, is concerned with two major questions: what is the best life for a person to lead and what conditions will make such a life possible. For Aristotle, these questions are questions of virtue and they, along with their answers, constitute the ethical life. In order to appreciate his virtue ethics we must understand his view of the human being and we must start with the soul.

Soul (or psuche in Greek, sometimes translated psyche) was a term used to explain two faculties of life, the ability to move and the cognitive capacities of perception and reasoning. The pre-Aristotelian philosophers viewed the body and soul as separate distinct entities joined in some mysterious way. Aristotle disagreed with this view but the details of his alternative account take us beyond our purpose. What is important for us to know is that the soul was not the giver of life to a lifeless body but an aspect of the living organism, enmattered to use Lear's term. Thus the soul was "the nature of living things" and the nature of man is a rational being. This rationality makes us different from other living organisms, not so much because it repudiates our connection to them but because it is an extension of capacity. In this way, Aristotle's view of the soul has aspects that we share with all living organisms; it is a hierarchical model of the irrational embedded within the rational. Understanding the relationships between these aspects lies at the heart of Aristotle's virtue ethics and it is to this that I now turn.

There are two aspects of the soul, the irrational and the rational. The irrational which we share with all other living organisms has two parts, the vegetative and the appetitive. The vegetative is that faculty concerned with growth, nutrition, and reproduction which we share not only with animals but also with plants. In addition to these capacities, the appetitive (or desiring) aspect of the soul is shared with animals and includes sensation or perception and the capacity for movement. In this aspect of the soul are also included the passions, or emotions, as we would say today. Critical to Aristotle's position are two factors. First, the rational element of the soul does not originate action, action is only originated by the appetitive aspect of the soul. This turns out to be critical because of the importance of our desires in virtue ethics. Second, in contrast to most of Western philosophy which considers desires, emotions, or passions as irrational, Aristotle maintains that these desires may be either rational or irrational. In his view, if they are controlled by reason they are rational and if they are not, they are irrational. We will need to know what is meant by the control or reason but before turning to this, we need to look at reason as the second aspect of the soul.

The rational element of the soul is itself divided into two parts. One part is the completely rational which Aristotle calls theoria or theoretical reason. This type of rationality deals with eternal, unchanging truths of scientific knowledge or episteme. For Aristotle, this knowledge was knowledge of the heavens and of mathematics.

The second part is the incompletely rational or practical reasoning (phronesis). It is this aspect of the rational soul which deals with those matters which do change, the matters of everyday life and thus ethics. Because ethics for Aristotle was not a matter of eternal, unchanging truths, but the contingency of day-to-day matters, he cautioned his students in expecting too much precision from the study of ethics.

Thus far, we see that Aristotle views the soul as the nature of the living organism which in man has two parts, the rational and irrational. The latter is composed of the vegetative and appetitive or desiring parts of the soul, both of which we share with all living organisms. The rational part of the soul also consists of two parts, the completely rational and the incompletely rational. It is the incompletely rational or practical reasoning which concerns us in ethics. Essential to Aristotle's view is his position that the appetitive part originates action and that these appetites or desires can be either rational or irrational depending on their control by reason. Understanding how desires are controlled by reason leads us to deliberation and practical wisdom, the heart of Aristotle's virtue ethics.

Since ethics is concerned with the practical affairs of everyday living, its central concern is with action, that is, things we do. Although Aristotle distinguishes between making and doing, that need not concern us here. What is important for Aristotle is that action is aimed at some end point. Indeed this is how Aristotle[2] begins the *Nicomachean Ethics*:

> Every art and every inquiry, and similarly every action and pursuit, is thought to aim at some good; and for this reason the good has rightly been declared to be that at which all things aim (p. 1).

To put it another way, our actions are not random but are directed towards some end point. It is this end point that Aristotle equates with what is good. For example, the good in education is the instruction of others and the good of nursing is the care of others. Aristotle recognizes that there are numerous endpoints of action and thus numerous goods. These goods are nested and hierarchically organized. An example of this from the health professions would go something like this. A good of health care is health but there are numerous other activities which have their own distinct ends and yet are subordinate to health. For instance, the good of medical technologists is the accurate assessment of laboratory specimens but this is subordinate to the good of the patient's health. At the same time, the good of laboratory administration is the creation and maintenance of effective working conditions which is subordinate to the good of the technologists. In this nested hierarchy, a given action is done for the sake of another. For Aristotle, however, activity done for its own sake is the chief good. This chief good is eudaimonia, commonly translated into English as happiness but a more apt rendering would be well-being or flourishing. In this way, there are several goods which can lead to the chief good of human flourishing. Now we can examine how virtue fits into Aristotle's view of the good of human flourishing.

As we saw, virtue for Aristotle meant something different than it has come to mean under Christianity. Various scholars have referred to the notion of virtue in the latter as a general goodwill or a rather ascetic lifestyle particularly in terms of sexuality. The Aristotelian notion of virtue is really quite

---

[2] References to Aristotle's works are to page numbers in the Oxford paperback edition of the *Nicomachean Ethics* and do not include the standard system of notation.

different. Although the Greek word, arete, has been translated as virtue, to the Greeks, it meant excellences. To be virtuous for the Greeks was to be excellent at some activity. Since for Aristotle, excellence in activity applies to both the rational and desiring or appetitive faculties of the soul, there are two types of virtue or excellence, moral virtue and intellectual virtue. Aristotle defines moral virtue (ethike arete) in the following:

> Since things that are found in the soul are of three kinds-passions, faculties, states of character-virtue must be one of these. By passions I mean appetite, anger, fear, confidence, envy, joy, friendly feeling, hatred, longing, emulation, pity, and in general the feelings that are accompanied by pleasure or pain; by faculties the things in virtue of which we are said to be capable of feeling these, e.g. of becoming angry or being pained or feeing pity; by states of character the things in virtue of which we stand well or badly with reference to the passions, e.g., with reference to anger we stand badly if we feel it violently or too weakly, and well if we feel it moderately; and similarly with reference to the other passions (p. 35).

So the first thing that Aristotle says about a moral virtue is that it is a state (or disposition) of character, but we also notice the intimate connection with feelings and in fact, character is defined in relation to them. The nature of this relationship is that character is a matter of getting feelings right in terms of the particular demands of the situation. Aristotle says this a little further on:

> I mean moral virtue: for it is this that is concerned with passions and actions, and in these there is excess, defect, and the intermediate. For instance, both fear and confidence and appetite and anger and pity and in general pleasure and pain may be felt both too much and too little and in both cases not well: but to feel them at the right times, with reference to the right objects, towards the right people, with the right motive, and in the right way, is what is both intermediate and best, and this is characteristic of virtue (p. 38).

This connection between passions and character should make sense when we recall that it is the desiring or appetitive aspect of the soul which desires or wishes for an object or activity, perceives a given situation as relevant to the desired end, and originates action to obtain that end. Before one acts, one must desire and perceive that for which one acts. In this way, our desires motivate our activity and thus occupy center stage in Aristotle's account of the virtuous life. Desires, however, we share with the animals but it is reason which makes us distinctly human. Therefore, we must keep in mind that desires will be rational or irrational insofar as they come under the control of the rational part of the soul. As some scholars have explicitly noted, Aristotle's ethics and virtue is the organization of desire in keeping with reason (Lear, 1988; Norman, 1983). Now I turn to intellectual virtue.

Aristotle described five types of intellectual excellences, namely, science, art, practical wisdom, intuitive reason, and philosophic reason. Each of these is directed towards a different kind of truth; practical wisdom (phronesis) is the intellectual virtue concerned with the good for man. In Aristotle's words, practical wisdom is,

> knowledge of how to secure the ends of human life...it is a true and reasoned state of capacity to act with regard to the things that are good or bad for man (p. 142).

Aristotle goes on to tell us that,

> practical wisdom is concerned with the ultimate particular, which is the object not of scientific knowledge but of perception (p. 148).

This means that since scientific knowledge is the knowledge of universals, it cannot tell us how to act in any given particular situation. Practical knowledge (or wisdom), on the other hand, can tell us because it depends on perception which tells us that the situation is one demanding x action and not another type of situation demanding y action. For example, practical wisdom tells us that "for a given act to *be* courageous...a person must know that in these circumstances taking a stand would be the right thing to do. He must be aware that this is not a case of foolhardiness, bravado, or silliness" (Lear, p. 170).

Practical wisdom is also concerned with choice or deliberation. Deliberated choice or rational choice (prohairesis) according to Aristotle is:

> rightness with respect to the expedient-rightness in respect both of the end, the manner, and the time (p. 150).

We have seen that virtue is action in accordance with the good for man and the good is the end of activity which we desire for its own sake. Once our perceptive and desiring faculties have given us knowledge of such a situation, practical wisdom enables us to deliberate about the manner (or means) by which to obtain the end as well as temporal factors relevant to the means and end. This might suggest that the ends are given and static. Yet, in her analysis, Sarah Broadie (1991) interprets Aristotle to mean that the worthiness of any given end is continually re-evaluated:

> in the light of means, means to means, and their consequences. So when he says that moral virtue makes the end, or the target, right, he is not saying that virtue reveals to the agent which of various possible ends is the right one to aim for, but that virtue ensures that whatever is aimed for is aimed for rightly at any stage and pursued only in terms on which pursuit is best (p. 245).

Broadie is making the very important point (which I paraphrase) that what is relevant to obtaining the end may change and that deliberation serves continually to re-evaluate the worthiness of the end to be an end in view of the changing relevances.

Deliberation then involves several things: a wish for a particular end, accurate perception of circumstances relevant to the situation, action, and a continual process of evaluation of all of this in terms of the worthiness of the end. The product of this deliberation is a rational choice leading to the right response for the right motive. Moral virtue and intellectual virtue are not the same although they are intimately related. Both, however, are essential to choice; as Aristotle says,

> the choice will not be right without practical wisdom any more than without virtue; for the one determines the end and the other makes us do the things that lead to the end (p. 158).

In this brief outline, I have attempted to give an introduction to those concepts essential for a beginning understanding of Aristotle's virtue ethics.

Duty

In everyday usage, duties are responsibilities to fulfill certain obligations incurred as the result of assuming a particular role. Duties are important to social life because they set up what people reasonably might expect from each other (Williams, 1985). In classical ethics, duty was extremely important but was not a matter of ethics. As we saw, duties were given by convention and ethics concerned one's desires and one's judgements. Christianity altered this and, following from this tradition, Kant transformed the classical, everyday understanding of duty to a that of a very precise meaning, that of obligation to the moral law in accordance with reason. In so doing, Kant essentially reversed the classical notion of ethics; by making duty a matter of ethics, all those dimensions of life which previously had been regarded as a matter of ethical import were dismissed as irrelevant. In this section, I provide very brief views of some of Kant's main ideas and of duty and nursing.

Kant

Given that it would be impossible to do justice to Kant's very complex position and, furthermore, that the understanding of this research does not require it, the purpose of this section is twofold: I wish to highlight some of the keen differences between Aristotle's virtue ethics and Kant's deontological ethics and, in so doing, provide a glimpse of some of the ideas involved in a philosophical theory of moral duty. The first thing to notice is the striking contrast in the relation between reason and emotion. Kant saw all knowledge as belonging to one of two categories; material and formal. To the latter belonged logic while material was divided into the laws of nature and the laws of freedom. The laws of nature encompassed physics while the laws of freedom included ethics. Ethics, in turn, was held to have an empirical part which Kant called practical anthropology and a formal part which he called the metaphysics of morals or simply morals. Practical anthropology could describe what people actually do but since it was a matter of contingencies rather than rationality, it did not concern Kant (*Foundations of a Metaphysics of Morals*, 1785/1959, hereafter abbreviated as *FMM*). At this point, it is impossible not to notice and to comment that Kant would have thought this research project as useless in gaining any understanding about morality. For Kant, only the formal or rational part was considered essential to morality. Rationality, for Kant, is universal and timeless, that is, true for all people in all times. Kant lays out the basis of a formal ethics in the *Foundations*. It is worth noting that Kant's work was an answer to Hume who argued that morality was a matter of sympathy. By sympathy, Hume meant "a capacity to be moved or affected by the happiness and suffering of others" (Norman, 1983, p. 71). Sympathy was not a virtue for Hume but the source of our moral judgements. In other words, the sympathies we hold were seen to explain the moral judgements of blame or approval that we make (Norman, 1983). That the basis of morality could be such a contingent matter as a capacity to be moved by suffering was intolerable to Kant. Thus, Kant begins the first section of *FMM* with his famous dictum:

> Nothing in the world-indeed nothing even beyond the world-can possibly be conceived which could be called good without qualification except a *good will* (p. 9).

For Kant, it is reason and only reason which determines the will. Because he severs all ties between reason and emotion, Kant maintains that only those actions done for the sake of duty are moral actions. We may perform many laudable actions for other reasons but, whatever these actions are, they are *not* moral actions. The consequence of this is that moral value (which is to say, duty) is the only unconditional value and as such, takes precedent over all other value. In this way, Kant maintained a sharp distinction between the moral and non-moral domains. Hume, on the other hand, did not draw a distinction between the two. He argued that such a distinction could not be drawn and also that the idea was not in keeping with human sentiments. Kant found this particularly offensive. Given that ethics for Aristotle was a matter of our desires and how they were shaped by practical reason, I think it would be accurate to say that Aristotle, like Hume, draws no distinction between the moral and non-moral domains.

Another major difference between Aristotle and Kant concerns the relation between goodness and action. As we saw above for Aristotle, goodness is embedded in the action because the action aims at some good. For Aristotle there is a definite connection between the action and the end it is supposed to accomplish. This is not the case for Kant where the goodness lies in the action of willing and not in the outcome of the action directed towards some aim or object. Kant puts the matter thus:

> An action performed from duty does not have its moral worth in the purpose which is to be achieved through it...Its moral value, therefore, does not depend on the realization of the object of the action but merely on the principle of volition by which the action is done, without any regard to the objects of the faculty of desire (*FMM*, p. 16).

The reason for this insistence is that Kant recognized that contingent factors might play a causative role in whether or not a given action was actually carried out. Thus, repeatedly throughout the *FMM*, we find that Kant is concerned to remove all contingency from the moral domain. In order to do this, morality must not be a matter of what we desire because desire is not reliable. Instead, morality must reside in the will because only the will can be commanded. We are commanded, as we saw, not by a divine lawgiver, but by the requirements of reason. Inclusion in the moral community is solely a matter of our being rational beings. Such a notion has interesting implications for both moral education and moral accountability. Here again we see a major contrast with Aristotle. For the latter, the attainment of virtue depended on having been brought up with the right desires that were subject to reason. The right environment which shows the child the life of virtue and introduces him or her to the pleasures of acting for the sake of virtue is essential if one is to grow into the virtuous adult. For Kant, on the other, moral education was a matter of recognizing moral principles through a rational process (Hill, 1992). One must not teach morality by giving examples.

Duty and Nursing

Nurses have duties by virtue of their assuming a certain role in society. For example, nurses have duties to have certain kinds of knowledge, without which they would not be able to help patients; to conduct themselves in such a way so as to promote that helping; and to protect the people in their charge. Although many roles are not codified within society, those that become recognized as professions generally move to that. The recognized duties of contemporary nursing are put forth in the American Nurses' Association's Code For Nurses. In fact, one of the three original purposes of the first meeting of what is now the ANA was "to establish a code of ethics" (Freitas, 1990, p. 197). That duties are conventions and therefore reflective of specific historical contexts can be seen in the transition from emphasis on "manners" and unquestioning obedience to increasing responsibility and accountability (Crowder, 1974; Freitas, 1990; Winslow, 1984). Yet, in a very interesting study, Davis (1991) demonstrated that nurses did not know the content of the code but, instead, used other sources of knowledge as the basis of their practice code. These included four areas of what Davis called sensitizing experience: clinical, personal, nursing school, and experience with clinical research protocols. Nurses experienced situations in each of these domains and in which values were embedded; these experiences subsequently sensitized nurses to other ethical dilemmas. Davis concludes by asking:

> If nurses have little knowledge of this code, what does this possibly say about using our professional collective values in ethical reasoning through clinical ethical dilemmas?" (p. 1362).

I think Davis need not be as pessimistic as her tone implies for the following two reasons. First, this study does indicate collective values. There *was* collective agreement in her study; these nurses had similar experiences in these domains. And if this is true for these nurses, there is good reason to believe it is true for others. Also this agreement indicates a certain experience with the world--a picture of how the world is and these nurses used guides for their practice in accordance with that world. In my view, this study suggests just how intimately duty is linked to virtue and cultural ethos, thereby arguing against a Kantian conceptualization of duty as the sole relevant feature of morality. Second, inability to verbalize the code of ethics need not mean that nurses are practicing some arbitrary and "personal" morality. Like the previous work mentioned in which nurses spoke neither the language of rights nor care, these nurses may speak a language that reflects the work they actually do and the values embedded within. Not knowing the code does not equate necessarily with unethical practice.

Cultural Ethos

As mentioned in the introduction, there is no ethical theory of cultural ethos per se as this is a matter of political philosophy and organization. This is not to say that political philosophy and sociological theories would not have been useful. On the contrary, they are absolutely essential to a complete account of ethical experience. Excluding them was, however, a matter of deliberate choice as I elected to focus on those theoretical perspective which would best serve my needs at this early stage in my work. The term, cultural ethos, is used in this study to refer to those aspects of the nurse's experience which reflect ethical concerns with structural or organizational elements. Examples include management, intra-agency departments, Medicare, and peer conflict which extends beyond the immediate parties involved. In the nest chapter, I review select foundational and empirical literature in nursing ethics.

CHAPTER THREE

REVIEW OF THE NURSING LITERATURE: FOUNDATIONAL AND EMPIRICAL

Introduction

The fact that modern nursing had its origins in religious community life shows that the ethical imperatives embedded in the care of the sick are as old as the practice itself (Donovan, 1985; Kalisch and Kalisch, 1986). Secularization, however, did not do away with moral language as descriptive of our practice; nursing has been heralded as "a moral art" (Curtin, 1979, p. 12) and the "morally central health care profession" (Jameton, 1984, p. xvi). But a rich discourse on the nature and meaning of the ethical foundation of our practice is a relatively recent development. In this chapter, I explore the shape this discourse has taken in both the non-empirical and research literature.

Before beginning, I want to clarify my use of the term foundational. In the technical, philosophical sense, foundationalism is associated with the epistemological project of modernity in which rationality was taken to be a universal and context-free faculty of the mind. Reason would show how systematic knowledge was built on very simple and basic elements which were taken as true and indubitable (Bordo, 1987; Danford, 1990; Jaggar and Bordo, 1989). One's position on the origin of these basic building blocks would place you in one camp or another: if you took them as originating in elementary sense data, you were an empiricist and if you held them as internal to reason itself and independent of any experience, you were a rationalist (Cottingham, 1984). In spite of this division, both camps shared fundamental assumptions about the nature of the world and of knowledge. According to Jaggar and Bordo's (1989) excellent summary outline, these included the philosophical positions of metaphysical realism, objectivism, rationalist bias, epistemological individualism, and universalism (p. 3). Metaphysical realism refers to the idea that reality has "an objective structure or nature unaffected by or independent of either human understandings of or perspectives on it" (p. 3). Add to this the belief that this objective reality can be known through human reason and we have the philosophical doctrine of objectivism (p. 3). Perhaps the two most important notions, at least for the present purpose, are epistemological individualism and universalism. According to these tenets, the individual comes to know the world as a solitary being, "rather than as socially constituted members of historically changing groups" (p. 3). Universalism refers to the belief that reason is the same for all individuals at all times in all situations. In other words, reason is independent of such factors as sex, class, race, and culture (p. 3). Rationalist bias reflects the primacy given to the powers of human reason regardless of whether reason alone or in conjunction with sense data is seen as the elemental building blocks of knowledge. In either case, the result will be the true account of reality, that is, reality as it really is, independent of those subjective factors just mentioned. Such an account is said to be objective. Thus, foundationalism is one aspect of a philosophical system, the endorsement of which led to the dualisms with which we now struggle; mind/body, fact/value, reason/emotion, nature/culture, subjective/objective (Hanen, 1987; Jaggar and Bordo, 1989; Toulmin, 1990). As expected, Western moral philosophy and it's applied branches such as bioethics has also come from this same tradition. In the previous chapter, we saw that many of the contemporary criticisms of bioethics are directed at one or more of these systematizing pillars of epistemological theory.

The purpose of this very brief outline is to contrast this precise, technical use of the term in epistemology with the contradictory uses of the term in the discourse on nursing ethics. Several authors have explicitly used the term; consider for example, such titles as "The Nurse as Advocate: A Philosophical Foundation for Nursing" (Curtin, 1979); "The Moral Foundation of Nursing" (Yarling and McElmurry, 1986); "The Philosophical Foundations of Caring" (Fry, 1990). These authors use 'foundation' in ambiguous ways; for example, Gadow (1980) rejects traditional Western notions of rationality and its corresponding principle-based ethics. She rejects the representative theory of mind and reality (Benner and Wrubel, 1989) in favor of a view which sees human life, including rationality, as embedded in a historical context and therefore, in a given set of understandings and practices (Rabinow and Sullivan, 1989). Fry (1990)'s terminology is confusing in that a foundation of caring is a contradiction in terms. Caring, to be caring, is particularized knowing in response to the concerns of a given situation (Benner and Wrubel, 1989; Noddings, 1984) and thus cannot be foundational in the philosophical, epistemological sense. Fry (1990) claims to be endorsing a philosophy of care but, in fact, this is not the case since her "model of caring" is based on ethical theories which remain concerned with epistemological issues such as validating and justifying moral truths.

Foundational is used in another sense by Cunningham and Hutchinson (1990) who talk of foundational concepts as those concepts which set up what counts as relevant to us. This sense seems to reflect ordinary use and everyday understandings. As a concept conveying relevance, it is partially contained in Taylor's (1989) concept of moral stance which he proposes as an alternative. By moral stance, Taylor means a sense of the good, that is,

> whatever is picked out as incomparably higher in qualitative distinction. It can be some action, or motive, or style of life, which is seen as qualitatively superior. 'Good' is used here in a highly general sense, designating anything considered valuable, worthy, admirable, of whatever kind of category (p. 92).

In this first section, I discuss the foundational positions or moral stances which have appeared in nursing ethics literature in the last thirteen years. I have chosen to present them chronologically in order to see the path this discourse has taken over time. The second section reviews the empirical literature.

Foundational Position/Moral Stance

Davis and Aroskar (1978) initiated the contemporary dialogue in nursing ethics with the publication of "Ethical dilemmas in nursing practice." This work is important in several ways. First, as the authors noted in the preface, the literature on nursing ethics prior to this publication reflected the view of ethics as restricted either to legality or etiquette. In contrast to such a view, they introduced nursing to the principle-based approach dominant in moral philosophy. This approach was also beginning to be taken up by medicine. Second, despite the fact that they talked largely of ethical dilemmas, they called attention to the idea that these dilemmas occur within the context of nursing practice. Their claim was that there is something about the nature of nursing practice which casts a different light on traditionally conceived health care dilemmas; and therefore, nursing ethics was not reducible to medical ethics. Third, Davis and Aroskar discussed the institutional constraints on nursing practice, thereby anticipating some of the major criticisms to come, particularly those of the feminists.

Two authors simultaneously published proposals for a moral stance in *Advances of Nursing Science*. Curtin (1979) argued that nursing needed to be defined philosophically and not sociologically. In the latter view, nursing is seen as a series of tasks or role expectations rather than a practice. Curtin argued that nursing is not a series of tasks, but a practice whose aim is the well-being of patients which is brought about not primarily through an instrumental rationality but rather, through a certain kind of relationship, a central concern of which is the meaning of the illness for the patient. In this way, Curtin anticipated much of the work to come on the importance of meaning in illness. Based on this reasoning, she called for a moral stance of advocacy which she viewed as being rooted in the notions of respect for persons, integrity, freedom, and dignity. For Curtin, "these concepts have crystallized in what we call human rights" (p. 13) and emanate from our common humanity, shared traditions, and biological continuity. This advocacy for human rights however, was not to be understood as a form of the patients' rights movement. Finally, Curtin acknowledged the power of nursing practice while recognizing the reality of institutional constraints. In her words,

> To claim that nurses can institute progressive change is not to ignore the many organizational and social barriers that nurses face. We can control our actions. To be sure, there are inflexible policies and insensitive orders from physicians, but the professional nurse has a great deal of latitude in the implementation of such policies and orders. Our ethical responsibility is not reduced by the actions of others, but in fact may be magnified by them...In many instances nurses are not free to disclose certain information to patients/clients and their families. That is, they are not free unless they are willing to pay the price, a price that may well include loss of employment or even licensure. This situation is wrong because it violates both the patient's and the nurse's integrity. Moreover, it constitutes a direct infringement of the nurse's rights to practice nursing and interferes directly with the nurse-patient relationship. This situation must, can and will be changed (p. 19).

In the very same issue, Carper (1979) proposed "The Ethics of Caring" as the stance for nursing. Carper emphasized that the work of health care is indeed care and that this care, which serves to keep the patient and not the disease the central focus was being eroded by increasing specialization and the proliferation of technology. In essence, the patient was disappearing and could only be revived by the process of caring. Drawing on the seminal work by Mayeroff, Carper discussed the process and key elements of caring. Important to her construction is that caring is specific, rather than abstract and general, and depends on self knowledge. Furthermore, caring was seen as being humane which could be learned. To this end, she argued for a much stronger role for the humanities in nursing education. Although knowledge of the humanities does not necessarily make one more humane, it could lead to increased empathic understanding which "can extend our range of imagined possibilities" (p. 18). Thus, it is no accident that Carper appealed to literature to illustrate her point about care. She writes poignantly of the story of Dr. Frankenstein and his creature to show the tragedy that is science without care.

In suggesting what this care should look like, Carper appealed to Veatch's three models of the patient-physician relationship, namely, the engineering, the priestly, and the contractual models. According to Veatch, the contractual model is the ideal for which practitioners should strive. This model is characterized by mutually, honesty, respect for the dignity of the other, and a sense of obligation on both sides. While it is clear from Carper's description that this contractual model more nearly resembles a covenantal model, as delineated, for example, by May (1983) and Stenberg (1979), contractual nonetheless remains an unfortunate choice of words. Furthermore, it remains unclear that a covenantal model satisfactorily articulates the ethics of caring in nursing practice. Although I find the notion of covenant has much to recommend it, a significant limitation is that it doesn't provide an adequate account of those instances in nursing practice where caring practices are sabotaged or rejected by patients and yet the care must continue. I am not against ideals, but when they are the focus, the situation as experienced by the participants can be overlooked and the ways in which nurses cope with the difficulty are easily silenced.

In a very impressive work, Stenberg (1979) also argued that nursing needed a moral stance grounded in some understanding of nursing practice. She examined the four concepts of code, contract, context, and covenant and, after a very thorough analysis, concluded that covenant was the concept most suited to a nursing ethics. Covenantal relationships are characterized by mutuality and a promise on the part of the practitioner to act in the best interests of the patient. According to religious ethicist May (1983), covenantal ethics originate in the biblical tradition but can also be seen in the Hippocratic oath. In the latter case, the covenant begins with a gift from the teacher to the initiate--the gift of being taught the skills of the craft of medicine. In return, the practitioner promises to return the gift by executing his craft as masterfully as possible and doing his utmost to help the patient. Covenantal ethics are compatible with practice accounts of morality in that both a high degree of skill and concern with the uniqueness of the patient are central. May writes,

> Covenantal fidelity to the patient remains unrealized if it does not include proficiency. A rather sentimental existentialism unfortunately assumes that it suffices morally for human beings to be "present" to one another. But in crisis, the ill person needs not simply presence but skill, not just personal concern but highly disciplined services targeted on specific needs (p. 136).

Gadow (1980) proposed a moral stance which she called existential advocacy. Gadow agreed with Curtin on the need for nursing to be defined philosophically rather than sociologically. Like Stenberg, she argued for a conceptual framework which she envisioned as an ideal. Central to her conceptualization is the distinction between advocacy and both paternalism and consumerism. Existential advocacy is

> distinct from both paternalism and consumer protection. It is based upon the principle that freedom of self-determination is the most fundamental and valuable human right, and therefore is a greater good that any which health care can provide...In positive terms, this meaning of advocacy has far greater implications for the professional, which extend beyond the narrow realm of proscriptions into the realm of ideals. The ideal which existential advocacy expresses is this: that individuals be assisted by nursing to authentically exercise their freedom of self-determination. By authentic is meant a way of reaching decisions which are truly one's own--decisions that express all that one believes important about oneself and the world, the entire complexity of one's values (p. 84).

In her view, advocacy would serve to 1) do away with the false distinction between personal and professional; 2) make the distinction between the lived body and the body as object; and 3) participate with the patient "in determining the personal meaning which the experience of illness, suffering, or dying is to have for that individual" (p. 97).

Authenticity is also essential to Nelson's (1982) moral stance. Authenticity is a complex concept which includes a commitment to one's world, a willingness to 'take a stand' and accept the responsibility for the consequences of one's action. In the language of the existentialists from which Nelson draws, one is free to choose their commitment and free to act. By accepting responsibility for this choice and commitment, one expresses authentic being and engages in ethical practice. These are critical issues and I do not want to deny their relevance. Yet they leave one with the impression that ethical practice is always a battlefield where heroes are made or broken. I want to keep heroes, we need them. The danger is that in focusing on the hero, we forget to look at the battlefield--how was it constructed, who commands the resources, where is it located, what's at stake, how is it connected to the larger society. The metaphors of hero and battlefield are apt ones for many instances of lived ethical experience in nursing practice; yet our practice is also rich with times of peace and a sense of community. These two realities constitute a tension rich with political and practice implications. Because this tension is illuminated so clearly in the next two papers, I explore them in some detail.

If Nelson celebrated the hero, Yarling and McElmurry (1986) called attention to the context of the battlefield. In their provocative and now classic paper, "The Moral Foundation of Nursing", Yarling and McElmurry argued that nurses were not free to be moral, a claim they acknowledged was first raised by Davis and Aroskar (1978). The authors were very clear in stating that what they meant by free was not "a reference to transcendental freedom of the will, for freedom in this sense is a necessary condition of even being a moral agent and having moral problems" (p. 63). Rather, free referred to "freedom of action in the sense that acts are free from unforced choice" (p. 63-4). Furthermore they qualified their conclusion by restricting it to those nurses who practiced in hospitals which are hierarchically organized and not controlled by nurses. Like their colleagues discussed above, Yarling and McElmurry agreed that the basis for a nursing ethic should be the nurse--patient relationship; they concluded, however, that the nature of the hospital organization consistently undermined that relationship. This resulted from conflicts between the hospital's end of "institutional maintenance" and the nurse's commitment to the needs of a particular patient

(p. 65). For Yarling and McElmurry, "at stake in this conflict, for nurses, is nothing less than the nurse-patient relationship...It is the necessary foundation for a nursing ethic" (p. 65).

The authors noted that nursing's primary commitment to the patient as distinct from the hospital is a relatively recent historical phenomena (Winslow, 1984). Because of this, Yarling and McElmurry forcefully argued that a strong sense of professional autonomy and a shift in accountability from physician to patient were necessary, although not sufficient conditions for nurses to be moral. It is important to note that when the authors speak of professional autonomy, they are not referring to the notion of radical individualism with which the word autonomy has frequently come to be associated. Instead, they are arguing for the autonomy of nursing as a practice, that is, for practitioners who are free from unforced choice to act on behalf of their patients. Because Yarling and McElmurry sparked an impassioned controversy in nursing ethics which also mirrors the current re-evaluation of our cultural understandings of autonomy, it is important to examine this debate in some detail.

> The moral situation of nurses is most poignantly revealed when they perceive that the right to freedom and well-being of patients in their care and treatment is threatened or violated by a physician, another nurse, or some other health care provider for whom the hospital is responsible...The moral predicament of nurses arises from their commitment to patients, and that commitment is grounded in nurses' status as moral agents. Were nurses simply the instrument of those around them, as they are often assumed to be, then they would have no moral problem and no sense of not being free. An incident demonstrating this point occurred a couple of years ago when the

> first author, two nurses, and a physician formed a panel for a freshman medical school class in medical ethics. Under discussion was the role of the nurse in disclosing information to terminal patients. The question was, if the physician of a terminal patient had ordered that no information regarding the patient's prognosis be disclosed to the patient, and if the patient asks the nurse about the prognosis, what is the nurse's duty?
>
> Every medical student who spoke in class that day held that the nurse had a moral duty to disclose and that the physician's order was unjustifiable. The physician on the panel, however, argued that the nurse had no such duty. One of the student's asked, why not? The physician replied, "Because the nurse's relationship with the patient is different than the physician's. It does not require independent moral judgement by the nurse." That is to say, nurses have no duty to make autonomous moral judgements about what their relationships with patients require because their relationships with patients are different. They have no moral status. In this sample, the nurse-patient relationship--the moral foundation of nursing and of a nursing ethic -is negated and denied moral status (p. 64-6).

Miller (1981) discussed the four senses of autonomy in contemporary philosophy. In this explication he drew on the work of several philosophers including Beauchamp and Childress, Dworkin, Englehardt, Callahan, Frankfurt, and C. Taylor. These four senses include autonomy as 1) free action; 2) authenticity; 3) effective deliberation; and 4) moral reflection (p. 24). Feminist scholars have also made these distinctions but note that any meaningful aspect of autonomy develops as a matter of socialization (Code, 1991; Meyers, 1989). According to Miller,

> autonomy as free action means an action that is voluntary and intentional. An action is voluntary if it is not the result of coercion, duress, or undue influence. An action is intentional if it is the conscious object of the actor...Autonomy as authenticity means that an action is consistent with the person's attitudes, values, dispositions, and life plans. Roughly, the person is acting in character. Autonomy as effective deliberation means action taken where a person believed that he or she was in a situation calling for a decision, was aware of the alternatives and the consequences of the alternatives, evaluated both and chose an action based on that evaluation...Autonomy as moral reflection means acceptance of the

> moral values one acts on (p. 24-25)

He goes on to say,

> It is important to note that if an action is not a free action then it makes no sense to assert or deny that the action was autonomous in any of the other senses. A coerced action cannot be one that was chosen in accord with the patient's character and life plan, nor one that was chosen after effective deliberation, nor one that was chosen in accord with moral standards that the person has reflected upon. The point is the same if the action is not intentional (p. 27).

An in-depth discussion of autonomy is impossible here but there are important reasons for providing even this very brief exposition. First, I want to show the sense in which Yarling and McElmurry were using the term autonomy. Second, as mentioned, their article generated significant controversy and a major reason for this controversy is the different meanings and uses of the term. Third, as we have already seen, autonomy is a common concept within the nursing ethics literature. Fourth, the controversy generated by Yarling and McElmurry mirrors that of the larger culture. As Miller notes, "Whether one can, or should choose a life plan or a religious belief by reasoned inquiry (effective deliberation at the most general level) is a matter of controversy in philosophy and theology" (p. 25).

According to Miller's analysis, it is clear that Yarling and McElmurry were using autonomy in the first sense of voluntary and intentional action. Yarling and McElmurry did not absolve nurses from their responsibility to act morally, indeed, "their responsibility is inescapable" but "the principle indictment is intended for those institutional structures that systematically create formidable obstacles to responsible action...They must be held responsible for the suppression of the moral impulse in everyday life" (p. 71). They concluded "that a responsible ethic must be a social ethic," that is, an ethic concerned with "structures and policies of social institutions" (p. 71).

Yarling and McElmurry offered two solutions. First, they noted the history of nurses as social reformers and argued that "the social reform tradition and its major prophets must be enshrined in the memory of the profession" (p. 72). Yarling and McElmurry believe that such an appeal to our own historical tradition is absolutely necessary if "nursing ethics is to become more than a footnote on medical ethics" (p. 72). They note the power of stories in shaping our nursing identities.

> Even older nurses volunteer stories about ethics from early in their careers about patients who suffered serious injury or harm, which they thought might have been prevented if they had acted more aggressively. They are stories in which the nurses felt helpless and painfully compromised. Why do nurses tell these stories? Because they represent the symbolic socializing events through which their moral predicament was revealed to them in its full-blown dimensions. Although largely repressed, these are the experiences around which young nurses formulate their professional identity, however fractured that image may be (p. 69).

Because stories can heal as well as illuminate, this history is essential to us.

Their second solution is far more radical; if nurses can not obtain more power in hospitals they must "terminate its employee status with the hospital, move outside the hospital, and serve hospital patients from the vantage point of some new nursing-controlled organization" (p. 72). I must admit I have considerable sympathy with this view having come to the same conclusion about ten years ago. To assume such a stance is merely to recognize the interdependence of all health care professionals. If, for whatever reasons, this mutuality between professions is absent, we must seriously examine the consequences to our patients and ourselves.

Finally, it can be said that Yarling and McElmurry anticipated some of the feminist critiques discussed in the previous chapter in claiming that bioethics "has been staunchly nonreformist. In a word, medical ethicists have explicitly disclaimed any interest in reform" (p. 72).

In their 1987 paper, "Nursing Ethics in an Age of Controversy", Bishop and Scudder responded to Yarling and McElmurry with a moral stance based on a view of the nurse as the "in-between" person charged with the day to day activity of the patient. They are not unique in viewing nurses as the "in-between" health care professional; philosophers MacIntyre (1983) and Englehardt (1985) have also offered accounts of this position. In answering Yarling and McElmurry, Bishop and Scudder make four arguments.

First, from their perspective, nursing practice is care which stands in sharp contrast to the medical world of cure. Bishop and Scudder accused Yarling and McElmurry of buying into the medical model of cure as well as advocating yet further specialization. They begin their paper thus;

> An ethic for nurses must concern foundational issues in health care that give direction to policy formation. A current major controversy concerning the very nature of health care practice itself will affect the future of all health care policy and practice. The controversy focuses on whether health care primarily concerns cure or care as far as policy and practice are concerned. But as the authors have shown elsewhere, it is rooted in underlying philosophical issues, some of which are very important in ethics. Some interpreters of health care claim that health care is aimed at cure and that it will continue to become an applied science. They begrudging admit that present limitations in medical science require the continuation of the archaic view of practice as care, but eventually as medical science advances, care will be abandoned. Such a view of health care places nurses in an ambiguous situation because nursing traditionally has been identified with care. As medical science advances, will nurses become medical technicians, assistants to physicians in curing patients, or specialists in a type of care required to support curing? If nurses become specialists, this will require that they establish an area of expertise that they can direct autonomously. Since establishing an area of expertise will put nurses in competition with health care professionals, nurses will have to reform health care policy and practice (p. 34-35).

I find this position confusing on several counts. First, the authors make far too great a distinction between care and cure than is warranted by actual practice. I certainly agree that on a cultural level we are highly biased in favor of cure. After all, biomedical research receives much more money than do services aimed at delivering care. And I heartily support the proposal that this inequity be addressed by public policy. At the level of practice, however, this sharp distinction simply does not hold as others have shown (Benner, 1984; Benner and Wrubel, 1989; MacIntyre, 1983). Bishop and Scudder make it sound as if only nurses care and only physicians cure. This is an unhelpful and false dichotomy at the level of practice. The authors mention nursing's tradition of care but fail to acknowledge that this care has historically been defined by others, namely physicians (Ashley, 1976; Engelhardt, 1985; MacIntyre, 1983; Reverby, 1987). As MacIntyre (1983) writes,

> For a very little consideration makes it clear that nursing has been defined residually; to the nurse has been allocated whatever has been left over from the often self-defined functions and tasks of the physicians and surgeon and the bureaucratically defined tasks of the hospital administrator (p. 79).

While MacIntyre is referring to the historical pattern in nursing, Koenig's (1988) research on new technologies corroborates his view.

Secondly, it isn't clear why Bishop and Scudder consider autonomy as leading to specialization. Furthermore, their belief that advances in medical science will make curing technicians of nurses seems to point to a belief in medical progress that is not warranted. Medicine has indeed made several advances, but the result has been a dramatic increase in chronic illness--just those patients who need care.

The second criticism Bishop and Scudder offer is their charge that Yarling and McElmurry operate "within the context of traditional philosophical moral decision making" (p. 35). For Bishop and Scudder, this means that Yarling and McElmurry focus on autonomy which is viewed as equivalent to a principle-based applied ethics as well as on reform of the health care system. In the view of Bishop and Scudder, reform of the health care system is intermingled with the concepts of cure and autonomy.

> Yarling and McElmurry's arguments sound convincing because they develop them within the context of traditional philosophical moral

> decision making. Their position will appeal to many who, *like the authors*, support their contention that nurses need more autonomy, greater accountability to patients, and more involvement in the reform of health care (p. 35; emphasis is mine).
>
> Yarling and McElmurry begin with academic moral decision making as it is taught in typical ethics courses. Ethicists have traditionally argued that one acts morally by bringing one's action under the control of a moral norm that defines the good...To act in accordance with a moral norm, one needs autonomy. Therefore, autonomy becomes a necessary condition for acting morally. Thus, Yarling and McElmurry conclude that nurses lack sufficient autonomy to be moral agents. To support their position, they usually choose examples in which the nurse acts on behalf of the patient in tension or conflict with physicians or hospital bureaucrats. Since in these examples *nurses obviously lack autonomy*, Yarling and McElmurry contend that nurses can truly be moral agents only when the health care system has been reformed so that nurses can act as autonomous individual professionals. In fact, they contend, that nurses need to be less concerned with traditional personal ethics and more focused on reform of the system (p. 36; emphasis is mine).

There are several responses that can be made to this argument. First, in the above passage, the authors note that one must have autonomy to act in accordance with a moral norm and therefore, autonomy is a necessary condition for acting morally. Of course, this is Kant's (1959) position. Yet what Bishop and Scudder fail to realize is that it is autonomy in Miller's first sense of action as voluntary and intentional that is required. In other words, what is required to act in accordance with a moral norm is autonomous action. Without autonomous action there can be no morality in the strict sense, only passive rule-following. Indeed, this is the basis of Wallace's (1988) criticism of absolutist morality--that it is not autonomous action, but passive rule following.

Second, the italicized segments in the above indicate that Bishop and Scudder do agree with Yarling and McElmurry, thus making their position very confusing. Bishop and Scudder do not mark the distinction in the four senses of autonomy as Yarling and McElmurry do. Instead, they seem to collapse all differences into the fourth sense of autonomy which involves the moral refection on one's values and specifically, how 'free' is one in choosing their substantive philosophical or religious beliefs. This is one aspect of radical individualism which is, as mentioned, a controversial issue in contemporary philosophy and theology. In this context, Bishop and Scudder repeatedly refer to the nurses' power to foster "communal decisions" (p. 42). Yet, in their indiscriminate condemnation of autonomy, they fail to acknowledge that fostering communal decisions itself requires autonomy. There could be no cooperation or sense of community without autonomy at least in the first sense and I believe a strong case could be made for the other senses as well. One can repudiate radical individualism and yet not reject the conception of autonomy as free and voluntary action.

The third argument that Bishop and Scudder offer is their concern over the call for reform of the health care system. In failing to give adequate attention to the location of practice, Bishop and Scudder ignore that ethics is comprised of virtue, character, and duty as well as a way of life. (Williams, 1985; Yearling, 1990). In other words, a significant part of a way of life is the political organization. To reject reform is to limit ethics to virtue, character, and duty. Since the issues regarding reform are also related to the next argument, I will say more about this in the following section.

The fourth argument which Bishop and Scudder present is a view of ethics based on what they call the moral sense of nursing. This is a phenomenological perspective which attends to the lived moral experiences of nurses. In this view, the work of care is the essence of nursing and permits nurses access to what they call the in-between position. According to Bishop and Scudder,

> In our desire for nursing autonomy, however, we cannot ignore the moral stance already present in nursing, the opportunities to reform health care from within, and the privileged in-between position of nurses in reaching moral decisions (p. 35-6).

By in-between they mean that nurses occupy the nexus of connections between physicians, patients, and hospital management. Expert nursing practice establishes and sustains this nexus, thereby fulfilling the moral sense of nursing. The expert practice of this moral sense confers what the authors term legitimate authority. As I understand this concept, legitimate authority is manifested in the day to day realities of ethical practice. What is not clear, however, is how legitimate authority works in situations of breakdown, the magnitude of which Yarling and McElmurry are concerned. I agree that legitimate authority is a powerful notion and should be expanded to illuminate those situations of breakdown. Yet there are difficulties with how Bishop and Scudder present their in-between argument. In their words,

> Being caught between these various factions makes it difficult for nurses to make decisions without taking into account the roles, rights, and possible responses of physicians, patients, or hospital administration. However, the in-between place of nurses, rather than freeing them from the responsibility of moral decision making, makes their contributions to moral decisions more important than if they could act autonomously
> (p. 41).
>
> Thus, any moral decisions nurses make concerning the well-being of the patient must take all of these factors into consideration (p. 42).

Bishop and Scudder seem to think that nurses do not have to be autonomous but will nonetheless have their decisions treated as such. This seems incongruent to me. If nurses are not autonomous, why should anyone else on the team even listen to them, let alone act on their recommendations. Bishop and Scudder view agency as a matter of legitimate authority but want to deny that agency involves autonomous action. In other words, they fail to distinguish legitimate authority from autonomy. Also, in claiming that nurses must take into account all of the above, are they not simply stating Yarling and McElmurry's position? Furthermore, this passage would suggest that Yarling and McElmurry claim that nurses are 'free' not to make any decisions at all, that is, are 'free' of any culpability. This is simply not the case; for Yarling and McElmurray (1986) note that even in adverse circumstances, "their [nurses] responsibility is inescapable" (p. 71).

There is another deeply puzzling issue posed by Bishop and Scudder. By now, it should be abundantly clear that Bishop and Scudder do not like the word autonomy when applied to nurses. Yet, supporting autonomy in patients has central import in the practice of nursing, even for Bishop and Scudder. In their book, *The Practical, Moral, and Personal Sense of Nursing* (1990), they refer in several places to notions of autonomy regarding patients; for example, the duty to "respect" patients as persons (p. 12); patients must be "willing" (p. 27); "illness results in a surrender of one's autonomy" (p. 35). Not only do they refer to autonomy directly but they also use language that, in everyday life, is generally associated with ideas of autonomy. The implication of this is that while nurses must safeguard the autonomy of others, they may not demand it for themselves. This is profoundly disturbing to me, even more so when the work of care is set in opposition against reform of the institution in which this care takes place. This issue, as well as the conflict over the meaning of autonomy, is the central issue not only of this debate but also of nursing and feminist ethics. As I see it, the dilemma for a nursing and feminist ethics is how can we preserve our caring practices while at the same time promoting institutional change?

This debate clearly illustrates how each side frames the issues. Yarling and McElmurry highlight the necessity of reforming our institutions exactly because they can stifle and deform care. Bishop and Scudder, on the other hand, emphasize the power inherent in skilled nursing practice--a position I also hold. Moreover, I also share their deep commitment to having nursing understood from the perspective of a practice account of morality. Nevertheless, in terms of this debate I find that Yarling and McElmurry make a better case. Bishop and Scudder fail to convince me for four reasons: first, they do not provide an adequate account of autonomy; second, they were unfair in some of their criticisms because they took the concept of autonomy and concluded that this concept stood for an entire philosophical system; third, they do not provide an adequate description of the in-between position; and fourth, they do not show how legitimate authority is effective against instances of institutional violence.

I agree that we need to rethink the meaning of autonomy, and I also agree that a nursing ethic needs to reflect the moral sense of nursing. But I am exceedingly wary of changing the meaning of autonomy when care is set in opposition to institutional reform. There may indeed be excellent reasons for dropping autonomy from our ethical discourse; as a living system, language can become archaic and outlive its usefulness. However, words and concepts vary according to the context in which they are expressed and proposals for change must include an examination of all the contexts. To discard autonomy without such an examination would be premature. Indeed, an appropriate end for research in nursing ethics would be to understand which nurses, under what circumstances, in which ways, to what ends, use the variety of terms in our common ethical discourse. The present investigation provides some insight in this regard. As we will see, the word autonomy was mentioned but rarely although a major feature of their discourse was support and preservation of patient agency.

The danger of abandoning autonomy without clarifying the meaning and/or replacing the term is that care can easily become a doctrine which hides the inequities in health care. As MacIntyre (1983) has warned, care can serve an "ideological function of concealing the lack of intellectual justification for the established division of labor and the conventional hierarchies of the medical and health care world" (p. 80). Making a voice for care but failing to attend to the realities of institutional life would be disastrous. It would be tantamount to what, I believe, Hannah Arendt has called "bureaucratic violence." But it is also the case that one person (or group of persons) cannot accomplish this dual task alone. For these reasons, it is unfortunate that Yarling and McElmurry and Bishop and Scudder presented the issues in so oppositional a manner. How much nursing would gain if their moral passion and intellectual acumen worked together on this very important but difficult issue. As stated, I have given these two sets of authors a great deal of attention because their debate highlights as essential tension in nursing and feminist ethics. Now, I return to the two remaining responses to Yarling and McElmurry.

Packard and Ferrara (1988) claimed that Yarling and McElmurry failed to specify three essential items: 1) the moral foundation of nursing; 2) ways of knowing that foundation; and, 3) the political nature of nursing. In an attempt to address these issues, Packard and Ferrara suggest that the moral foundation of nursing must derive from the meaning of nursing which is viewed as practical activity reflecting some idea of a moral good from our culture's historical tradition. Packard and Ferrara suggest, for example, equality, freedom, and justice. In the case of nursing, this idea is health because, in their view, health can be shown to relate to these moral ideas. In their view, the meaning of nursing is an idea, the knowledge of which is discerned through the successful consequences of nurses' practical activity which is to make someone live better.

One more response was made to Yarling and McElmurry. Cooper (1988) argued that the foundational grounds of both Yarling and McElmurry and Bishop and Scudder were inadequate because they failed to account for the covenantal nature of the nurse-patient relationship. As mentioned above, a covenantal relationship consists of both skilled practice and moral content; the practitioner exercises his or her expertise for the well-being of the patient. Cooper sees Yarling and McElmurry as concerned with reform of the institution and Bishop and Scudder as concerned with the role of the nurse on the health care team. Cooper's criticism rests on the grounds that she does not see either of these as foundational for a nursing ethic; yet, if we are taking foundational to mean relevant, I fail to see how concern with the character of our institutions and with the political space we occupy in those institutions could be thought irrelevant. Furthermore, while Cooper is correct in her identification of the emphasis the previous authors give their work, she is mistaken in claiming they are unconcerned with the nurse-patient relationship. As previously cited, Yarling and McElmurry passionately state, "at stake in this conflict, for nurses, is nothing less than the nurse-patient relationship" (p. 65).

I mentioned earlier that the idea of covenant is a potentially helpful one but there are limitations. Covenant implies the notion of mutuality and nurses must frequently care for patients who are abusive and who sabotage, undermine, and reject care. Furthermore, a covenant is a gift that traditionally is the gift of God's grace. This makes sense in a religious context but can the notion be salvaged for the secular and atheists among us? I would like to see it tried. It would be instructive to see what a covenantal ethics would look like to Yarling and McElmurry, Bishop and Scudder.

Care

At this point in time, the discourse in nursing ethics has turned for the most part to the concept of care. The centrality of care to nursing practice was raised in the late seventies with the work of Carper (1979), Leininger (1977), and Watson (1979); within ten years, care has become a dominant voice in nursing ethics. If the literature just discussed showed that the moral stance of nursing practice is the relationship between the nurse and the patient, the care literature shows that the work of caring is the vehicle for this relationship--nurses care for patients. But the notion of care as a moral stance is not unproblematic. Although my aim in this chapter is the review of nursing literature, one cannot discuss care without referring to feminist theory. In noting this distinction, I should not be interpreted in any way as implying that nurses are not feminists.

As I see it, there are two major difficulties which are especially relevant to nursing. One stems from the premise that the work of caregiving has both instrumental [caring for] and expressive [caring about] relations (Abel and Nelson, 1990; Tronto, 1989). Another is the gendered nature of care which leaves open the cultural possibility of continued exploitation of women (Houston, 1987; Tronto, 1989). Although these are intimately related issues, I discuss them separately for the sake of ease of presentation. But first, let's start with the advantages of care as the moral foundation for nursing.

Tronto credits Ruddick (1980) with "rehabilitating" caring as labor--as a set of practices. In her book *Maternal Thinking*, in which she expanded this initial work, Ruddick (1989) gave a "practicalist" account of the work of mothering. This practicalist conception of reason came from Wittgenstein but is very similar to that of Wallace (1988). These accounts rehabilitate by making explicit, and therefore publicly recognizable, the skill, knowledge, and moral dimensions embedded in the practice. Such a process is especially transformative for the practitioners themselves as there is a recognition of the worth of one's labor. Carper initiated this rehabilitation in nursing with the publication of "The Ethics of Caring" and Benner continued it with, *From Novice to Expert*. When nurses read Benner's paradigm cases, the disparaging 'I'm *just* a nurse' becomes a proud and confident '*I'm* a nurse.' That this occurs is significant, indicating that these descriptions ring true to nurses; they validate the importance of the work that nurses do. In turn, this confirmation encourages the speaking of nursing's concerns. Because being silenced is a form of oppression (Parker, 1990b) which leads to "moral madness" (Morgan, 1987) speech is a profound act of resistance, if not liberation. It remains unclear to me, however, what it is to speak the language of care.

Some advocates for care give transformative visions for expanding the public place of care in our society (Benner, 1988; Watson, 1985) which, theoretically, make possible a caring public policy (Schultz and Schultz, 1990). In contrast, there are those who remain skeptical about care as the foundation for a morality; for several reasons, they urge caution against wholesale acceptance as a moral ideal and discourse (Aroskar, 1993; Card, 1990, 1991; Davis, 1990; Houston, 1987; Jaggar, 1991; Liaschenko, 1993; Tronto, 1989). In the discussion to follow, I address one particular aspect: the separation of caring for and caring about, the instrumental from the expressive.

In their excellent review of caring in the nursing literature, Morse, Solberg, Neander, Bottorff, and Johnson (1990) note that caring is conceptualized as human trait, moral imperative, affect, nurse-patient relationship, and therapeutic intervention. While problems are discussed with caring as affect, there is no comparison between caring as affect and caring as moral imperative. If we take the labor of nursing to be caring for and if nursing fulfills a social mandate, caring about understood as emotions or feelings poses a problem--what happens when we don't like a patient? Specifically, Gadow (1985), for whom caring is a moral imperative, repudiates the equation of caring with emotions or feelings. I quote her at some length.

> The image of the caring person is of one who is solicitous, tender, sympathetic, supportive. To describe the nurse-patient relationship as essentially one of caring might then require those traits of nurses rather than others like detachment or efficiency.
>
> I suggest that this is a trivial notion of both caring and nursing, if we are endeavoring to establish the moral essence of the nurse-patient relationship. Certainly the traits are useful; they are part of a technology of interaction that has been refined to an awesome extent but that is only a means, not an end (unless we are willing to reduce nursing to technique for its own sake). Caring as a moral ideal, rather than as an interpersonal technique, entails a commitment to a particular end. That end, I am proposing, is the protection and enhancement of human dignity. Caring as the moral ideal of nursing is concern, above all, for the dignity of patients.
>
> Dignity, too, has its trivial definitions--not because they are inane but because they are fragments portrayed as the whole. Closing the curtains around a patient's bed during an examination, allowing patients to wear their own clothes, allowing them finally to die, by

> removing the machines, illustrate a current ideology of privacy more than a substantive concept of dignity.
>
> What does a richer meaning of dignity involve? Simply expressed, a being has dignity when it gives to itself its meaning and so creates for itself integrity. Integrity thus implies both the coherence which meaning gives to experience and the origin of that meaning within, rather than outside, the individual (p. 32-3).

In Gadow's view, caring is concern for dignity understood as finding meaning--caring is not merely "solicitous, tender, sympathetic, supportive" attention. I agree with Gadow in her attempt to avoid equating caring to some mere sentimental notion. And yet, I believe that caring is nonetheless related to some positive emotion which is a source of motivation. Gadow seems to imply that while the process of helping the patient find meaning cannot be separated from the relationship per se, the process can be separated from a relationship characterized by some kind of positive affect. What would this relationship look like? Certainly, you can find meaning in a hostile, unfriendly, or abusive relationship but I doubt that this would lead to the integrity she requires. And the meaning will not come form a neutral, detached relationship so what is left?

Philosophers Jecker and Self (1991) discuss caring for as different from caring about within the context of professional stereotypes in health care; nurses care for (instrumental) while physicians care about (expressive), a distinction previously noted by feminist scholars as mentioned above. In their analysis of the concept of care, Jecker and Self present four types of caring in health professionals: 1) those who care for and about; 2) those who care for but not about; 3) those who care about but not for; and 4) those who care neither for nor about (p. 301). These authors note that the traditional image of nurses as the caring profession can "obstruct efforts to re-define professional relationships and provide political fuel for traditional hierarchies" (p. 285-6). Having acknowledged this recognition and knowing the focus of their paper is care versus cure in professional stereotypes, I nonetheless find their paper unsatisfying for the following reasons. For one, the authors emphasize only one side of their conclusion; while they establish that physicians are just as caring as nurses because they care about rather than care for, there is simply no mention at all of the fact that the caring for by nurses is what makes cure possible in the first place. This is a little disheartening in a special issue devoted to nursing ethics. Second, Jecker and Self claim that:

> since nursing and medicine are largely gender segregated professions, the answers to these questions [to the division of labor; to the perception that only nurses care] may lie as much in gender-related tendencies as in the histories of nursing and medicine (p. 286).

What the authors fail to note, however, is that the histories are themselves gendered (see Ashley, 1976; Reverby, 1987). Third, I think that the separation between caring for and caring about is not as possible in practice as Jecker and Self would have us believe. This is a very complex issue and deserve much more time and space than can be allotted here; nonetheless, much of the remainder of this section will provide the outline of my argument.

Empirical studies demonstrate that caring is understood to be related to liking the patient (Kahn and Steeves, 1988) and showing love and concern (Kelly, 1990). In responding to Kahn and Steeves Watson (1988) is profoundly distraught and even outraged by this notion. She sees a relationship between caring and liking as setting "a dangerous ethical and praxis precedent for nursing's caring mission in society" (p. 218). She goes on to argue that at the moral level of the profession, liking has nothing to do with caring. Watson's reply may be typical of those who are fearful of seeing care linked to emotions or feelings. In an earlier study of the moral concerns of psychiatric nurses, I also found agreement with Kahn and Steeves (Liaschenko, 1989)--when positive connection to the patient was not present, it became very difficult to care for the patient. It is important to note that a positive connection did not mean 'love at first sight' or even global, wholesale liking between nurse and patient. On the contrary, psychiatric nurses frequently deal with extremely difficult and abusive patients. Rather, the work of caring for patients frequently involves 'finding' points of expressive connection or reasons for caring about; the lack of such a connection is a moral problem. These points of connection usually occur when the nurse has come to some understanding of why the patient is who he or she is. This understanding brings with it the possibility for compassion which may or may not lead to 'liking'. But, when this connection does not happen, the nurses have difficulty caring for. As we will see, the present study also confirms this.

Like Kahn and Steeves, I too see caring and affect as related, but seeing such a relationship also leads me to ask; if caring is characterized by attention to the particular and the unique, how can we care for or about a stranger about whom we know nothing? What in our moral discourse helps to create and sustain a relationship while caring is being made manifest? I wonder if it might be the notion of respect. Respect runs through much of the discourse on nursing ethics from Davis and Aroskar (1978) to the present. Although the concept is largely associated with the domain of Kantian moral theory and held to hold between equal and rational agents, others have suggested otherwise. For example, Davis and Aroskar state,

> In addition to respect for the individual's autonomy, it [principle of respect for persons] also recognizes that individuals are members of a human community, which involves consideration (at the same time) that most of the decisions we make affect others. It acknowledges the interconnectedness and interdependence of individuals. This view rejects an extreme view of individualism...(p. 41-2).

Empirically, Kelly's (1990) research indicates that nursing students understand both respect and care to be the essence of their practice. A problem with this work however, is that it is Kelly (1990) and not her students who make the differentiation between care and respect. Furthermore Kelly (1990) is not very clear as to how she distinguishes between the two either conceptually or in practice. Yet, like Davis and Aroskar (1978), I think there might be something to this notion of respect that does not necessarily reflect an ontology of extreme individualism. In situations where we care for difficult or abusive patients, I think that our moral discourse about respect does play a role and might go something like this. Respect for persons is part of our cultural moral language and thus constitutive of part of our self-understanding which is that every person is (or should be) worthy of respect. We could give abstract and formal definitions of what this means but in our moral psychology, I think that respect may serve to mediate the distance between ourselves and others in difficult or unfamiliar circumstances. This mediation would preserve the distance necessary to protect ourselves while at the same time, offering the possibility that this distance can be transcended. This possibility comes from the past in that we are led to wonder how the patient came to be as they are--we are led to wonder, who are you? Thus we are in some sense seeking their identity as unique individuals. I think the possibility that this distance can be transcended is deeply rooted in our shared humanity of common need. By this I mean that as biological and social beings we have certain needs which must be met and therefore, we are similar regardless of the circumstances which now separate us. So for example, with psychiatric nurses, the point of connection, (or emotion) comes from realizing that something went wrong in this person's life--we seek an understanding, even if patients have spit on us for the fifth time that day or have verbally assaulted us in our attempts to help. Thus, in my thinking, the notion of respect may serve to navigate a sometimes difficult space and time which makes caring for possible while we hope for caring about.

I think it is frequently in this difficult space and time between caring for and caring about that reflection occurs for nurses--reflection about one's practice, the end of the practice, and about the kind of person one is. Concerns with the kind of person one is are concerns of self-evaluation and thus with character and virtue. Before looking at the place of virtue in the discourse of nursing ethics, I want briefly to discuss the second reason for which care is considered problematic as a moral foundation for nursing.

The second reason is the gendered connotation of care in this culture. In Tronto's (1989) analysis, women care for and men care about. In her discussion, caring about refers to objects rather than to emotions per se; men care about the public, important things and women care for the private, less important things--like the family. Of course, this points to a patriarchal devaluation of emotions and caring practices as well as the family. And several feminists agree that emotions and caring practices are one of the most critical things learned in the context of the family (Baier, 1985b, 1985c, 1987a, 1987b; Gilligan, 1982; Noddings, 1984; Ruddick, 1989). But what are the implications of adopting a morality of care? Houston (1987) notes the sense of pride she gets from claiming the distinctive morality of care but also notes that it:

> is self-defeating, or highly dubious, when exercised in our relations with men, with those more powerful than ourselves, or when exercised in conditions in which the social structures are likely to deform our caring or disguise it as a form of consent to the status quo (p. 252).

This is echoed by several authors (Aroskar, 1987; Davis, 1990; Liaschenko, 1993). Tronto (1989) agrees; in her view, the hope of those who want to transform society by changing caring practices "cannot be recognized unless we also revise our view of the political context in which we situate caring as a moral phenomenon" (p. 173). Davis (1990) thinks this reasoning is particularly important to nurses. She argues for the necessity of both moralities to nursing practice, suggesting that we frequently need the morality of justice in order to make possible the morality of care. In her words,

> professional socialization, role models, and the dominant value system of cure and efficiency in hospitals can limit caring to technical

> knowledge and skill, whereas situations often call for an unfolding of our most basic human qualities to the other person. The most demanding and deeply human aspect of caring is the art of being fully present to another; it is both caring for and caring about (p. 27).

Card (1990), in her provocatively entitled paper, "Caring and Evil", asks:

> Can an ethic of care without justice enable us adequately to resist evil? By resisting evil, I have in mind something relatively modest: resisting complicity in evil-doing (p. 101).

For Davis we may need all the power a principled morality in this society can give us in order to create conditions in which our caring will not be deformed. As Houston (1987) has cautioned, "whatever morality women develop or adopt, it had better be one whose virtues do not cost us our freedom" (p. 262). Perhaps we should be comforted in knowing that the problems of the gendered aspects of care in a sexist society are not unique to the late twentieth century. Florence Nightingale was inflamed at the idea raised by another woman that hospital nursing should be done voluntarily (Pajunen, 1987).

Where do I stand in this debate on the role of distinctive moralities? Somewhere in the middle but not the middle of a simple mix. I, like Houston (1987) am swelled with the power of expert caring when I see it but like Davis (1990) and Yarling and McElmurry (1986), I have had too many painful experiences with the traditional power structures of hospitals to think that the morality of caring as generally understood by nursing (Morse et al, 1990) is sufficient to transform our world. I would add that the pain was not merely hurt feelings; it was the pain of being unable to take my place in the arena of speech where ends are decided and action endorsed. The present study corroborates similar experiences from these nurses. When nurses can not assume this place, they are reduced to 'artificial persons' (Wolgast, 1992) and harm is done to both patients and nurses. On the other hand, I think there is some truth to Baier's (1987b) belief; she thinks that if Gilligan is right and women do have different moral aptitudes, it likely will be they who have to make the proposal of marriage between the morality of care and the morality of justice. Notice, however, that even the overture requires women's speech.

Held (1984) has argued that it is unhelpful and erroneous to insist that there is or need be only one morality. Different moralities may be appropriate to different situations and one function of moral inquiry is to determine what aspects are relevant to a particular case; in some instances, a morality of caring will be preeminent while in others, it will be justice and yet for others, one still to be articulated. Rather than a simple mix, I think we require a creative vision of existence and thoughtful approaches to ways human life can be nourished within the political, social, and ecological structures that will constitute that existence. Instead of searching for the 'Holy Grail' of the one true morality, nursing ethics would be better served by the best possible "moral diagnosis" (Arras, 1991).

Virtue Ethics

Virtue ethics has been receiving renewed attention in moral philosophy (see for example, Casey, 1990; Dent, 1984; French et al, 1988; MacIntyre, 1984; Pincoffs, 1986; Yearly, 1990) and within nursing (Brody, 1988; Knowlden; 1990; Salsberry, 1992). Knowlden has argued for viewing caring as the virtue of nursing and Brody has suggested that virtue ethics would be a good alternative to the mainline deontological and utilitarian views as a basis for nursing practice. According to Brody (1988), the two former perspectives focus "on either the action or the outcome as the determining factor in the moral scheme" (p. 88). In contrast, virtue ethics focuses on the moral agent in the context of action; virtue unites the actor to the act (Pincoffs, 1986). Brody (1988) concludes that a virtue ethics would be helpful to nurses because it will not demand the either/or alternatives of the other approaches. When that happens, nurses "become outside judges trying to apply formal and abstract guides to a complex interpersonal situation and to ignore personal involvement" (p. 95).

I am extremely supportive of virtue ethics but not as nursing usually represents it. The problem is that nursing either argues for or assumes that care is the content of an ethics of virtue. Such positions merely obscure the insights that an understanding of virtue could yield. Our ethical world is composed of the three realms of virtue or character, duty, and a form of life (Williams, 1985; Yearly, 1990). Nursing would benefit by the articulation of thick ethical concepts (Williams, 1985) which would traverse all three domains of ethical experience. An impressive example of this type of ethical approach is demonstrated by the nurse and philosopher team of Winslow and Winslow (1991) in their essay, "Integrity and Compromise in Nursing Ethics". In this work the authors acknowledge the reality of compromise in our ethical lives and show how compromise is possible without loss of integrity. Integrity is a thick ethical concept which relates directly to virtue ethics but as demonstrated in practice cuts across institutional and disciplinary boundaries; it encompasses our characters, our duties, and our form of life.

Empirical Research

In this section, I examine the nature of the ethics research that has been conducted in nursing to date. I look at it from the perspective of the critique of bioethics discussed in chapter two. Because I am interested in the kinds of questions that researchers have asked and to what end rather than a specific content area, this discussion is necessarily selective. To this end, I have relied on comprehensive reviews for two reasons. First, well-done critical reviews tend to provide very good road maps for how research has proceeded over time. Second, the majority of research in nursing ethics has been dissertations which have not been published in other forms. In a few instances I have discussed a piece of research in great detail because I think it illustrates a point particularly well; however, my overall comments are addressed to the general pattern of the research. I draw on the important works of three scholars, Penticuff (1991), Ketefian (1988), and Parker (1990a). Although Gortner (1985) also conducted a review, I have not included it because the majority of empirical research was conducted after that work. There are two exceptions to these comprehensive reviews--work by Cooper (1991) and Lutzen (1993). These investigations merit singular attention because of their relevance to the present study.

Penticuff

Penticuff (1991) provided an excellent analysis of the conceptual frameworks used to date. These include bioethical theory, moral development theory, and role conception. Bioethical theory is a principle driven approach which attempts "to explain nurses' ethical practice or ethical decision making in terms of broad principles such as respect for autonomy, beneficence, and justice" (p. 236). According to Penticuff, there are three problems with this framework for research: 1) the exclusive reliance on these principles obscures the role that other factors assume in our practice; 2) these principles "do not reflect the breadth and diversity of concepts available in the general ethics literature" (p. 237); and, 3) the formalism inherent to this approach leads to a procedural or "formula ethics" (p. 239).

The problems with the moral development perspective are 1) that "it is not certain that moral development is predictive of ethical practice" (p. 240) and 2) the abstract, impartial characteristics of the justice orientation of morality.

In the role conception framework, there is a hypothesized "relationship between the nurse's conception of role--either professional or bureaucratic role orientations--and ethical practice" (p. 243). The assumption made in this research is that there is a connection between those nurses who have a professional role identity and their level of ethical practice. As Penticuff points out, however, "only about 25% of nurses sampled were categorized as holding clearly professional role conceptions" (p. 243), that is, most of the nurses in this research had both role identities. Another problem is that this research does not take into account "the context within which role conceptions are enacted" (p. 244). This failure precludes an exploration of the role of institutional factors in shaping nurses' role conceptions. Penticuff notes that "numerous studies of nurses' authority in hospitals have concluded that nurses do not have the autonomy and organizational influence necessary to carry out their professional responsibilities" (p. 244). Yet, Penticuff maintains that this research has been important precisely for these reasons.

As an alternative framework, Penticuff proposes what she calls, "integrated ethics research" (p. 244) which includes ethical theories as well as nursing theories. She argues that the "traditional foundational concepts of nursing--person, nursing, environment, and health" (p. 245)--combined with the concepts of ethical theories will advance and enrich both nursing ethics and bioethics (p. 252).

Ketefian

Ketefian (1988) completed an outstanding review of the published research literature and doctoral dissertations in nursing ethics between the years 1983 and mid-1987. There were 37 studies which included both quantitative and qualitative works; 28 of the 37 studies reviewed were doctoral dissertations and only 3 of the 28 were published. This research fell into one of two categories; moral reasoning or ethical practice. The investigators clearly endorse a positivistic account of morality and their method of research follows from that. Only two of these studies did not use any instruments at all and these were described as phenomenological.

In the methods section of her review, Ketefian included definitions of ethical constructs; namely, moral reasoning and ethical practice. A positivistic science requires a separation between logical, observational, and theoretical terms and because of problems in assuring the validity of theoretical terms, they are restricted to those that can be "operationalized" and therefore measured (Suppe and Jacox, 1985). Ketefian stated that there are difficulties in attempting to do this because "it is the nature of measurement that when a construct is operationalized the entire range of meanings cannot be addressed" (p. 4). She acknowledged that "this presents special difficulties with respect to the domains under consideration" (p. 4). She went on the note that despite the failure to clearly define and differentiate the constructs of moral reasoning and ethical practice, the former is generally held to be the cognitive processes involved in thinking about "moral choice" (p. 4), while the latter is considered to be the specific content of the reasoning and actions taken in "ethical dilemma situations" (p. 3).

Moral reasoning. All research on moral reasoning was based on the cognitive developmental model of Kohlberg. There were 15 studies in this section with the following range of designs; 7 descriptive/correlational, 4 descriptive/exploratory, 2 quasi-experimental, 1 experimental, and 1 qualitative. In the majority of these studies the sampling method was one of convenience and the subjects were nursing students rather than practicing nurses.

The factors utilized to predict moral reasoning were educational level, academic major or type of program, ethics courses, cognitive development, critical thinking or intelligence, college grade point average and scores from the Scholastic Aptitude Test, religion, age, gender, socio-economic status, area of practice, and prior clinical or work experience. The Defining Issues Test, the Nursing Dilemma Test, and the Moral Judgement Interview were the instruments used to measure moral reasoning.

Overall, results were ambiguous at best. This research did not support the work of the developmentalists who hypothesized a positive relationship between educational level and sophistication of moral reasoning. In contrast to this, the cognitive variables of intelligence, critical thinking, college grade point average, and Scholastic Aptitude scores were found to be positively related.

As for the remaining predictors, the effect of course work in ethics on moral reasoning was quite variable, area of practice was insignificant, and age, gender, and socio-economic status were either unrelated or contradictory. In discussing why there should be so little correlation between education and moral reasoning, Ketefian noted that many researchers failed to control for cognitive variables and attributed this to a failure "to appreciate fully the underlying assumptions of the cognitive-developmental theory of moral development" (p. 25). In the qualitative study, two types of moral reasoners were described along with the principles used to justify action and the contextual elements which extenuate the invocation of those principles.

Ethical Practice. Ketefian noted that the operationalization of ethical practice is particularly troublesome. Although there has been some significant agreement between scholars as to the operational definition of moral reasoning terms, this is not the case with ethical practice. As a result of this, investigators developed their own tools for measuring the latter with the result of questionable validity and reliability. The one exception to this was the instrument developed by Ketefian in which both validity and reliability were reported and found to be adequate. In all cases except one, the measure was a written vignette after which the respondent was asked a series of questions.

Six designs were used in a total of 22 studies: 11 descriptive/correlational, 5 descriptive/exploratory, 2 descriptive/qualitative, 2 phenomenological, 1 quasi-experimental, and 1 experimental. The majority of the subjects were practicing nurses and the samples were of the convenience type. The predictor variables used were, educational level or type, variables related to the work environment, moral reasoning, previous ethics education, and training in ethics. It is not clear how these latter two were seen as distinct.

Findings indicate that educational level was unrelated to ethical practice but was positively related to the selection of a patient advocate model of practice in student nurses. Academic level was also positively correlated to risk taking attitude by student nurses, negatively correlated to anxiety about the ethical situation, and not correlated to the ability to resolve the situation. Neither ethics education nor level of moral reasoning were found to correlate with ethical practice with one exception to the latter. Ketefian noted that the results from several of the studies support the literature regarding the effect of the work environment on nurses' ethical practice. These included such things as perceived autonomy and powerlessness.

Ketefian has provided a sterling review of the literature; it is comprehensive, well organized and well written. In view of the fact that most of this work is unpublished dissertations, the nursing world owes her a debt of gratitude. Yet her view of both ethical practice and the nature of research in ethics is limited. One could approach this from many ways; I want to talk of it in terms of Kohlberg's work since the research she reviewed was stimulated by and built upon his work. Furthermore, Kohlberg's work comes directly from a view of moral philosophy which is being challenged by practice and narrative accounts or morality.

In her endorsement of the Kohlberg model, Ketefian accepts several assumptions. First is the view of morality as essentially a matter of moral knowledge which can be discovered and then "applied to" the situation by a systematic use of formal principles. This view stands in opposition to both the practice and narrative conceptions of morality. In other words, for Ketefian, morality is largely a cognitive activity which exists somewhat independently of our daily lives. Focusing on morality as a cognitive enterprise allows it to be abstracted from lived realities. As I have suggested in the previous chapter, the unfortunate result of this abstraction is that it dose not capture the lived moral experience of those involved. The failure to attend to lived realities renders our moral discourse impotent to change practice in significant ways. This is not to suggest that a cognitive, procedural ethics does not change practice because indeed it does but the nature of these changes tends to subject practice to ever more technical, bureaucratic solutions. Ethics then becomes a matter of whether or not the appropriate policy was followed. For example, in the institution where I work, there are procedures in psychiatry for patients who are placed on legal holds for reason of being a danger to themselves, others, or gravely disabled. These procedures which were designed for maximum patient safety involve placing the patient in a locked room with no furnishings save a mattress on the floor. The patient is required to undress and wear hospital pajamas and must remove all personal objects including jewelry and eyeglasses. Such a procedure is required whether or not it is in the patient's best interest. In this case, the laudable aim of patient safety is controlled procedurally rather than by the demands of the situation. Unfortunately, adhering to policy is no guarantee of a moral life lived well. Furthermore, this approach tends to highlight the crisis approach to ethics. For example, Warren (1989) has argued that we focus on whether or not informed consent was obtained but not on the conditions which make truly informed consent possible.

Another complex issue concerns the whole notion of 'stage' in Kohlberg's theory. As we saw in the previous chapter, these stages are seen as invariant, sequential, necessary, and universal. As a former graduate student in developmental psychology, I recall that this notion consistently proved troublesome for developmentalists. As Gruber and Voneche (1977) stated, stage proved quite troubling for Piaget who actually said little about it. One of my professors concluded that we frequently confused the concepts of stage and development; his conclusion was that development was in the child and stage was in the world. Berger and Luckmann (1967) note this distinction; in their discussion of the role of the symbolic universe in structuring biography, they note that in primitive societies, ritualized rites of passage serve to mark a transformation in the individual's biography from one phase of social life to another. An essential feature of these rites is the reinforcement of social connectedness between the individual and the group (p. 99). They go on to note that in contemporary society, such transformations are marked by our psychological theories where:

> the individual passing from one biographical phase to another can view himself as repeating a sequence that is given in the "nature of things," or in his own nature. That is, he can reassure himself that he is living "correctly." The correctness of his life program is thus legitimated on the highest level of generality. As the individual looks back upon his past life, his biography is intelligible to him in these terms. As he projects himself into the future, he may conceive of his biography as unfolding within a universe whose ultimate co-ordinates are known (pp. 99-100).

I find this a particularly insightful way of examining the stage theory of moral development according to which a child moves from an intensely affective relationship with a very few people to an expanding circle of people and social life. Parallel to this increased participation in social life, however, is a directly inverse relationship with emotional connectedness. In the Kohlberg model, this progression is seen to reflect "the nature of things." Of course, in an important sense, Kohlberg and Piaget are not wrong for as Fox (1990) has argued, in our society, ethics is conflated with legality which is based on the notion of autonomous individuals who possess free will and are the bearer of rights. Where they are wrong is to equate ethics with legality and in assuming that our legal system reflects a "natural" category rather than a particular social construction which originated in response to certain historical conditions and that is amenable to change. All the alternative accounts presented in the previous chapter argue against such a view.

Parker

Parker (1990a) has provided us with a very thorough and well done critique of the problems associated with Ketefian's approach to moral theory and research. Parker noted "that the vast majority of theoretically derived hypotheses are not supported by the research data" (p. 213). According to Parker, the inconsistencies revealed in Ketefian's review have four possible explanations: 1) lack of construct validity in the measuring devices; 2) an inadequate theory; 3) methodological concerns; and 4) too limited a view of moral reasoning (p. 213). Parker examined each of these in detail, conducting an extensive review of the literature which, in each case, supported her conclusion. In her discussion of methodological concerns she poses what I think is the critical question; namely,

> A more pressing issue is the significance to nursing of measures of moral reasoning; that is, how relevant is research that ostensibly measures the ability of nurses to read a hypothetical dilemma and prioritize a list of predetermined ethical issues? (p. 215).

She goes on to note that the Defining Issues Test (DIT), the Nurses Dilemma Test (NDT), and the Moral Judgement Interview (MJI) which are the instruments which have been used, "do not enable an investigator to determine the ability of nurses to identify real moral dilemmas and their inherent ethical issues" (p. 215) but which "are a prerequisite to effective clinical decision making" (p. 215). To support her claim, Parker cites the three studies in Ketefian's review (Holly, 1986; Keller, 1985; Zablow, 1984) which supposedly demonstrate that nurses have difficulty identifying moral dilemmas. For Parker, this difficulty "underscores the importance of developing more effective tools for measuring the moral decision-making abilities of nurses" (p. 215).

In her conclusion, Parker used the work of Gilligan to show that Kohlberg's understanding of moral theory is far too limited to accommodate the experience of nurses. Parker suggested that both an ethic of care and an ethic of justice are necessary to the practice of nursing. "With such an approach, nursing can develop a theory of ethical practice that is true to the unique voice and experience of nursing" (Parker, p. 217). It would seem, however, that in choosing a methodological approach to the study of nursing ethics, Parker clearly favors Gilligan's narrative way. She ends her paper with the following:

> Research and theory-building efforts should reflect a commitment not only to empower nurses to articulate their moral concerns but also to act on their moral integrity. To that end, we nurses must listen to our own voices (p. 217).

In another work entitled "Nurses' Stories: A Search for a Relational Ethic of Care", Parker (1990b) takes up the theme of the power of narratives directly. What she says is important and I want to quote her at some length.

> I have never met a nurse who does not have a story to tell...Embedded in these too often untold stories are the rudiments of a nursing ethic that could be truly meaningful to nurses. Yet as professionals, we are struggling to develop a theory of ethics without really listening to what our experiences with patients tell us.
>
> The struggle continues because nurses are still memorizing the conventional scripts of biomedical ethics. When the story line of traditional moral theories fails to inform our experiences as nurses, we question our moral competence. This uncertainty further reinforces our passive, subservient role...And yet our subservience has also carried a subversive quality about it: nurses have been rewriting the official scripts of biomedical ethics since the Nightingale era. We have just taken most of our stories underground (p. 34).
>
> Many nurses have taken their stories underground to maintain personal integrity or to avoid further devaluation. Stories once spoken with passion have been silenced, rendered unspeakable by the threat of being ignored, intimidated, or judged morally inept. Consequently many of the stories stay within the confines of nurses' private dreams. "Mike's Story" and the stories embedded in the hopes and dreams of nurses need to be shared unabashedly again and again until nurses are able to understand their meaning and can articulate them to others. To do any less would make the tragic ending of Mike's life, and the lives of others like him, meaningless (p. 39).

I doubt that few who read her account of "Mike's Story" would fail to be moved; furthermore, her impassioned statement leaves no doubt as to her belief in and commitment to the power of nurses' narratives to reflect nurses' moral experience. I commend Parker (1990a, 1990b) for her contribution to nursing ethics and I want to respond to her work in three ways. First, there is a puzzling inconsistency in her combined work; on one hand she claims that we need to develop better measuring devices for nurses' moral decision-making (1990a, p. 215) and on the other hand, she advocates a narrative approach (1990b). These are incompatible approaches. Secondly, I want to discuss the idea that nurses can not identify moral issues. Thirdly, I want to add a cautionary note about how we use the terms care and justice as well as the moral principles of autonomy, beneficence, and nonmaleficence.

I begin with the first issue. I am puzzled by this confusion in her work. To say that we need better instruments to measure nurses' moral decision-making is to accept the same assumptions as does Ketefian. Yet, from the crucial question Parker (1990a) raises in her first paper and in the answer she gives in her second work, it is clear that Parker (1990b) rejects these assumptions. I think what may be at issue here is a failure to distinguish adequately the debate regarding the relevance of an ethic of justice versus an ethic of care for nursing from the issue of an appropriate way to study nursing ethics. In other words, there is a subtle implication that one can (and must) measure justice but listen to care. This is simply wrong. Can we not also have stories that reflect our lived experience with justice, supporting patient autonomy, and not doing harm? I would suggest that rich narrative accounts of these experiences would broaden our understanding of the conditions under which these terms become salient to practicing nurses. In so doing, we would be explicating some of Warren's (1989) housekeeping issues. We can clearly reject the need for a measuring morality and yet not reject the concepts of justice and autonomy.

The second point is of deep concern to me. Parker (1990a), Cunningham and Hutchinson (1990), and Akerlund and Norberg (1985) have all claimed that nurses have difficulty in identifying and articulating moral issues. I find their analyses important and instructive although for highly differing reasons.

Parker (1990a) makes a contradictory claim. On one hand, she acknowledged that the existing measures of moral reasoning "do not enable an investigator to determine the ability of nurses to identify real moral dilemmas and their inherent ethical issues" (p. 215) which "underscores the importance of developing more effective tools for measuring the moral decision-making abilities of nurses" (p. 215). Yet, on the other hand, she rejects this formalist approach in her paper on narrative and argues that the failure of ethical theories to reflect our experience leads to a sense of moral incompetence with feelings of uncertainty and passivity. If in fact nurses do not identify moral dilemmas, feelings of uncertainty and passivity regarding moral competence provide a plausible explanation. I think this is a very important point and merits further work.

Cunningham and Hutchinson (1990) argue that a myth of health care ethics is the belief that "ethical issues do not come up (exist) unless people disagree about what to do; or, if ethical questions are really significant, they will be obvious to everyone" (p. 237). This statement reflects contemporary bioethics which is dilemma and crisis oriented. The authors reject this view and endorse a practice account in which ethical issues are inherent to the practice. They attribute the inability to see the ethical issues embedded in practice to the lack of what they call ethical imagination. Cunningham and Hutchinson suggest that this failure of "ethical creativity is often peer group pressure--pressure to conform, the belief safety is located in consensus and protocol" (p. 237). This interpretation supports Parker's (1990b) and both views would suggest that Yarling and McElmurry (1986) have reason to be concerned with the institutional context of practice.

In a study of the attitudes of nurses on feeding severely demented elderly patients, Akerlund and Norberg (1985) state outright that ethical dilemmas will not be resolved if nurses are unable to articulate ethical theory. Because I find this conclusion and the assumptions of this study highly questionable I want to discuss it at some length. Akerlund and Norberg make two assumptions which merit scrutiny. Their first assumption is that ethical dilemmas can be understood as instances of double bind conflicts.

> A double bind situation occurs when an individual is involved in an intense relationship where two orders, levels or logical types of messages are expressed, one which contradicts or denies the other. The individual is also unable to comment on the communications and their messages, i.e. metacommunicate, to correct his/her discrimination of which order of messages to answer (p. 208).

The double bind conflict theory was originally developed as a way to explain schizophrenia but subsequently has been applied to other areas of conflict. A danger in using double bind theory, however, if that persons are pathologized. This is unacceptable on two counts. First, it is morally questionable when someone's concerns are reduced to pathology and secondly, such pathologizing leaves the larger context in which the conflict occurs essentially unexamined. In terms of ethical inquiry, to use double bind conflict theory, as Akerlund and Norberg have defined it, is to accept the traditional moral theorizing which is concerned with the logic, hierarchy, and conflict of principles. Ethics in this case is limited to a logical conflict between two equal but conflicting claims--the traditional ethical dilemma. For these reasons, I object to using double bind theory for ethical inquiry. The second assumption Akerlund and Norberg make is that knowledge of and ability to communicate about formal ethical theories will necessarily resolve ethical problems.

The participants in their study included 39 (35F-4M) health care workers including registered nurses, mental health nurses, practical nurses, and nurses' aides in a psychogeriatric clinic in Sweden. The researchers found that when severely demented people were no longer able to take food or fluids voluntarily, the staff were required to feed them. This was unproblematic as long as the patient was able to speak but once patients were no longer able to voice their concerns and preferences, the staff experienced intense anxiety. The anxiety resulted from "the difficulty in interpreting his behavior" (Akerlund and Norberg, p. 209) and from the possible necessity of force feeding. In this case, force feeding referred to spoon feeding since the setting's policy was to avoid tube feedings and intravenous feedings were only rarely used. The staff struggled with the meaning of force feeding which "could be anything between mild persuasion and physical violence" (Akerlund and Norberg, p. 209). For most of those interviewed, force feeding was equated with physical violence which generally meant holding the patient's head while forcing the spoon into their mouth. Most (but not all) participants found this action reprehensible and did not do it; however, Akerlund and Norberg do not provide specific numbers.

The authors grouped the nurses according to the ethical rule which they interpreted the participants as using to guide their behavior. Group #1, guided by the rule 'keep people alive', did not experience anxiety and contained all those participants who did force feed. In contrast to the other groups, these participants did not view their method of feeding as violence even though they "used fairly harsh methods" (Akerlund and Norberg, p. 210).

Group #2 followed the same rule but understood that they were causing the patient to suffer. This group experienced the greatest degree of anxiety which was related to their fear that feeding would choke the patient. Moreover, they were distressed by their inability to understand what the patient felt.

Group #3 was guided by the rule "'Don't cause the patient suffering' at the same time as they realized the primary task: 'Keep the patient alive'" (Akerlund and Norberg, p. 211). These care givers had few fears of choking patients. It is curious that what is an ethical rule for other groups ('keep the patient alive') is transformed to a task for this group. Regrettably, Akerlund and Norberg do not address the meaning or implications of this.

'Don't cause suffering' was the rule guiding group #4. These nurses expressed little anxiety and were emotionally distant from their patients. According to the authors, this group experienced a great deal of difficulty in their work. Their moral rule was interpreted as a psychological defense against closeness with their patients and did not apparently result from moral reasoning.

The nurses in this study were clearly concerned with the particularized knowing of their patients and experienced anxiety when this knowing was made far more difficult through loss of speech. And there most certainly was conflict, but Akerlund and Norberg seriously misplace the source and reason of this conflict. According to the authors,

> When not exposed to the fact that theories are systems not always immediately applicable to a concrete situation, the care workers become caught in double bind conflicts they could neither see not solve (p. 214).

This shows how the authors recognize that contemporary bioethics fails in the lived world but then go on to interpret this failure as the result of inadequate moral reasoning on the part of the respondents. Akerlund and Norberg write that what is needed is an understanding of the "different logical levels" of the conflicting demands (p. 215) and a determination of the priority of ethical principles. Interestingly, almost as an afterthought, they do say that nurses must seek to understand the meaning of the patients' behavior in keeping their mouths closed.

Akerlund and Norberg conclude that if nurses could reason accurately, they would not experience anxiety and distress over force feeding. This limited interpretation is inadequate in four ways. First, it ignores the very real possibility that the distress is likely an expression of the sense of sadness inherent to this difficult situation. Second, it fails to acknowledge the real sense of frustration at living in a culture whose ethical language does not reflect our lived experiences. Third, our ethical lives are not a matter of making a decision about the logical priority of one principle over another. Rather, they are a matter of the kind of people we want to be, the way we want to live, and what is of value and concern to us. This is a matter of cultural discourse on the meaning of our lives, not logical decision making. Fourth, their interpretation reflects a common but unhelpful view of suffering, that is, the myth that suffering is avoidable. Suffering is viewed as a problem to be solved, molded, and manipulated until it is amenable to some form of intervention, usually technological. In this way, suffering becomes manageable so that the intervention can be focused and precise but when intervention fails, the patient is seen as experiencing stress. For the practitioner, patient stress as a result of failed intervention makes suffering an embarrassment which must be denied or glossed over. Yet in stark contrast to this, the nurses in this study did not deny and did not gloss over--when the primary moral rule of avoiding causing suffering was found impossible, the nurses felt intense anxiety about the distress they caused patients and the nurses themselves suffered. According to these authors, the remedy for the nurses' distress is the ability to articulate formal ethical theory. Hence they interpreted the nurses' experience of suffering as a failure in knowing and articulating ethical theory. This is an example of the belief in contemporary ideas of rationality in which formal knowledge is held to be the "solution" for the mastery of feelings (Schott, 1988). But the assumption that ethical theory is sufficient to cope with suffering is simply wrong. Ethical theory has little to do with the lived experience of suffering. Nietzsche (1968) claimed that suffering is not merely the endurance of loss or physical pain, but rather, suffering is a disruption in the meaning of one's life. To suffer in this sense is to endure some intensely felt physical or psychological pain for no reason. It is the very absence of meaning which if it does not actually cause suffering, at the least, makes it unendurable (Brody, 1987; Kleinman, 1988). The nurses in the Akerlund and Norberg study were struggling with the meaning of force feeding elderly, demented patients; they found little meaning in the formal ethical theory which enabled them to cope with the human sadness in front of them. In suffering with their patients, these nurses demonstrated a morally coherent response to a difficult and tragic situation, a response which acknowledges our shared humanity and the inevitability of death. For Akerlund and Norberg to reduce their suffering to a deficit in moral reasoning is to do violence to the practice of nursing and nurses' moral concerns.

Finally, I want to make my third point; namely, that we must guard against the careless reduction of all of our ethical terms. Without the context in which the terms are used, whether they be care, justice, autonomy, respect, or rights, the terms become like computer bits, abstract and interchangeable. When this happens, our ethical experience is in morbid danger of being reduced to some common denominator of barrenness, or worse, trivialization. I believe it is unfortunate that Akerlund and Norberg focused on the articulation of ethical theory for one final reason. Their concern with formal ethics, I believe, actually obscured the potentially very valuable and insightful thick description (Williams, 1985) of the moral meaning of the behavior of the four groups of participants. Providing thick descriptions of our lived ethical experience can illuminate the various conditions which constitute our ethical experience; our understanding of ourselves as we are and want to be, the social relations which comprise our form of life, and the duties and obligations which obtain in our various practices. A discourse rich in thick descriptions might just offer a vision of a better way to live as well as a way of holding "a continuing conversation about moral responsibility" (Cunningham and Hutchinson, 1990, p. 238).

Cooper

I make special note of Cooper (1991) because her overall aim and methodology are so similar to the present study. As in my investigation, Cooper sought to understand ethical concerns from a practice perspective, she employed a narrative methodology, each participant was interviewed twice, and she asked a nearly identical question: "Tell me a story about an ethical or moral dilemma you have experienced in your work" (p. 24). Her study differs from the present one in four ways. First, Cooper's aim was "to begin explicating the moral framework informing the practice of nursing by examining the role of principle-oriented ethics and the ethic of care" (p. 23). In my study, although I was interested in seeing the moral language that nurses employed, I did not presuppose any particular framework. Also, I was particularly concerned to see two things: 1) what these nurses identified and labeled as ethical concerns, and 2) an understanding of practice from which these concerns arise. Second, Cooper restricted the wording of her research question to dilemma whereas I utilized the technically broader conception of concern. The significance of this is unclear, however, in that concern, problem, and dilemma are frequently used interchangeably in everyday language. Third, her population consisted of critical care nurses whereas the participants in this study were psychiatric and home care nurses. Fourth, she had a smaller sample, 8 as compared to 19.

Lützén

In a series of investigations constituting her doctoral dissertation, Lützén studied psychiatric nurses' understandings of their relationship to patients. She used both qualitative and quantitative approaches; the former were grounded theory and phenomenology. What emerged early in this work were the moral dimensions of these nurse-patient relationships. These moral dimensions included the vulnerability of the patients and the fact that their autonomy frequently is restricted by nurses. Furthermore, the ethical concerns of the nurses in her studies lie within the everyday realities of practice and the nurses' emotions were important to their motivation and self-evaluation regarding their work. The findings of my research corroborate much of Lützén's work. There are some differing theoretical implications for nursing ethics, however. For while Dr. Lützén also questions the usefulness of a principle-based ethics to nursing practice, she, like Cooper, is far more supportive of the language of care to articulate a nursing ethic than am I. Her work is important and merits the attention of the international community of psychiatric nurses. In the next chapter, I discuss the methodology and sample characteristics.

CHAPTER FOUR

NARRATIVE AND NURSING ETHICS

Section One: Narrative Rationality and Methodology

Thus far, I have indicated my agreement with the following two arguments; 1) that our ethical world is a triadic composition consisting of the kind of people we are and want to be, duty or obligation, and our form of life and 2) that thick concepts of our ethical experience are more relevant to our ethical lives than are ethical theories. As Williams (1985) indicates, thick concepts, for example, brutality, courage, indifference, and care are tied to our reasons for acting; furthermore, the moral agent is embedded in a shared world, a form of life. Thick descriptions allow us to articulate our ethical experience as we actually live it. Such an articulation of our ethical experience is important because it can pose not only a better vision of ethical life but also because it holds the possibility of better ethical practices. Thick descriptions, however, are possible only within a discourse unconstrained by abstract, formalistic language; they require speech which gives vent to the entire range of human meanings. As Geertz (1973) states,

> The thing to ask about a burlesqued wink or a mock sheep raid is not what their ontological status is. It is the same as that of rocks on the one hand and dreams on the other--they are things of this world. The thing to ask is what their import is: what it is, ridicule or challenge, irony or anger, snobbery or pride, that in their occurrence and through their agency is getting said (p. 10).

In this chapter I suggest that narrative discourse is the most appropriate discourse for understanding clinical ethics. Specifically I argue for the use of narrative as method and methodology for research in clinical health care ethics. I believe such an approach to be a corrective to many of the criticisms of contemporary bioethics that I have discussed. Before proceeding with a discussion of narrative, I want to clarify my use of the terms method and methodology.

Method and Methodology

In calling attention to these concepts, I draw on the work of Sandra Harding (1987) for definition and analysis and on that of Nicholas Maxwell (1984) for relevance to academic inquiry. Harding makes a distinction between method, methodology, and epistemology. In her view, method is a technique for gathering evidence which, in the social sciences, can be only interviewing, observation, or examination of documents. On the other hand, methodology is a theory of how research should proceed, and epistemology a theory about knowledge, that is, who can be a knower, what can be known, and how it can be known (p. 2-3). Questions of methodology concern the purpose of the research, who the research subjects are, and the nature of the relationship between the researcher and participants. These issues challenge the rational-world paradigm views that knowledge is neutral, that the goal of research is knowledge, and that all knowledge is important just because it is knowledge. For Harding, failing to note these differences results in confusion which often leads to a focus on method obscuring the more important issue of methodology. I return to Maxwell in a later section.

In demonstrating the relevance of narrative for discourse and research in clinical ethics, I discuss the following topics; 1) the nature of narrative, 2) a philosophical framework for understanding narrative discourse, 3) the relevance of narrative for understanding our ethical lives and clinical ethics in particular, and 4) the comparison of a narrative approach with other types of qualitative research methods.

The Nature of Narrative

According to the Oxford English Dictionary (1982), the verb narrate meaning to recount or relate is a relatively recent addition to the English language, making its first appearance in Scotland sometime around 1750. Etymologically the word is related to the Latin gndrus, meaning knowing or skilled and "thus related to know" (p. 1896). Interestingly, however, narrative was a term in Scotch law as early as 1561 and referred to "that part of a deed or document which contains a statement of the relevant or essential facts" (p. 1896). Shortly afterwards in 1566-7, narrative as "an account or narration; a history, tale, story, or recital (of facts, etc.)" enters the English language. Yet noted literary critic, Roland Barthes has claimed that "the narrative is present at all times, in all places, in all societies; the history of narrative begins with the history of mankind; there does not exist, and never has existed, a people without narratives" (quoted in Polkinghorne, 1988, p. 14). Indeed, White (1980/81) has noted that people of various cultures can understand each other's stories even when they do not understand specific cultural thought patterns. This has led him to suggest that narrative is a "metacode, a human universal on the basis of which transcultural messages about the nature of a shared reality can be transmitted" (p. 2).

A narrative is a recounting of some event(s) according to a temporal structure consisting of a beginning, middle, and end (Prince, 1987, p. 59). According to literary theorist Burke (cited in Lucariello, 1990), "narrative requires an actor, an action, a goal or intention, a scene, and an instrument" (p. 131). Some imbalance among this pentadic relationship must occur against a background of canonicality (Lucariello). That is, narrative presupposes a background of regular, expectable activity which is ruptured by some form of imbalance among the five elements. As Wiedemann (1986) notes, "stories are not concerned with just any events but with those which are out of the ordinary" (p. 48).

Another essential feature of narrative according to literary theorists Greimas and Courtes (cited in Lucariello) is "the subjectivity of the protagonists" (p. 132). When an imbalance does occur, the consciousness or subjectivity of the actors or narrator is brought to the fore. The illumination of this consciousness or subjectivity serves to highlight the relationship of the actor or narrator to the event.

According to Wiedemann (1986), "story-telling is a modus operandi in which the narrator transforms incidents into experiences thereby creating his own subjective reality" (p. 47). This sounds much more idiosyncratic than I believe Wiedemann intends. I think that what he means by subjective reality is not some essentially private, foreign, and unsharable world such as, for example, the delusions and hallucinations of the schizophrenic. Rather, he is suggesting that the process of story-telling introduces a reflective mode through which the teller establishes the nature of his or her relationship to the events. While story-telling establishes a claim of connection to the events, it does not necessarily mean that the events are accepted for they can as easily be repudiated. But what does happen is that the teller is transformed from a passive recorder of incidents to a being with personal agency, an agency which establishes connections to and makes moral evaluations about various events. In this sense, mere events become *my* experience.

By positing that story-telling or narrative transforms events into experience, Wiedemann is calling attention to a subtle but nonetheless crucial distinction in the relationship between events, experience, meaning, and narrative. I believe it is fair to say that most theorists agree with Polkinghorne (1988) who claims that "experience is meaningful" and that narrative "is the primary form by which human experience is made meaningful" (p. 1). This would seem to suggest that all people have experience. While Wiedemann agrees that experience is meaningful, his view suggests that story-telling is not the making of meaning but rather the making of experience itself; without narrative we have only events. Prince (1987) defines an event as,

> a change of state manifested in discourse by a process statement in the mode of do or happen. An event can be an action or act (when the change is brought by an agent: 'Mary opened the window') or a happening (when the change is not brought about by an agent: 'the rain started to fall'). Along with existents, events are the fundamental constituents of the story (p. 28).

For Wiedemann, narrative form does not make experience meaningful for experience is inherently meaningful; instead, narrative form makes experience out of events. In this view, we do not automatically have experience which becomes meaningful through story-telling; rather, we witness or take part in events which are transformed into experience by story-telling. This, of course, implies that we do not all have experience simply because we have witnessed or even participated in events. I find Wiedemann's distinction an intriguing one with implications for practice, education, and the kinds of discourse we support culturally. Much more needs to be said about this but the task must await another time.

The subjectivity of the protagonists or narrator comprises what is known in literary theory as stance, perspective, or voice. Whereas stance and perspective refer to "who 'sees'" and "whose point of view governs the narrative", voice "provides information about who 'speaks,' who the narrator is, what the narrating instance consists of" (Prince, 1987, p. 102-3; Lanser, 1981). Voice comes from a person and thus is located in place and time; it is embedded in and reflects the structural and interpretable relationships of actor, action, intention, scene, and instrument. According to Mishler (1984), voice represents "a specific normative order, a particular assumption about the relationship between appearance, reality, and language" (p. 63). Narrative voice illuminates the interaction between personal agency and "system-level constraints" (Personal Narratives Group, 1989, p. 6).

Stories grouped together by common themes comprise a tradition (McGuire, 1990) thereby linking individual narratives with aspects of the broader culture that include both a history of the past and a horizon of possibilities for the future. Narratives thus serve to socialize us into a community (Benner, 1991; Coles, 1989; Howard, 1991; Miller and Moore, 1989; Ruddick, 1989), shape our identity as persons (Bell, 1988; Bertaux, 1981; Brody, 1987; Bruner, 1987; Cohler, 1982; DeConcini, 1990;

Greene, 1991; Polkinghorne, 1988; Sandelowski, 1991; Warnock, 1987), sustain our connection to community (Benner, 1991; Parker, 1990b; Stuhlmiller, 1991) justify our actions and moral stances (Burrell and Hauerwas, 1977; Eller, 1990; Hauerwas, 1986; Warren and Messinger, 1988) and provide ways to understand and cope with our world (Bell, 1988; Brody, 1987; Howard, 1991; Kleinman, 1988; Kotre, 1984; Williams, 1984).

Philosophical Framework For Understanding Narrative Discourse

The contemporary interest in narrative originated in the philosophy of history as an answer to the cause/reason debate (Polkinghorne, 1988; Walkup, 1990). Since that time, a narrative tradition in the human sciences and humanities has developed with scholars drawing on a variety of sources. In this section I discuss the philosophy of narrative discourse as delineated by Walter Fisher (1987) in his *Human Communication as Narration: Toward a Philosophy of Action, Value, and Reason*. Fisher is concerned with communication understood not merely as what we say and how we say it but rather, as reasons for acting, specifically with the moral content of our reasons for acting. Such a view can be seen as a positive account of practical reasoning (Wiggins, 1978) which begins with the exploration of what it means to act for a reason. Fisher explores how the nature of narrative discourse influences our evaluation of those reasons.

This section includes several parts: 1) a brief history of the fragmentation of discourse in Western thought with the resulting rational-world paradigm; 2) resistance to this dissolution; 3) the narrative paradigm as an alternative; and 4) narrative as method and methodology for ethics research. All references to Fisher pertain to his 1987 work and because this is the explication of Fisher's theoretical position, I have been liberal in quoting. Also, I have been liberal in giving page numbers even when not using direct quotes.

Fragmentation of Discourse and the Rational-World Paradigm

Discourse understood as meaningful speech between participants who share a language (Mishler, 1986a, p. 10-11) can take several forms: everyday speech, literature, technical speech. This is not a contemporary distinction but dates back to the Pre-Socratics, and to Plato (Murdoch, 1977) and Aristotle who initiated the transformation of logos from its original meaning (Fisher). As Fisher writes,

> In the beginning was the word, or more accurately, the logos. And in the beginning, "logos" meant story, reason, rationale, conception, discourse, thought. Thus all forms of human expression and communication -from epic to architecture, from biblical narrative to statuary--came within its purview (p. 5).

In this sense, all communication was consequential and "presumed to be rational" (Fisher, p. 24). Imagination and everyday speech were not separated out and held to be inferior or secondary. But this changed with the pre-Socratics, Plato, and Aristotle as discourse became fragmented. Logos was transformed from a generic term into a specific one applying only to philosophical, that is, technical discourse. In this way, logos was separated both from rhetorical discourse which is concerned primarily with the practical life of the polis and poetic discourse which is concerned with personal knowledge and consciousness. Mythos or imagination was seen as governing poetic discourse while rhetoric was the province of the realm where logos and mythos meet.

Such a division confined true rationality to philosophical (or technical) discourse. This fragmentation underwent further refinement with Francis Bacon who separated even philosophy from technical discourse. It is with Bacon that we begin to recognize the origins of our contemporary world view which privileges science as the only legitimate rationality. The effect of Bacon's thought was to ground knowing in scientific method, a set of procedures for establishing truth claims. "Philosophy retained a high status but only as it focused on science. The "demotion" of philosophy was a concomitant of the new theory of knowledge--that knowledge concerns the physical world and is strictly empirical" (Fisher, p. 8). Descartes' (1985) contribution was to ground scientific method in mathematics so that only what could be known mathematically counted as true knowledge. Philosophy's answer was not to challenge this narrow view of rationality but rather, philosophers themselves sought to become technicians of the word (Barrett, 1978). Thus in the beginning of the twentieth century we have the philosophic framework of logical atomism, largely the work of Wittgenstein, in conjunction with Russell and Whitehead (Barrett, 1978). [It is acknowledged that in his later writings, however, Wittgenstein reversed his position, arguing that language is constitutive of social life (Barrett, 1978).]

Logical atomism holds that thought and language are comprised of very basic, discrete propositions which are organized by logic and which parallel the atomic facts of the physical world (Barrett, 1978; Cottingham, 1984). This of course was the basis of logical positivism, now defunct as a philosophy of science (Cottingham, 1984). Yet the debates about method persist. With the achievement of logical atomism, we can see the deformation of logos in two ways. First, rational discourse is radically limited only to what can be expressed in logical, lawlike statements. Second, the questions and concerns about human existence which were articulated through logos are now severely reduced. Rather than struggle with the mysteries of life and death, philosophers now engage in endless "hair-splitting debates" (Barrett, 1978, p. 23).

My favorite example of these hair-splitting debates comes from philosopher Mary Midgley (1989) who is highly critical of both academic philosophy and science for failing to respond adequately to the significant problems of the world. She cites the example of a debate on euthanasia between Doctors Tongs and Hammer:

> In the approved style, Hammer began his attack with a disclaimer, stressing that neither he nor Tongs was saying anything about the

> wider issue of euthanasia itself; his intention was simply to find fault with Tongs' reasoning. This he did for thirty pages, without, so far as he could see, committing himself to saying anything at all about the actual problem (p. 252).

In her commentary on this debate, Midgley (1989) responds that "it is worth just noting that nobody, from the Angel Gabriel downwards, has ever produced an article about which this kind of criticism could not be made" (p. 252).

For Fisher, the above example is an expectable result of the progressive fragmentation of discourse which has led to what he calls the rational-world paradigm. The assumptions of this view are:

> 1. Humans are essentially rational beings.
> 2. The paradigmatic mode of human decision making and communications is argument--discourse that features clear-cut inferential or implicative structures.
> 3. The conduct of the argument is ruled by the dictates of situations--legal, scientific, legislative, public, and so on.
> 4. Rationality is determined by subject-matter knowledge, argumentative ability, and skill in employing rules of advocacy in given fields.
> 5. The world is a set of logical puzzles that can be solved through appropriate analysis and application of reason conceived as an argumentative construct (p. 59).

The net effect of this world view is to fragment the self and limit the possibility of "rationality and sane praxis" by making public debate a matter for the experts (p. 19). This rational-world view is pervasive, although not totalizing; there are and have been alternative views.

Threads of Resistance

The poetic and rhetorical voices were not completely silenced with the transformation of logos by Plato and Aristotle. In Roman times, Cicero was a staunch defender of the logic of rhetoric; he well understood the role this discourse assumed in everyday life. In his *DeOratore*, as quoted by Fisher, Cicero states,

> For men decide far more problems by hate, or love, or lust, or rage, or sorrow, or joy, or hope, or fear, or illusion, or some other inward emotion, than by reality, or authority, or any legal standard, or judicial precedent, or statute (p. 37).

Rhetoric continued to command a noteworthy place in the scholarly worlds of the Middle Ages and the Renaissance. Even with the ascension of the new scientific method, the cause of rhetorical logic was strongly defended and ultimately advanced by Giambattista Vico. Vico emphasized two things in particular; one, the importance of imagination (Burke, 1985) and two, the probabilistic nature of human life which is one of the main tenets of rhetorical logic. Vico writes,

> ...whosoever intends to devote his efforts, not to physics or mechanics, but to a political career, whether as a civil servant or as a member of the legal profession or of the judiciary, a political speaker or a pulpit orator, should not waste too much time, in his adolescence, on those subjects, which are taught by abstract geometry. Let him, instead, cultivate his mind with an ingenious method; let him study topics, and defend both sides of a controversy, be it on nature, man, or politics, in a freer and brighter style of expression. Let him not spurn reasons that wear a semblance of probability and verisimilitude (cited by Fisher, p. 41).

In arguing that Descartes' (1985) method for guaranteeing certain knowledge was not applicable to the study of man, Vico anticipated Dilthey who was significantly influenced by him (Burke, 1985). Contemporary scholarship is beginning to acknowledge the debt they owe Vico (for example, Dallmayr and McCarthy, 1977; Gergen, 1984; and especially, Toulmin, 1990).

The contemporary world has maintained the separation of literature and science with a vengeance; literature is fictional, science is factual. Yet Vico, a poet himself, vehemently rejected the exile of mythos or poetic voice from the logos of the day (Burke, 1985). A contemporary biographer recognizes that "in an age when the split between the literary and scientific approaches to the understanding of society is widening into a chasm, there is much for us to learn from Vico" (Burke, p. 9). Bruner (1986) tells us that science does indeed make frequent use of metaphors to climb "the abstract mountain" but once there, the poetic devices are discarded for formal, ideally, mathematical theory. The once useful mythos must bow to causation and is relegated to the history of science which is, of course, not thought of as part of science at all (p. 48).

This is exactly what Maxwell (1984) argues against in his very provocative book, *From Knowledge to Wisdom*; he holds that this separation of academic inquiry into innumerable disciplines is profoundly destructive to rational inquiry. I take Maxwell's impassioned plea as a stand against the still continuing historical battle over which discourse "owns" logos (Fisher, p. 6). For Maxwell, academic inquiry must move from the problem of improving knowledge "to the dual tasks of articulating our problems of living, and proposing and criticizing possible solutions, namely possible human actions" (p. 3). I think Maxwell has extremely important things to say and I will return to him later. For now, I wanted only to make the point that although Maxwell does not talk of the rhetorical tradition per se, he is arguing for a new discourse of intellectual inquiry.

The dissolution of the original sense of logos has led to a fragmentation of discourse and the splintering of the individual and of the society. Many of our cultural dualisms are illuminated by seeing logos, mythos, and rhetoric relegated to separate domains. Logos rules reason, the expert, and the objective world; mythos reigns over emotion, imagination, art, and the subjective world. Rhetoric remains the discourse of public life but its meaning has degenerated to that of manipulation and deception (Toulmin, 1990).

Yet, the survival of rhetoric has been a force resisting the fragmentation of discourse. The negative meanings which rhetoric has come to hold in modern times are undergoing scrutiny. Scholars of varying persuasions are directly using and or discussing the term rhetoric (for example, Gusfield, 1976; Mishler, 1986a; Szasz, 1991; Toulmin, 1990) while concern with discourse is a major focus in the work of social criticism (Bellah, Madsen, Sullivan, Swidler, and Tipton, 1985; Reynolds and Norman, 1988; Stout, 1988; Walzer, 1987). But, for the most part, our institutions and practices remain structured in such a way so that the rhetorical tradition remains on the periphery of mainstream life, academic and otherwise. Yet the rhetorical tradition may attain more prominence in view of both Fisher's own work on narrative rationality and the recent upsurge in interest in narrative. I, for one, vigorously support a discourse which is inclusive of all of human experience and I maintain that such a discourse is absolutely essential to any meaningful account of ethics. This section is best summarized by Fisher himself.

> At issue in the story to the interrelations of logos and mythos is which form of discourse--philosophy (technical discourse), rhetoric, or poetic--ensures the discovery and validation of truth, knowledge, and reality, and thereby deserves to be the legislator of human decision making and action. The two stories inform one another and both are necessary to a full realization of the relationship between communication and what humans are and can become (p. 6).

Narrative Paradigm

As the above statement professes, Fisher's central concern is the nature of communicative experience and the moral content embedded in that experience. Of special import to him is the evaluation of reason and moral content. He claims that the failure of "theories of human communication and logic" to recognize and account for "the role of values in the constitution of knowledge, truth, and reality" (p. xi) has lead to a distortion of human life with serious consequences, the most disastrous of which may be the impossibility of public moral debate. Fisher argues for a transformation of logos and believes this is possible by viewing communicative experience within a narrative paradigm. A major advantage of the narrative paradigm is that it:

> shifts the controversy from who "owns" logos to a focus of what specific instances of discourse, regardless of form, provide the most trustworthy, reliable, and desirable guides to belief and to behavior, and under what conditions (p. 6).

The best way to summarize Fisher's ideas is to list his assumptions and then discuss them in brief. The underlying assumptions of the narrative paradigm are the following:

1. Humans are essentially storytellers.

2. The paradigmatic mode of human decision making and communication is "good reasons," which vary in form among situations, genres, and media of communication.

3. The production and practice of "good reasons" are ruled by matters of history, biography, culture, and character...

4. Rationality is determined by the nature of persons as narrative beings--their inherent awareness of narrative probability, what constitutes a coherent story, and their constant habit of testing narrative fidelity, whether or not the stories they experience ring true with the stories they know to be true in their lives.

5. The world as we know it is a set of stories that must be chosen among in order for us to live life in a process of continual re-creation (p. 64-5).

Assumption #1: Humans as Storytellers. Human beings are creatures endowed with symbol using capacities. For Fisher, "symbols are created and communicated ultimately as stories meant to give order to human experience" (p. 63). Stories are seen as "symbolic interpretations of the world occurring in time and shaped by history, culture, and character" (p. xi). As temporal beings, our stories are not uniquely our own. Rather, we are linked to a community of others through the stories of those who came before us and to those who will follow us. This capacity to narrate is universal to all cultures and is transmitted from generation to generation through socialization. The function of stories can be said to "justify (or mystify) decisions or actions already made or performed and to determine future decisions or actions" (p. 187). In this way, the consequence of accepting a given story is to "constitute or reconstitute listeners or readers as selves, to constitute or invoke the experience of community, and to shape the meaning of one's world" (p. 145). Because these stories are central to who we are and the kind of world we live in, there is a truth to them. In effect, human beings do not just tell stories, they dwell in them (Booth, 1988).

Assumptions #2 and #3: Good Reasons. The notion of good reasons is of critical import to the narrative paradigm, for the moral content of our discourse is embedded in good reasons; good reasons are why we believe certain things and act in certain ways. They are "elements in human discourse or performance that we take as warrants for belief or action" (p. 194). This stands in sharp contrast to the rational-world paradigm in which people are thought to believe and act in certain ways in accordance with the soundness of an argument.

Fisher claims that all rationality is concerned with a logic of reasons, that is, with such things as the formulation of propositions and the definitions of terms (p. 108). But Fisher sees this as a means not an end; they are a means to act rationally. In Fisher's words:

> concern is with the evaluation habit, the set of criterial questions that one is supposed to internalize so that one can ascertain the weight of reason in any given message, including one's own (p. 108).

In other words, Fisher wants to evaluate the moral content of the reasons themselves. He believes that such a focus transforms a logic of reasons into a logic of good reasons. This transformation requires five elements: 1) Fact--what is the moral content of the communication? 2) Relevance--is the moral content appropriate to the task at hand? 3) Consequence--what are the consequences of accepting the moral content of the message for "one's concept of oneself, for one's behavior, for one's relationship with others and society, and to the process of rhetorical transaction?" (p. 109) 4) Consistency--is the moral content in keeping with what I know of the speaker and the world? 5) Transcendence--independent of the truth value of the message, does the moral content, "in the estimation of the critic, constitute the ideal basis for human conduct?" (p. 109) The last is especially important for Fisher; he maintains that although these issues are always present in discourse, they are rarely "brought to the surface" (p. 109). But when they are, "they reveal one's most fundamental commitments" (p. 109). The logic of good reasons is the logic behind any of our claims to truth and knowledge of reality (p. 194).

Assumption #4: Narrative Rationality. Fisher argues "that there is, for our species, such a thing as narrative rationality and that we all understand and test for this rationality whenever we create or experience communication" (p. 193). Narrative rationality is a "'logic' intrinsic to the very idea of narrativity" (p. 19). This logic differs from other logics or conceptions of reason, most radically from that of technical discourse. In contrast to technical discourse, narrative rationality restores the original sense of logos as including mythos thereby rejecting the notion of reason as a technical, mathematical form of discourse devoid of moral content. Fisher certainly does not want to do away with technical discourse but, in his view, it no longer holds a privileged place and instead, is subsumed under the broader narrative rationality. As he says:

> the values of technical precision are not as important as the values of coherence, truthfulness, wisdom, and humane action, which are necessary for transforming technical logic and empirical knowledge into a force for civilized existence (p. 48).

The logic of narrative rationality also differs from rhetorical logics. Recall that when logos became differentiated, rhetoric became the discourse of the polis, of everyday community life. As such, rhetoric stood somewhere in the middle of logos and mythos; it was a form of practical reasoning, not unconcerned with moral content. Yet the distinctive feature of rhetorical logics is that they rely on "argumentative proof" (p. 49). By this Fisher means that rhetoric has always taken the form of an argument as central to reason in human communication. In other words, the criteria for evaluating both reason and moral content is argumentative form or the structure of the argument itself. Fisher does not disagree with this but argues only that this approach is too limiting. The assessment of communication, for Fisher, is more than the form of an argument--it is a matter of coherence and fidelity; these are the logical principles of narrative rationality.

Coherence (or probability) concerns how the discourse "hangs together." It is concerned with "the integrity of the story as a whole" (p. 105). Coherence has three parts: structural, material, and characterological (p. 47). Structural probability has to do with the internal dynamics of the discourse and we are familiar with these; does one element follow from another, is the story free from contradictions (p. 88)? Material probability is concerned with how this particular communication compares with what one already knows to be the case from other discourses (p. 47). For Fisher, characterological coherence is the most important and it underlies a fundamental difference between other logics and the logic of narrative rationality. Whereas other logics are concerned principally with "formal relationships and certitude" (p. 110), the logic of narrative rationality insists that the character of the speaker is extremely relevant to whether or not their discourse should be believed or acted upon (p. 47). Character, for Fisher, is "an organized set of actional tendencies reflecting values" (p. 147).

> Coherence in life and in literature requires that characters behave characteristically. Without this kind of predictability, there is no trust, no community, no rational human order. Applying this consideration of coherence is an inquiry into motivation. Its importance in deciding whether to accept a message cannot be overestimated (p. 47).

Fisher states that we need knowledge of agents as well as knowledge of the world. He writes:

> With knowledge of agents, we can hope to find that which is reliable or trustworthy; with knowledge of objects, we can hope to discover that which has the quality of veracity. The world requires both kinds of knowledge (p. 78).

The assessment of the moral content of a message by looking at the motivations of the speaker is also important because it is related to the notion of an audience. In accepting or rejecting a given discourse, we are in effect comparing the moral content of our own lives to that of the speaker. In so doing, we become connected or distanced from others. Fisher writes, "if one finds endorsement in a person's decisions and actions, one sees an extension of oneself in the community" (p. 148). His claim that narrative rationality works by identification rather than deliberation is clearly seen in this regard. That is to say that a given communication will be accepted or rejected not on the basis of formal argumentative form, but rather, on the basis of how the message reinforces my view of myself. For example, in discussing public moral argument, he writes,

> Any story, any form of rhetorical communication, not only says something about the world, it also implies an audience, persons who conceive of themselves in very specific ways. If a story denies a person's self-conception, it does not matter what it says about the world. In the instance of protest, rival factions' stories deny each

> other in respect to self-conceptions and the world. The only way to bridge this gap, if it can be bridged through discourse, is by telling stories that do not negate the self-conceptions that people hold of themselves (p. 75).

Thus we can see the pivotal importance of character to Fisher's account of narrative rationality. It is a position shared by Burrell and Hauerwas (1977) in their narrative account of morality. From both these arguments, we can conclude that appeals to narrative rationality will require attention to the character of narrators or actors.

The second principle of narrative rationality is fidelity or truthfulness. In contrast to coherence which is concerned with the story as a whole, "fidelity pertains to the individuated components of stories--whether they represent accurate assertions about social reality and thereby constitute good reasons for belief or action" (p. 105). Fidelity is assessed through "the logic of good reasons" (p. 47) which was discussed above.

A central characteristic of narrative rationality is that it works by identification, not deliberation. If I understand Fisher correctly in this matter, the rational assessment of discourse is not a matter of deliberating over alternatives which are hierarchically organized. Rather, it is rooted in the idea that we share narrative capacities; "we ask whether or not an account is faithful to related accounts we already know to be true. On these terms, we identify with an account (and its author) or we treat it as mistaken" (p. 194). Identification implies that we connect emotionally with others through the logic of good reasons.

Another important characteristic is that in contrast to traditional logics, narrative rationality is not normative, that is, there is no procedure prescribing the correct rules of reasoning. Narrative rationality is descriptive, which is to say "it offers an account, an understanding, of any instance of human choice and action..." (p. 66).

Assumption #5: The World as Set of Stories. Because the world presents a variety of stories we are exposed to a variety of moral contents. Fisher holds that some stories are clearly better than others when judged by the criteria of good reasons. Furthermore, the stories we endorse say a great deal about the kind of people we are and can become. Thus the narrative paradigm through the logic of good reasons offers a way to judge stories, thereby recognizing that "the end of communication is practical wisdom and humane action" (p. 92).

Narrative as Methodology

"The end of communication is practical wisdom and humane action" (p. 92). This is, I believe, Fisher's most powerful and noteworthy point. And if this is so for communication in general, it is certainly the case for ethical discourse; I believe it should be the aim of academic inquiry as well. For these reasons, I suggest that the narrative paradigm is the appropriate research methodology for research in ethics. Earlier, I discussed Harding's use of the term, methodology and now I turn to Maxwell (1984). Many of Fisher's concerns are shared and addressed by Maxwell (1984) whose work has deeply impressed me. Basically, Maxwell is arguing for a new philosophy of academic inquiry. He maintains that present academic inquiry operates under the philosophy of knowledge. The basic premise of the philosophy of knowledge is that,

> inquiry can best help us realize what is of value in life by devoting itself, in the first instance, to achieving the intellectual aim of improving knowledge, in a way which is dissociated from life and its problems, so that knowledge thus obtained may subsequently be applied to helping us solve our problems of living (p. 65).

In this view, the problem of knowledge is the central focus of academic inquiry.

In contrast,

> The central and basic intellectual task of rational inquiry, according to the philosophy of wisdom, is to help us imbue our personal and

> social lives with vividly imagined and criticized possible actions so that we may discover, and perform, those actions which enable us to realize what is of value... (p. 66).

Under this philosophy of academic inquiry, the mistake of transforming social inquiry to social science can be rectified. Maxwell's major claim:

> is that the social and humanistic disciplines...need to be pursued and understood not as sciences at all, but rather as methodologies of our diverse social endeavors, helping us pursue these endeavors more rationally and successfully (p. 115).

Explicating Maxwell's position would take me beyond the confines of the present work but I have tried to show in a matter of a few paragraphs the central position that moral content and humane action hold in his thinking on academic inquiry.

Social science understood as methodology and guided by moral content for the end of humane action has certainly been evident in feminist research (see, for example, Hall, 1992; Stevens, 1992; the Personal Narratives Group, 1989). Also it is firmly rooted in qualitative research whether or not conducted by feminists. For instance, Wax (1971) speaks of the power of moral commitment which becomes manifest in doing fieldwork. According to Bogdan and Biklen (1982), qualitative research had its origins in the impassioned journalism of the turn of the century; journalists began writing of the misery of the people living in the devastating conditions of the cities. In response to this writing, social surveys were instituted to further document the conditions. Bogdan and Biklen quote journalist Lincoln Steffens who published *Shame* of the Cities in 1904.

> This is all very unscientific, but then, I am not a scientist. I am a journalist. I did not gather with indifference all the facts and arrange them patiently for permanent preservation and laboratory analysis. I did not want to preserve, I wanted to destroy the facts. My purpose was no more scientific than the spirit of my investigation and my reports; it was, as I said above, to see if the shameful facts, spread out in all their shame, would not burn through our civic

> shamelessness and set fire to American pride. That was the journalism of it. I wanted to move and to convince (p. 8).

Within a twenty-five year period (and countless surveys later), the impassioned moral stance of journalism gave way to the disinterested knowledge of sociology. In his address to the American Sociology Association in 1929, William Ogburn argued that "sociology would have to develop new habits to be scientific."

> One of these new habits will be the writing of wholly colorless articles, and the abandonment of the present habit of trying to make results of science into literature...Articles will always be accompanied by the supporting data, hence the text will be shorter and the records longer...The sociologist will of course work on problems that tend to make sociology an organized systematic body of knowledge, but also he will choose for his researchers the study of those problems the solution of which will benefit the human race and its culture...But the scientific sociologist will attack these problems once chosen with the sole idea of discovering new knowledge (cited in Bogdan and Biklen, p. 8).

But the narrative turn recently taken by social science suggests that the journalists' writing has been more fruitful than the scientists' research in stirring moral passion to humane action. Sixty years later, in his presidential address to the Southern Sociological Association, John Reed (1989) stated:

> we do not give enough attention to narrative skill in graduate training...and...we should place more value on descriptive, story-telling sociological work, for reasons both intellectual and (broadly speaking) political (p. 2).

With the narrative turn, writing once again assumes major significance (Clifford and Marcus, 1986; Olesen, 1989; Richardson, 1990a, 1990b; Van Maanen, 1988) as social scientists recognize the power of narrative to call forth a response from readers or audience.

Scholars have illustrated the functions of narratives as described by Fisher. Narrative sets the context making possible a more complete understanding so that researchers do not have to choose between "the constraints of social structure or the power of individual agency" in articulating social reality (The Personal Narratives Group, 1989, p. 5). It should be noted that as an interpretive enterprise, the narrative paradigm does not make clear and distinct boundaries between these functions. Rather, they are woven together, providing a context which sets parameters yet permits fluidity. This is especially important in ethics research if we accept Williams' (1985) and Yearly's (1990) understanding of the ethical world as consisting of virtue and character, duty and obligation, and a form of life, for clearly, these can not be divided sharply.

There is one other central reason that the narrative approach is the most appropriate methodology for research in the ethics of health care; that reason concerns death. To accept a narrative understanding of human life is to accept our temporality and thus our vulnerability, not in any abstract way, but in the full recognition that we will die and those we love will die (DeConcini, 1990; Verhave and van Hoorn, 1984). To paraphrase Kierkegaard, we live our lives forward but we understand out of the past. When we have run out of future, our past looms large indeed. When "death asks us for our identity" (Fulton, 1976, p. 3) we must reckon with ourselves as moral beings. This is an eminently important task for ourselves and our community. And in this society, the person's meeting with death is (usually) inextricably bound with health care practices and institutions. Yet the dominant bioethical discourse with its abstract and technical focus functions as an abstraction to "detach ourselves from our temporal experience" (DeConcini, 1990, p. 116) leaving us little to offer patients or practitioners. In contrast, the narrative approach cannot deny our temporality and vulnerability. Research would open up the possibility of learning new stories for coping with the tragic in human life.

In summary, I have argued that bioethical discourse must reflect the realities of our ethical experience and research in ethics must seek to support practice. I believe that a narrative methodology is the most appropriate approach for ethical inquiry because it can lead to "practical wisdom and humane action" (Fisher, p. 92). I have suggested that Fisher's account of narrative would be an appropriate methodology for research in ethics. This version provides an account of human communication which encompasses the person, social life, rationality, and the function and aim of discourse, all of which are constitutive of ethical life.

Narrative Methodology and Qualitative Research

Thus far I have attempted to show two things: first, that people understand themselves and their world largely in terms of narrative discourse, and second, that there is a narrative rationality in that discourse which lends itself to research in ethics. This section continues the discussion of narrative as methodology in terms of qualitative research. The best way to approach this is first to make some comments about qualitative research in general. In so doing, I draw largely on Tesch's (1990) impressive work, *Qualitative Research*. According to Tesch, the term qualitative research in its most correct sense "means a certain approach to knowledge production" (p. 55) and is commonly understood as standing in opposition to quantitative research (see for example, Leininger, 1985; Munhall and Oiler, 1986; and Packer and Addison, 1989). It can be noted that this understanding is in keeping with Harding's (1987) distinction between epistemology, methodology, and method. Yet Tesch maintains that the adjective qualitative is somewhat of a misnomer in this regard because in the strict sense, qualitative refers not to a research methodology but to a type of data. For Tesch, "qualitative data is any information the researcher gathers which is not expressed in numbers" (p. 55). According to both Tesch and Patton (1990), qualitative, strictly speaking, refers to the type of data which can consist of "(1) in-depth, open-ended interviews; (2) direct observation; and (3) written documents" (Patton, 1990, p. 10). What is important is that regardless of source, the data are words. Words, however, can be treated in different ways, which leads to a second point made by Tesch. In contrast to quantitative data which has a unified procedure of analysis in the form of statistics, qualitative data has no such general method of analysis. The analysis of qualitative data understood as words spans a range from statistical treatment to a deep personal reflection on the part of the researcher as in heuristic inquiry (Douglass and Moustakas, 1985). In the words of Tesch:

> the notion of qualitative analysis is fluid and defies definition. It is applied to a wide variety of principles and procedures. The only agreement we would find among qualitative researchers is that analysis is the process of making sense of *narrative* data (p. 4, emphasis is mine).

Use of the term narrative data implies that ordinary discourse used as data for the purposes of research, be it open-ended interviews, written or oral descriptions of observations, or written documents such as letters, diaries, memoirs and the like assumes a narrative form. This is equally the case for discourse about ethical issues. Given the canonical background of narrative in everyday discourse, what methods of analysis would be the most fruitful in exploring the narratives of clinical ethics? Tesch identified 26 approaches to qualitative data or, as commonly understood, 26 types of qualitative research. Several of these methods would be appropriate for research in ethics, depending on what aspect of our ethical lives was being examined. For example, ethnography might be used to investigate the culture of clinical practice (the form of life) while heuristic inquiry (Douglass and Moustakas, 1985) might serve to explicate our understanding of ourselves as the kind of person we are and want to be. If we grant, however, that everyday discourse, including discourse about our ethical lives is narrative in nature, then content analysis and life history might be the most fruitful methods in an overall, general sense. Since content analysis is the most straightforward, I discuss this first.

In her examination of qualitative research, Tesch classified the 26 varieties into four categories according to the major research interests; these include the characteristics of language, the discovery of regularities, the comprehension of meaning, and reflection. It is important to note that Tesch considers this division useful primarily for educational purposes since most research does in fact accomplish more than one aim. Language can be studied either as a structure or as communication (Tesch; Todd and Fisher, 1988). Linguistics is usually concerned with the structural features of language and narrative form has been much studied from this perspective (for example, Chafe, 1986, 1990; Gülich and Quasthoff, 1986; Labov and Fanshel, 1977; Linde, 1986). Language as communication may be studied as an art form, the exchange of information and knowledge, and interpretation. The disciplines dealing with language in this way include the humanities, specifically literary criticism, the social sciences, and hermeneutics respectively (Tesch). According to Tesch, the social sciences have used content analysis as a method of studying language either as communication or as culture. Altheide (1987) notes the difference as either quantitative content analysis (QCA) or ethnographic content analysis (ECA) respectively. According to Starosta (cited by Altheide, 1987), QCA or traditional

> content analysis translates frequency of occurrence of certain symbols into summary judgements and comparisons of content of the discourse...whatever "means" will presumably take up space and/or time; hence, the greater that space and/or time, the greater the meaning's significance (p. 66).

In contrast, ECA, or what Tesch calls the ethnography of communication, focuses on "human beings engaged in meaningful behavior" (Altheide, 1987, p. 66). Furthermore, it draws on and produces narrative accounts. Now in claiming that content analysis is one way by which to study clinical ethics, I am clearly not talking about QCA. ECA on the other hand offers a way to explore "the patterns of social interaction among members of a cultural group" (Tesch, 1990, p. 61), in this case, health care practitioners.

This is also a way in which life stories are used. According to Bertaux and Kohli (1984), life stories are "oral, autobiographical narratives" which focus (1) on "the symbolic in social life and meaning in individual lives" and (2) considers interviewees as informants-ethnographic fashion" (p. 215). "Life stories show patterns of practices which constitute underlying sociostructural relations" (Bertaux, 1981, p. 36). Anthropologists have always collected first person oral accounts which were called life stories but when these were supplemented with other material, they were called life histories (Bertaux). Bertaux and Kohli (1984) noted, however, that recently anthropology has been caught up in the scientism of the day and "that life stories are no longer fashionable" (p. 231) although they are not unknown. Sociologists, on the other hand are returning to life stories after a long absence (Mishler, 1986a). As noted in a previous section, qualitative research began with life stories collected by journalists doing exposés on the conditions in deteriorating cities. The life story approach was abandoned in the 1940's as sociology turned to the survey in an attempt to gain scientific credibility. In the 1930's, Samuel Stouffer had adapted the survey format from instruments used by statisticians in the banking and insurance industries (Bertaux, 1981). But with the renewed interest in narrative understanding and discourse, social science has once again turned to life stories (for example, see Bell, 1988; Gergen and Gergen, 1984; Gusfield, 1976; Hall, 1992; Münz and Pelz, 1986; Personal Narratives Group, 1989; Richardson, 1990a, 1990b; Riessman, 1988; Silberstein, 1988; Van Maanen, 1988; Williams, 1984).

Bertaux and Kohli (1984) maintain that because narrative is studied across several disciplines including literary criticism (Bange, 1986; Benjamin, 1968; Chatman, 1980/81; Kermode, 1980/1981; Martin, 1986), anthropology (Clifford and Marcus, 1986; Geertz, 1973; Langness and Frank, 1988; Rabinow and Sullivan, 1989; Turner, 1980/81), history (Brüggemeier, 1986; Eller, 1990; White, 1980/81), psychology (Bruner, 1986, 1987; Cohler, 1982; Kotre, 1984; Lucariello, 1990; Sarbin, 1986), psychoanalysis (Schafer, 1980/81; Walkup, 1990), psychotherapy (Howard, 1991; Omer, 1993; Russell and van den Broek, 1992; Wrye and Churilla, 1979), psychotherapy from a linguistic perspective (Labov and Fanshel, 1977; Wiedemann, 1986; Wodak, 1986), linguistics (Chafe, 1986, 1990; Hardmeier, 1986; Linde, 1986), education (Baacke, 1986; Forrest and Jackson, 1990; Van Manen, 1990), philosophy (Carr, 1986; Kemp and Rasmussen, 1989; Ricoeur, 1980/81), ethics (Burrell and Hauerwas, 1977; Carson, 1990; Hauerwas, 1986; MacIntyre, 1984; Taylor, 1989), sociology (see above), nursing (Benner, 1984, 1991; Benner et al, 1991; Cooper, 1991; Hall, 1992; Parker, 1990b; Sandelowski, 1991; Stevens, 1992), and medicine (Banks, 1982; Barnard, 1986; Belli, 1986; Brody, 1987; Carson, 1982; Charon, 1986; Churchill, 1982; Churchill and Churchill, 1982; Coles, 1982, 1989; Daly, 1982; Hawkins, 1984, 1986; Hunter, 1991; Kleinman, 1988; Marston, 1986; Pellegrino, 1982; Rabkin, 1986; Sacks, 1985, 1986; Sexson, 1982; Smith, 1986) there can not be a "standard methodology" (p. 233) for narrative analysis. It is worth noting however, that the main intellectual tool for all qualitative research is comparison (Tesch).

What has emerged from this discussion is that narrative is not so much a form of analysis as it is the form of the data. In a very significant sense, analysis is more about seeing than it is about the application of techniques. What we see in a story and how we make sense of it is a matter of the context of the study and the data collection, the history of the researcher and participants, and the theoretical lenses which create possibilities for seeing; it is a matter of reflexivity (Olesen, 1989). The process of analysis itself produces narrative accounts which describe and explain (Polkinghorne, 1988). Yet some types of analysis clearly preserve the sense of narrative more than others. Since I thought this preservation imperative, I used strategies similar to Bell (1988) and Mishler (1986b) who approached their data as stories. Before discussing these further, however, I want to make two points regarding nursing ethics research and the preservation of data.

The first concerns the role of narrative in everyday discourse as a way of understanding ourselves and our world. Clinically, I have been struck by the power of narrative in people's lives at times of interruption. Research has now demonstrated that narrative arises when the canonical background is disrupted (Lucariello, 1990; Wiedemann, 1986) but this first became evident to me in the 1970's when I worked in a large medical school department of radiation therapy as a counselor. I worked on a referral basis which meant that the patients I was asked to see were deemed by some physicians as having difficulty coping. When I would ask how patients were doing or how things were going for them, I almost always was answered with some version of "fine." Yet when I asked how the cancer had interrupted their lives, I was told a story. Issues in clinical ethics arise against a canonical background--our lives are interrupted and we are faced with new challenges of action and meaning, both as patients and as providers. I strongly believe that the narratives told and listened to at that time can guide us in coping with the interruptions. I believe this because narratives keep the actors and the action central and that there is a narrative rationality against which we can judge reasons. Discussions about what to do must preserve narrative or we will sink to those discussions by ethics committees in which there is no person at all and talk centers on when someone is dead enough to be removed from machines (Flynn, 1991).

Second, I believe that narrative discourse can provide a bridge between the particularities of the situation and the "universals" of policy. The social organization of contemporary health care can not do without policy. And while it is important and has a positive side, it can also homogenize people and situations by disallowing discretionary judgement. Without narrative, health care practitioner's stand outside the situation and merely apply the action dictated by policy. Narrative discourse resists such attempts by opening the situation to include health care practitioner's--they are incorporated into the patient's story of disruption and bring their own as well. The expanded story now includes the "voice of medicine" and the "voice of the lifeworld" (Mishler, 1984) and both are subject to a logic of good reasons.

Dangers of the Idea of Narrative

The idea of narrative is not without its problems; the danger lies in our society's penchant for reifying things. In terms of narrative, my concerns are captured in the passionate words of Joel Frader (1991).

> Instead of case reports full of uninterpretable abbreviations, condemnatory remarks, and numbers, we now have disembodied texts sitting on chart racks on wards awaiting literary analysis. Have we substituted a highly intellectualized, but nonetheless alienated-from-the-patient, picture for a medicalized and degrading representation?...Have we taken up literary formalism to keep our distance from patients, just as students, house officers, and attendings use "techno-lingo" and unconscious insults in their speaking and writing? We need to demystify medical language, not replace it with other forms of obfuscation (p. 4).

I would add that my concern is not limited to our view of clinical case histories and what is written in the chart but extends to patients themselves. Following Frader, one could ask, instead of patients, do we have texts (literary, sociological, or otherwise) awaiting analysis? We must be aware of our ever present tendency to reify with its resultant diminishment of people. Smith (1986) has warned that language itself can be abstracted from human life and therefore we must remind ourselves that language is a tool for the interpretation of lives.

Summary: Section One

The fragmentation of discourse which has occurred over the centuries has resulted in a limited view of ourselves and our world. Because we have given priority to technical discourse, we have assumed that justification of our actions follows logical, deductive argument. When human communication is viewed as narrative, however, we find that our actions are justified by what Fisher has called "the logic of good reasons." The narrative paradigm is particularly concerned with the moral content of our reasons for acting and thus is especially suited to inquiry in clinical ethics. Narrative was compared with other forms of qualitative research and finally, the limits of narrative was discussed.

Section Two: Narrative As Method

The present research consisted of in-depth, open ended interviews of psychiatric and home care nurses that yielded narratives of practice. These narratives illuminated the relationships between nurses' moral visions, concerns, and the social context of practice. In this section I present the methods for data collection and analysis.

Recruitment of Subjects

Human subjects approval

Approval for research with human subjects was obtained prior to the initiation of the study. As a means of further protection, participants were not asked to sign a formal consent. Rather, they were given a printed information sheet and an opportunity to ask any questions regarding their potential participation. Their agreement to be interviewed was taken as consent.

Rationale for site selection

Because I sought to examine the ethical experience of expert psychiatric and home care nurses across the three domains of virtue, duty, and cultural ethos, I wanted a setting with both practice areas. This would allow for some stability of cultural ethos across the two groups. Two potential sites in the San Francisco Bay Area were identified; the choice was based on my familiarity with the facility. The psychiatric facility was a small, free-standing but medical university-affiliated institution which predominately served insured patients. It was also a teaching hospital. The home care agency was of medium size and serviced predominately Medicare patients. It was a department of the same medical university associated with the psychiatric facility.

Procedure

The directors of both home care and in-patient psychiatric nursing were contacted by telephone. After briefly explaining the project, an interview with the director was arranged to allow for more discussion. Their role was critical to this research, not simply for access but also because they would have to identify the expert nurses. The criteria for expert, taken from Benner (1984) and Zerwekh (1991), included a minimum of five years experience in nursing and being recognized by peers and supervisors as someone other nurses turn to for clinical advice. These criteria proved to be problematic and therefore were modified to include only the criteria of clinical experience. I will return to this momentarily. For right now it is sufficient to say that nurses were identified and my information sheet detailing the study was given to them.

Nurses meeting the criteria were identified by nursing management and provided with the information sheets. Nurses were given the opportunity to contact me either by postcard or telephone, the latter of which was used in all but one case. Once contact was made, the participant and I agreed to a mutually arranged time and place for the interview. The overwhelming majority of interviews were conducted at my home. Three psychiatric nurses and three home care nurses elected to have the interviews take place at the work site. This had been approved by nursing administration. All participants were interviewed twice with each lasting from one to one and a half hours. Two interviews were done for the following reasons: (1) a second interview would provide time for reflection; and (2) a second interview offered another chance to clarify issues which may have been unclear.

Problems

There were two problems in the area of participant recruitment; criteria for expert and difficulty obtaining participants.

Criteria for expert. This was raised by the nursing management group of the psychiatric facility. The director gave her approval to the study but also required the approval of her management team. I attended a meeting of this group and explained the study. Although supportive of the project, this group raised an interesting and challenging question about what constituted an expert as well as concerns about how staff morale would be affected by including some and excluding others in the pool of potential subjects. I had presented the notion of expert in terms of Benner's (1984) seven domains of competency and one manager specifically asked the provocative question; how many domains must a nurse be expert in order to earn the overall title? Since the facility has a clinical ladder, one possible solution was to include only those in the highest clinical level. This proved unsatisfactory to the managers because some nurses they thought expert did not meet the objective criteria for Level II while some who did were not thought experts by the managers. After considerable discussion, it was decided to include those nurses in both Level II and Level III who had five or more years of experience. Following this, the managers placed the information sheet in the mailboxes of those nurses meeting this criteria.

This notion of expert did not pose any questions or concerns for the director of home care, the only person with whom I had contact. After granting permission for the study, she agreed to find 10 participants who met the criteria. It is important to note, however, that there was a change in the experience criteria for home care nurses. Because home care is a fairly new area of practice, the director told me that very few nurses would have been in home care for five years or more. She informed me, however, that with few exceptions, all the nurses hired by her had at least five years experience in nursing. One home care nurse was six months short of the five year criteria but I accepted her nonetheless.

Obtaining participants. Although a few psychiatric nurses immediately responded to the information sheets, the original method of recruitment proved inadequate. As a result, the sampling was expanded to include clinical but non-staff nurses. Before resorting to this, I attended staff meetings and extended my recruitment efforts to the child psychiatric service. There was no response from the latter and only one from the former. I returned to the managers for help in understanding this and for any suggestions. They suggested specific nurses who provide clinical service but are not staff nurses. One obvious advantage in including these nurses was that their positions afforded them a wider view of the institutional setting and thus, a potentially rich source of insight. For this reason I included these nurses as potential participants and they did agree to the interviews. One of these nurses, in turn, suggested particular staff nurses who recommended yet other staff nurses. Thus, the sampling of psychiatric nurses was a mixture of purposive, direct referral, and snowball.

Some of the difficulty in recruitment may have been due to poor morale and anxiety about the state of psychiatric care in the city. This study took place within a budgetary context of severe cutbacks affecting psychiatric services as well as the possibility of a merger with the resultant restructuring. One nurse declined because of personal stress directly attributable to the merger. Furthermore, there is the reality of very busy lives. This may be the case especially with women who often bear the responsibility of child care. A recent newspaper article noted the difficulties of securing adequate child care for working nurses (Guthrie, 1992) and at least one person declined to participate for exactly this reason.

One final contributing factor was a misunderstanding. I had assumed that information sheets would go to all Level II and III nurses working both full and part-time. The managers, however, had understood they would go only to the full-time employees. I am certain the error was mine. In order to avoid the manager having to spend time identifying those nurses who met the time criteria, I opted to see if enough nurses would come forward through the other avenues and they did. One part-time staff nurse was recruited following my attendance at a staff-meeting.

Sample Characteristics

Number of Subjects

There were a total of 19 nurses in this study--10 home care and 9 psychiatric. A tenth psychiatric nurse did complete the first interview but then withdrew because of her concerns about patient confidentiality. The tape had not yet been transcribed and was relinquished to the interviewee. Another subject was not recruited because this was the end of the study and also because two home care nurses had previous psychiatric nursing experience, one being a clinical nurse specialist in that area.

Sex and Ethnic Origin

There were 4 men for a total of 21% and 15 women for a total of 78%. Although the absolute number of men is small, the percentage is higher than the percentage of men in nursing overall. All participants were white with the exception of two; one Latino and one, Euro-Asian. This was somewhat discouraging to me as I had hoped to obtain a slightly more mixed group especially from such an ethnically diverse geographical area. The reasons for such homogeneity are unclear. Perhaps it may be related to the particularities of the settings or to the practice area itself.

Religion and Religiosity

Overall, religion was not a significant factor in the current lives of these respondents. Although 78% (15) of the respondents named a religion, only one stated they were a devout practitioner. All of the others stated they did not practice at all or that they were a believer but did not attend church. Most of the participants who named a religion did so as a result of having been raised in that tradition. Some nurses, however, stated that while they were not religious, they were highly spiritual. Of this 78%, 9 named Roman Catholicism, 4 Protestantism, and 2 Judaism. Twenty-one percent (4) of the respondents claimed no religious identification. These questions were asked because religion is often a source of our ethical beliefs and a guide in our conduct; yet religion in this sense never arose in our conversations. I do not know how this sample compares with the population of nurses and how the specific geographic locale affects religious affiliation and practice. Yet the San Francisco Bay Area is recognized as a liberal area. Even the respondent who described themselves as a devout practitioner of Roman Catholicism is liberal by their church's standards. This person does Aids education and teaches the use of condoms which is against the official position of the Roman Catholic Church.

Nurses' religiousness and spirituality were not the focus of this study but I am intrigued by the work of Emblen (1992) who distinguished the two concepts. She notes that spirituality is a much broader concept which has come into being secondary to increasing secularization. In failing to appreciate the differences, we may falter in attending to patient needs. If morality is not only a matter of following rules, but also a matter of vision, (McNaughton, 1988) we may wonder how nurses' spirituality impacts on the ethical concerns of their practice.

Age, Years in Nursing, Years in Practice Area

Participants ranged in age from 28 to 54 with an average of 40.2 years. The age of home care nurses ranged from 28 to 46 with a mean age of 38.6. Psychiatric nurses were older with a range of 31 to 54 and a mean age of 42 years.

Not surprisingly, psychiatric nurses spent more time in nursing; the time ranged from 6 to 28 years with a median of 14.6. The time for home care nurses ranged from 4.5 to 18, the average being 11.6 years. The mean length of time for the total group was 13 years in nursing (range: 5.5 to 28 years).

There was a very striking difference between the two groups in the time spent in their current practice areas. The sample as a whole had been practicing in their current specialty for a mean total of 7.4 years with a range of 3 months to 28 years. The psychiatric group, however, had been in that practice area for a mean total of 13.2 years with a range of 5 to 24 years as compared to the mean total of 2.2 years for home care nurses. This difference can be explained largely by the relative newness and very rapid expansion of home care.

Education and Kinds of Positions Held

This was a highly educated group with considerable variety in progression and content extending from diploma through PhD candidacy. All had BSNs (this includes the two who are current BSN students) or other bachelor degrees with one exception; this participant holds an associate degree in nursing but was certified post degree in a related studies program. Six nurses had master's degrees and two more were current students. One had completed half the required work for a doctoral degree and one had been advanced to candidacy. The doctorates were being pursued in related fields of study.

All the participants currently worked in positions providing direct clinical services although not all are staff nurses. Three psychiatric nurses worked in liaison positions and three home care nurses did some management in addition to direct patient care. Only two nurses had held management positions for any significant time prior to their current positions.

Data Collection and Analysis

Collection

The interviews were collected over a period of seven months from August 1992 to March 1993. Problems of recruitment and the holiday season accounted for this extended interval. In nearly every case, the second interview took place within a one to two week period; in one instance, however, the intervening time was two months.

Method of Interviewing

This study is predicated on a practice theory of morality which sees moral considerations as embedded in our practices. In this view, the more familiar and traditional term of ethical dilemma is far too limiting; there are also moral problems, moral issues, and moral visions (Johnstone, 1989; McInerny, 1987). Because I was interested in how these broader issues are embedded in nursing practice, I asked only one question; can you tell me a story from your practice that exemplifies some ethical concern you have about your practice. Without fail, this initiated a sustainable conversation. Indeed, that this was so, frequently surprised some of the nurses; they did not know they had so much to say. This single question design gave maximum space from which to survey their practice, including the past, thereby inviting nurses to articulate and label their own ethical concerns. There is support for such a strategy from feminist theory as well in that set questions suggest pre-ordained categories which come from a given discipline. And yet, as Devault (1990) indicates, "'topics' for research do not necessarily correspond to categories that are meaningful in women's lives" (p. 98). Of course, not all the nurses were women but nursing is still women's work with all the inequities in power, status, and opportunities to speak that gendered work implies. Moreover, the methodology in this study embraces the feminist concerns in constructing knowledge (Acker, Barry, & Esseveld, 1991; Code, 1991; Devault, 1990).

Analysis

Listening served simultaneously as both an interviewing and analytic strategy. To say that listening was a central strategy in this research would seem to be stating the obvious or the unimportant except that very serious scholarship has been directed towards the importance of listening in feminist research (Devault, (1990). Listening served as an analytic strategy in several ways. It gave me direct verbal content in the sense of registering what the participant was saying. Of course, listening is never a passive activity because the listener is always making sense, connections, notes. The skilled and informed listener follows along, continuously aware of the possibilities the teller could travel. If the teller changes paths, or simply stops, there will be a disruption between the listener's grasp of the narrative and the teller's awareness of the listener's needs. When this occurs, the listener is most likely to ask, what is happening here? This happened regularly throughout the interviews. At these times, I would usually ask a question that would restore the break. For example, a nurse had been telling me a story of a person who had previously been adamant about not wanting any further treatment yet consented to an invasive procedure. The nurse was puzzled (as was I) but said nothing further. In situations such as these, we would work together to understand their response. In this particular case, I asked if the nurse had been able to talk with the patient and find out why they had changed their mind?

Numerous other strategies were also used, for example, what was that like for you, and suppose you had (or had not) done x or y, what would have happened? On other occasions, I wanted to challenge them to see another possibility or to provide a better explanation to me. At the same time, I wanted to be sure they did not see me as someone who had the right answers and was testing them. I handled this by saying, I'm going to push you a bit on this because I want to understand as best I can. Overall these strategies were successful in yielding productive interviews. Many times, I was told that I asked hard questions, or that they hadn't thought of x before.

The nurses who agreed to take part in this project were more than participants--they were partners in a joint effort to explicate the everyday morality of nursing practice. For the most part, this morality is centered in the relationship between the nurse and the patient because that is where the work of nursing takes place, if, that is, nursing is seen as more than a series of tasks performed on or for the patient. To articulate "the stuff" of relationship is no small task and both of us frequently struggled to bring forth in language some enigma of practice made manifest through our talking. Certainly, the listener brings much to the conversation and they hope to add even more through their writing or retelling of the stories. Yet, if the work is to be ethical as well as useful, it must remain faithful to the accounts of the tellers. I dealt with this in two ways. During the interviews when I was trying to help respondents clarify something, I specifically told them that I did not want to put words in their mouth and that they should correct me if I were wrong. At those times when I was struggling with my own articulation of an issue, I would tell the respondent this and ask them what they thought. In those cases where a nurse was talking of something brought up by another respondent, I would tell what the previous respondent had said and ask the present nurse to comment. This opened the possibility for agreement or refutation on an issue. The second means of addressing faithfulness to the data concerns data analysis and is discussed below.

Textual Analysis

Audio tapes of interviews were transcribed by a professional transcriptionist. Several of the transcripts were checked against the audio tapes for accuracy and since accuracy was not found to be problematic, this review was discontinued. Transcripts were read several times to ascertain the story line (Strauss and Corbin, 1990) which is always a matter of interpretation (Mishler, 1986b). Conveying how and why certain interpretations were made is a complex task which researchers face. In this case, three factors contributed to the arrived at interpretations. For one, interview transcripts were studied in detail. Once the plot or point of the story was determined, participant narratives were studied for the context and other elements of the story line; for example, who was involved, what were their actions and motivations, what motivated this issue of concern for the narrator, what was the physical setting of the situation, and so forth. This was a very lengthy process with some especially rich narratives requiring approximately 35 to 40 hours of attention. The result, however, yielded a coherent understanding of the participant's narrative. Moreover, such engagement with the phenomenon of study is one way to determine the credibility of qualitative research (Lincoln and Guba, 1985) which I will return to shortly.

The second factor related to my interpretations was that I stayed very close to the data (Mishler, 1990) in that the respondents' own labelings served as categories, such as listening, boundaries, and knowing the patient. In some instances, I used another sense of the word such as relationship for connection and testimony for advocacy. Finally, in two other instances, I imposed a linguistic category on descriptions of practice and these were acting for and having a life. Yet even with the former, I merely used a slightly different version of Henderson's (1966) theory of nursing. The case of having a life leads me to the third factor affecting my interpretations of these narratives and that is salience.

Given interpretations are partly the result of salience or what stands out as relevant (Lincoln and Guba, 1985). In research, the investigator's knowledge and experience, theoretical categories, and the contingencies encountered in the actual doing of research contribute to a definition of salience.

Having a life is a case in point. As this study sought to examine ethical experience across the domains of virtue, duty, and cultural ethos, I began by looking for instances of virtue, specifically references to loyalty, trustworthiness, courage, honesty, and so forth. But from an Aristotelian perspective, one sees virtue in relation to the end towards which some activity is directed. This alerted me to look for the end of nursing as understood by these nurses. Since this was not a question asked directly, the answer would be a level of interpretation further removed from the direct verbal data given by respondents. Such a state of affairs does not mean, however, that the interpretation is less accurate (Mishler, 1986b). The end of nursing typically is thought to be the health of the patient and yet when I returned to the data, I did not find these nurses speaking of health. Instead what I saw was concern with and attention to those aspects of the conceptual category of having a life as articulated by Rachels (1986) which includes a sense of agency, as well as temporal and spatial dimensions. This fit between conceptual category and initial re-examination of data created a sense of salience about the kind of data which would serve as evidence, that is, as empirical support for this conceptualization. In this way, the data provided evidence for the theoretical category.

The third factor involved in the interpretations given in this study concerns primary and secondary speakers about a particular topic. Each interview was treated as a narrative complete in itself and tended to be one of two kinds. One type was a story of a patient or situation in great detail while the other type was more general and reflected one's general orientation to practice. These seemed very similar to Denzin's personal experience story or self-story respectively (Denzin, 1989). By primary speakers, I mean that some respondents provided rich and detailed narratives regarding a specific aspect of practice, rather like the informants in ethnographic fieldwork. Secondary speakers, on the other hand, offered less detailed supporting evidence. Just as informants can show the researcher an insider's view, the stories of specific respondents in this study permitted me to share in a particular view of practice, for example, that of respect and relationship. Upon receiving such accounts, I looked for supporting evidence from other respondents or secondary speakers. Although lone accounts are not necessarily indicative of lack of validity, corroborating evidence does speak to shared experience and thus the commonality of the matter at hand. Furthermore, that these primary and secondary voices could be woven together to form a coherent story of the moral work and concerns of practice also suggests that my interpretations reflect the data. In the next chapter, the reader will find that I have relied extensively on respondents' own accounts. There are two reasons for this; I wanted the voices of these nurses to speak directly to the reader and in so doing, the reader can see the evidence I used in making an interpretation. In this regard, it is appropriate that I inform readers that respondents' texts were edited slightly for ease of reading and to decrease distractions irrelevant to the meaning of this research; primarily false starts and comments such as you know were removed. The purpose of the research dictates whether or not the texts could be edited and to what degree and still remain faithful to the data. For example, if this study were a linguistic analysis of the process of communication itself, the texts could not be altered. This process of textual analysis is concerned to illuminate how interpretations were made and therefore with the trustworthiness of the study which I discuss below.

Trustworthiness of the Study

This study is, to borrow Bosk's (1992) words, "a twice-told tale of witnessing". This is to say that the nurses in this study witnessed the lives of patients and gave testimony to those lives when called upon. In turn, this investigation is testimony to the stories of the moral work and concerns of these nurses; thus there are two levels of trustworthiness at stake here. Philosophers (Coady, 1992; Fisher, 1987; Fricker, 1987; Hardwig, 1985; Welbourne, 1979) have addressed this epistemological issue as one of accepting the warrants for believing something to be the case. Such a view marks an epistemological shift from what Fricker (1987) has called reliabilism to that of a justificationist conception of knowledge. As we saw at the beginning of this chapter, Fisher (1987) claims that people operate by a logic of good reasons which serve to justify their beliefs. Fisher, Hardwig (1985) and Welbourne (1979) emphasize the importance of the believability of the knower/speaker. I believed these respondents because I viewed them as experts on their own ethical concerns and was therefore epistemically dependent (Hardwig, 1985) on the knowledge of their authority. At the same time, I am a nurse who has worked for 24 years and, therefore, am not an outsider to nursing practice; their accounts were coherent and are faithful to the day to day realities of nursing as I know them. I, myself have experienced situations not unlike some of those spoken of in this investigation. This leaves the question of why my account should be believed.

It is possible that social scientists have been even more concerned than are philosophers with the issue of credibility. Researchers lie at a critical social junction where knowledge production intersects with the dissemination of knowledge, thus raising important questions of what research is to be accepted. With the waning of positivism's hegemonic dominance, social scientists working within the new paradigm have devised criteria for evaluating research that is more in keeping with the alternative epistemological assumptions (Lincoln and Guba, 1985; Mishler, 1990; Riessman, 1993; Sandelowski, 1986; Schatzman and Strauss, 1973; Strauss and Corbin, 1990). Like their philosopher colleagues, these social scientists have proposed the criteria of plausibility or credibility for evaluating the trustworthiness of research; the concept of relevance has also been used (Burgess, 1984; Hammersley, 1992).

For social scientists, the question of credibility is satisfied in several ways: the recognition of the experience upon hearing or reading the research, the ability of the research findings to persuade an audience, making explicit the actual procedures used to collect and analyze the data, respondent validation, and by the strength and richness of the conceptual linkages. The reader will at once notice that the first two of these can be determined only after the project has been completed and enters the public domain either verbally or in writing. On this criteria, the credibility of this investigation remains an open question.

As I have mentioned earlier, analysis is partly a matter of what one sees as relevant in counting as data and what use one is able to make of the "lenses" of concepts and theories. In the previous section, I was as explicit as I know how to be about something as difficult to account for as what one sees.

Respondent validation is considered a singularly important means for evaluating credibility although there are dissenting arguments (Sandelowski, 1993). Originally I had planned to return narrative summaries of my interview interpretations to one fourth of the respondents. Besides the particular interview, the summary was to have included the story line of my overall conceptualizations. Two factors changed my intended course of action. One was simply pragmatic in that I was increasingly pressed for time. The other, however, was far more problematic. As I began to think more about this, I realized I would have a dilemma should respondents object to my rendering of their moral experience. Their possible objection would not imply necessarily that I had "got it wrong" but might mean that they had had difficulty seeing the connection between their very personal experience and my much more abstract articulation as Sandelowski (1993) has discussed in a recent paper. While the practical limitations ultimately made the decision, I did have my thoughts confirmed during the last stages of writing when I returned to give presentations to the participating agencies. In the home care agency, the presentation was made to the management group who, with one exception, were not study participants. They were in overwhelming support of the findings. Following upon this, I was surprised to find that my presentation at the psychiatric facility generated little response. Upon discussion with the audience, several of whom had been study participants, I learned that I had conceptualized their stories in ways they had not thought about and they required more time to think.

Finally, there is the issue of the strength and richness of the conceptual linkages. Ultimately this is a question of the usefulness to nursing of this work for understanding the ethical dimensions of practice. This too awaits a future answer.

Before leaving this issue of credibility, there is a very interesting point worth noting. Hammersley (1992) argues that the evidence required to produce a credible study is relative to the claims being made by the researcher, that is, the more serious the claims and implications of the research, the more rigorous the requirements for evidence should be. To illustrate this he uses the example of deviance; if a given piece of research will result in people being labeled as deviant, the standards of evidence must be more stringent than for research not leading to such action. This is an ethical consideration of responsibility very similar to the morality of Fisher's (1987) criteria of good reasons, specifically, that which asks the question: what are the consequences to people and human life of accepting this story? This is a profoundly important point and admittedly, one which I have yet to give sufficient thought. Certainly my research makes no claims leading directly to the labeling (or, I believe, other harm) of individual nurses. But the ethical consequences to the profession of accepting this story of nursing ethics over that of principles or care must be answered in conversation with others.

Summary

This chapter examined narrative as methodology and method for nursing ethics research. It also included the sample characteristics so as not to interrupt the flow of the findings to which I now turn.

CHAPTER FIVE

NURSING ETHICS AND THE MORAL WORK OF PRACTICE

This study sought to understand the ethical concerns of psychiatric and home care nurses through narratives of their practice. I asked only one question: tell me a story from your practice that highlights some ethical concerns you have about your practice. A study so broadly conceived and designed presents the researcher with a dilemma. Since such an undertaking yields a vast amount of data, one can choose to focus on one or two issues in great detail or one can take a panoramic view. I chose the later because I wanted to construct a framework which would make sense of as many as possible of the ethical concerns voiced by these nurses. Another effect of such an approach was that one could say the sample was broadened. Because I did not put any constraints on the subjects, they frequently spoke of issues which happened in other times and places, in other specialty areas and even as long as fifteen years ago. Therefore, the study has stories about children as well as adults, ICU and medical-surgical units, as well as psychiatry and home care. Following from this choice the findings are, by necessity, broad serving to outline the field for further research and possibly to lead towards a beginning theory of nursing ethics--a theory based on the voice of nurses.

This broad outline encompasses the three central themes of having a life, relationship, and advocacy. Each of these has sub-themes which, when woven together, forms a tapestry of the work of nursing and the ethical concerns arising from that work. Having a life includes a sense of agency as well as spatial and temporal dimensions. Relationship, the primary vehicle for nursing work, involves the spatial distance between self and other which nurses call boundaries. Since a significant portion of nursing work involves acting for another, boundaries are ethically important because they serve to protect both the patient and the nurse. Finally, much of the ethical work of nursing is advocacy, a goodly portion of which is the giving of testimony. Although this tripartite structure of having a life, relationship, and advocacy can be separated for purposes of analytic discussion, the themes frequently converge in practice and thus there may be some overlap. In presenting these findings I have used the actual stories extensively so that this project would speak through the voice of the nurses who gave so generously, thoughtfully, and importantly of themselves. This project is the story of their ethical concerns.

Having a Life

Agency

Agency is the capacity to initiate meaningful action. Our acting in and on the world is what constitutes our projects, concerns, and engagements with others, in short, our lives. I deliberately choose agency over autonomy because the latter is currently a very contentious term and has several uses. More helpful is the meaning from self-psychology: the self is the center of initiative and strengths and weaknesses of the self lead to experiences of agency (E. Wolf, 1988, p. 65). Although this is a definition of self and not agency per se, it is illuminating in that we can see agency as a mix of motivation and physical action directed towards some end. Agency is concerned with what people do either through their own physical capability or sometimes through another. In the case of some professions, and in this case nursing, much of the work consists in doing for others. This is because disease and illness threaten and sometimes change people's experience of agency and therefore the kinds of life one can lead. This notion of the kind of life one can live is what has been referred to in traditional bioethics literature as quality of life. In this study, quality of life involved personal agency and engagement with persons and projects important to one. It should be obvious that these are not mutually exclusive but rather, interdependent. The following psychiatric nurse is explaining what she means by and knows of quality of life from her experience--she is emphasizing agency.

> Their bodies are going to deteriorate to the point of what's unacceptable to them, whether it's being incontinent, whether it's losing their memory from Alzheimer's disease or AIDS dementia, I mean we get that a lot. People make a lot of suicide attempts because their memory starts to go and they know the dementia is going to get progressively worse. I think the main issue and the issue that I hear from patients a lot is that they don't want to get to the point where they lose the ability to make the decisions about their life, like somebody else gets in control of their lives. I think that's the biggest fear of most people in their life, that they're going to end up in a nursing home, paralyzed, incontinent, and they're going to be left there (P1, p. 11).

Since, in this study, the end of nursing was helping a patient to have a life, agency was a matter of central import for these nurses. The following nurse expresses the commonly voiced concern by nurses in this study.

> I want people to be able to decide what it is they want to do in their lives as much as possible, within the confines and restrictions of their environment (P5, p. 10).

Protecting and nurturing patient agency, particularly under conditions of vulnerability is a fundamental feature of nursing work. By this protection and nurturance, nurses help to support self-confidence and success in areas of need which are and have been troublesome for patients. In the ensuing excerpt, a highly skilled psychiatric nurse is relating how she connects the patient's present situation with their past difficulties in achieving a similar end. Such a strategy by the nurse aims at longer term benefits to the patient than could be achieved if she were simply to act for the patient.

> We have some doctors who don't spend much time with their patients and some of the patients complained to me. So, what I do is, I work with them around assertiveness and asking the doctors to spend more time with them and role playing with them as to how to do it. Sometimes the doctors don't realize the patients want more time, and so I say, you never get anywhere unless you ask. And I try and reflect it back into what's gone on in their life and how they've

> been afraid to ask people in authority for things (P3, p. 1).

Nurses hope that by supporting the patient's agency, patients will make decisions and act in a way that makes sense in their particular life circumstances. A home care nurse specializing in maternal-infant care relates the following about women who are experiencing difficulty with breast-feeding:

> What they finally have to come up with for themselves is, how much do they really want to do this? And I'll tell them what's good about breast-feeding and why breastmilk is so good for the baby. But the final decision is theirs, and they shouldn't be doing this because someone else says they need to do this. It has to be something that they want to do, because it makes it easier for them if they've decided it's what they want to do. And that they're not doing it because somebody else wants them to do it and they don't really want to do it (HC7a, p. 23).

Indeed, it is a general belief of the nurses in this study that unless a given therapeutic goal is in synchrony with the patient's life and with his or her ability to achieve that goal, health care interventions will fail.

> You can come into a home with your ethical or medical/ethical ideals and say, this is what you should do. And if it doesn't fit into their lifestyle, they're not going to do it, you know. If they don't consider what you're telling them is going to help them live their life better, they're not going to do it. If it doesn't work into their routine, they're not going to do it. So you have to make it so, if they don't like it like this, maybe they will like it like this. You have to find out what will work for them (HC9, p. 24).

Not only is this nurse pointing out that the patient's agency intersects with the routines of their lived experience and with the goal of our therapeutic regimens but she is also implying the significance that place holds for the efficacy of patient agency. We will see later on that there is a potential for usurpation of patient agency in different spatial locations and that such arrogation is an ethical concern for nurses. In the meantime, we should look how the spatial dimensions of having a life were revealed in this study.

Spatial Dimensions

Three spatial aspects were apparent in this study: 1) people have bodies, they occupy space; 2) this space is not only a cosmic space in the sense of matter occupying volume, but they occupy social space as well--people belong somewhere; and 3) people are subject to what I have call, spatial vulnerabilities. This is an umbrella term by which I mean to convey a variety of ethical concerns raised by study participants. These ethical concerns involved harm to people by virtue of the nature of the health care spaces in which they did or did not find themselves. Put another way, to say that a person is spatially vulnerable is to say that they are susceptible to harm that results from a complex web of factors that are manifest in a given space in which they find themselves. Spatial vulnerabilities include such things as exploitation, homogenization of identity, and fragmentation of care. The first two of these aspects are directly concerned with those dimensions of life which constitute a *particular* person's life while the third reflects experiences of patients within the health care system which may threaten that *particular* life.

People have bodies. The most obvious dimension in this category is that people are material beings and therefore occupy space. If we treat this as so apparent as to be trivial, we will miss the pivotal fact that our personal identity is partly formed by our spatial circumstances and that our agency is constituted by how we act through space as well as time. As bodied beings, we are bounded by skin and learn quickly to mark distinctions between inner and outer, self and other (Wolf, 1988). If we accept a definition of the self as the symbol for the organism (Nixon, 1961), we can see that the body is the locus of our personal identity and our agency. Disembodied beings can not be said to have a life, at least in this world. Yet neither is having a body equivalent to having a life for these nurses; some capacity to act is necessary.

> I have three patients now who are on tube feedings. And the first one, I've had since I started on this job. And she evidently had Alzheimer's, and so her mind wasn't there for a lot of years. Then she aspirated and had pneumonia and was taken to the hospital. And when she came back, she must have stroked out at that point because she's never really regained consciousness. She'll open her eyes, and sometimes it's almost like she's really there, but she's not (HC8, p. 1).

Because this topic emerged in the context of death, I will have more to say of this in the section on temporal dimensions. We have, however, already seen how importantly the nurses in this study regard the patient's agency and it will emerge in numerous ways throughout this report.

Social and political space. It follows then, that people, as embodied beings, must be *somewhere*, that is, have a place. Although place can be viewed from several frameworks, these study participants referred to it in two senses. First, people were understood by the study participants to occupy social space in that they share in the lives of others. Our identity as agents is constituted in interactions with significant others which occur in certain spaces, thus making the spaces themselves meaningful to us. Our connection to others is made manifest in the spaces we inhabit.

> The lady I was talking about was 98; she had a good life. There are pictures in the house of her sister. Her sister will talk lovingly about her, talk about what she did, the work she did before, what she was like before all of this (HC8, p. 5).

> I mean, if somebody's made a decision that they want to be in the home that they lived in with their late husband, that they bought together and has all their memorabilia from Eastern Europe or whatever, and that's their decision and they don't want to hire someone because they don't want someone living in their home; if you took that person and forcibly put them in a board and care facility, you'd strip them of that life as they see it--[the life] that they've actually stated they want to keep. You've stripped it from them like their clothing by forcibly putting someone in a different setting (HC4a, p. 55).

> It's a very quiet place. It's run by monks for AIDS patients and they have round-the-clock care there. But it's very peaceful as you can imagine a Zen center being. Sometimes I would go and there would be very low music on and several of the people, residents there, would have incense burning. And I felt very reverent and peaceful when I was there. Anyway, the room is probably not much larger than the room we're in, and he had all of his entire, this is pretty sad, all of his entire life-long belongings in this one room. His one wall was almost covered with different pictures of different Buddhas. And in the middle of the pictures on this wall where he had not just pictures, but necklaces hanging, different kinds of beads hanging and different buttons that he'd had in his life, Peaceniks and that kind of thing, and right in the middle of the pictures was a picture of his Mom and a picture of his sister. It was a very crowded room, but this room was just filled with all of his things in his life that were most important to him in the end. It was a very intense moment in time (P6, p. 27-8).

Although this sense of belonging somewhere was related by both groups of nurses, home care nurses, because they had formerly practiced in hospitals, were particularly cognizant of the home as indicative of the belongingness of the patient. As the following nurse indicates, the patient's personal geography can show you their life.

> I never knew where anybody lived. Everybody is so much more alike in the hospital because they're all in their patient gowns and you don't see what's in their luggage. You don't see the bags that they bring in. So there's a lot of stuff that you just really don't see in the hospital that, when you get to see them at home, you see a whole different person. At home you see the other things that they're dealing with, besides whatever made them go into the hospital (HC7, p. 5).

> You're in their territory. You're guests in their home. They're not coming to you in the hospital. Very different. Very different. You have to meet them on their own terms (HC2, p. 49).

In the second sense of social space, the study participants viewed place in a social and political context in which different people occupy different social positions with the corresponding access or impediment to social resources, specifically health care, which such positions obtain. This inequity is a major ethical concern for these nurses as the following nurse indicates.

> The latest thing that has really been on my mind has been, when you go to nursing school, you're taught that you provide the same level of care to every patient, no matter what their source of income is, no matter where they live, no matter how their hospital bill is being paid or not paid. But being in home care, I think I'm finding that patients who are MediCal versus private insurance, being that I'm doing a lot of mother-baby and doing the home visits after they get home from the hospital, I see what seems to be a big difference with the private pay patient; they seem to get more interventions with the baby coming into the emergency room. It seems like they get more workup for certain things like jaundice, or the baby having feeding problems. It just seems like they're getting more intervention than someone who is on MediCal or whatever source of insurance they have, they don't seem to be quite as educated to the system or know as much about who to talk to, or being able to speak the same language as the health professional. It seems to make a difference in the overall type of care (HC7, p. 1).

As this narrative shows, the inequities are not always money but may be knowledge or cultural as well. Poverty was, however, seen as an important aspect influencing the kind and quality of health care.

Spatial vulnerabilities. Historically, the spatial circumstances of bodies have a critical role in nursing theory although we tend not to think of space but rather, of environment. Nightingale (1860/1969) stressed that the work of nursing is to put the patient in the best condition for nature to act. Such a charge required that nurses attend to cleanliness of surroundings, ventilation, light, visitors, and so forth. But in making her argument for the necessity of someone to manage or be "in charge" of the sick-room (and person), she was approaching contemporary social science understandings of space. For example, there is the concept of the 'locale' which "is a physically bounded area that provides a setting for institutionally embedded social encounters and practices" (Pred, 1990, p. 22). In locales, like other conceptualizations of space, personal agency intersects with institutional structures and practices. In the following narratives, the nurses in this study illustrate some of these spatial factors, all of which were identified as ethical concerns.

> It's come up very recently at work and one that's an ongoing one is when working in the residency training program, when there are things that you know a patient should get in terms of service, and there is either a resident or a medical student who's in charge of the patient, and I feel that they're not getting what they should get; it becomes a dilemma, how far to push. I don't like to say to a patient, you should be getting such and such and such, because then that sets up a split. So those are common occurrences. We had a private paying patient who came in, not that there should be any difference between private pay and non-pay. But this person, she and her husband had to pay for every single day that she was there (she had no insurance so these were out-of-pocket expenses), and she was assigned to a medical student who came in and presented himself as her therapist. The resident, who was overseeing the med student, was fairly green himself and the attending hadn't really tuned in. And this medical student was doing nothing, except aggravating the situation (P2, p. 1).

This nurse is well aware of the institution's multiple purposes and she has no moral objection to physician education. In this situation, however, there was no competent person overseeing the woman's care and the institutional function of physician education was taking precedence over patient care at great expense to the patient. The next narrative illustrates the homogenization of care with the resultant loss of patient identity in a context where that is particularly important.

> I'll just go with the one off the top of my head. One ethical concern I have is that there be a respect for a patient's individuality in regards to, let's say, ethnic origin, sexuality, religious basis, that be respected and acknowledged throughout the care of the patient, their treatment course while they're in the hospital, because my being inpatient, that's mostly what I'm concerned about. I find, sometimes, that the medical system or the treatment team, would like to homogenize people and put a kind of white middle class value on people as the standard by which to measure people and make their judgments about the patient on that, while this behavior is this because it doesn't match up to the baseline. Or they kind of like diagnose patients, especially in psychiatry. They'll diagnose certain behavior based on this kind of white middle class value system that may or may not work for every patient (P8, p.1).

This psychiatric nurse is pointing out how the space we occupy structures our perspectives or what we can see and therefore the judgements we make about patients. Hospitals are spaces where some people, the patients, leave their world and literally enter into the world of others, the providers. Since the work of hospitals is diagnosis and treatment of disease, other facets are deemed irrelevant. Indeed, in order to maximize the efficiency of its work, the institution is structured (or makes it possible) to attend only to certain things. Since values are inherent to the process of structuralization, those who make the routines do in fact set the standards. The following home care nurse illustrates how the space of the hospital structures what we see and the labels we use. She has been telling me a story of a diabetic patient who presented frequently to the hospital because of high blood sugars.

> When possible, we're in contact with the [diabetic] clinical nurse specialists in the hospital regarding certain patients. And in this particular lady's case, she was fairly well known to the CNS who didn't understand why this kept happening to this woman who is an intelligent, articulate woman. If you're not around her a lot, you don't see the lapses in her memory and her confusion that arises. So, I got the impression from this CNS that she just thought this woman was being difficult and non-compliant. She would say, well, what is the problem here? I don't understand. It's a very simple thing. She just has to check her insulin, check her blood sugar, take her insulin. It's like, why does she keep coming in here? And when I explained to her, this is where she lives. She doesn't even have a refrigerator to put juice in if she does have hypoglycemia. Then she forgets to even buy canned juice. I've tried to teach her certain foods that aren't perishable. She had no idea. Now, of course, they're told, insulin has to be refrigerated. Well, that would be the refrigerator in the kitchen, which is closed, except for cafeteria hours, and it's on the bottom floor, and it's totally impractical, you know. So there's real limitations. [When I told the CNS], she said, Oh! I don't think it even occurred to her (HC6a, p. 13-14).

The fragmentation of care is another spatial vulnerability which emerged from this study. This is a complex term and while both providers and recipients of health care have some experience with fragmented care, it is not well articulated, and certainly not as an ethical concern. Indeed, the nurses in this study did not employ the label, fragmentation of care. Nonetheless, they frequently spoke of the importance of helping patients get through the system as the following shows.

> I don't know how people who are outside the system ever get things done, most of the time. And imagine people who don't speak English or are from another country or you know, whatever. I have a hard enough time getting myself through the system. I have insurance here, so I know what it's like, and it's tough. So, I do feel, sometimes, that patient advocate means assisting them through the system (P6, p. 14).

These nurses were acutely aware of the vulnerability of many of their patients which further undermined the patient's ability to make the "system" work for them. Another nurse tells me that a very disturbed young man presents to the psychiatric emergency service for a prescription refill.

> Because he didn't meet the criteria for danger to self or others or grave disability, I mean it was, here's a list of resources that are available to you. But as I was giving them to him, I could see that he really didn't have the capacity to take that information and then do something with it. I think it was very difficult for me to just let him--I mean, he left and I think about him a lot. Could I have done something differently? Could I have intervened more aggressively in taking him by the hand and taking him to wherever he could get set up, because I think he just didn't have the capacity to do that (P4, p. 4-5).

This nurse did not take the patient but she remains deeply troubled by her failure to act against the institutional prohibitions of such an action. She implies that there is an institutional misunderstanding of the needs of the chronically mentally ill. She says:

> It's the way it has to be done sometimes. If the patient won't come to you, sometimes you have to go to the patient (P4, p. 9).

But the nurses in this study, in navigating patients through the maze of the contemporary health care system, frequently did fill the gaps by doing something they are not authorized publicly to do. A home care nurse gives an example.

> ...especially dealing with certain teaching institutions, where it's hard to get a responsible physician. Frequently physicians don't know the patient, or the person you got is unfamiliar with what needs to be done. And it can be very frustrating from a nursing standpoint. A case to illustrate this is a person who is basically in end stage cardiac disease, and very precarious fluid balance, that is on multiple diuretics. And the physician who had been caring for this person ended up transferring and accepting a fellowship at another facility, and the person was left in the lurch, still an acknowledged client of the clinic, but without a physician assigned, which basically means that any nursing practice that occurs between the time that the patient is without a physician, means that the nurse is practicing medicine without a license. Without a physician responsible and willing to participate in the plan of care, we're not supposed to be there. And trying to get a physician practically every visit. Since he was connected to the clinic, trying to get appointments at the clinic so that he could be seen by a physician, so then we'd have somebody assigned to his case. The clinic was anything but accommodating. I've never worked with a system that's more difficult. It's not patient friendly at all (HC3, p. 25-27).

What makes fragmented care an ethical issue for these nurses is that it prevents the patient from receiving what they need. Fragmented care prevents the smooth movement of the patient and/or resources. Moreover, when the nurse crosses the space, thereby filling the gap, they frequently place themselves at risk just as the above nurse felt they did. Such organizational mechanisms ensure that institutional and medical interests are met at the expense of nurses. Nurses' interests are compromised because their time from patients is misappropriated and in taking up the slack, they protect the public's view of physician practice and institutional purpose while privatizing the public's understanding of their own practice.

Another aspect of the fragmentation of care which directly affects home care nurses is paperwork. Home care nurses spend two to four hours per *day* doing paperwork! Because they function at the margins of gigantic bureaucracies, home care nurses bear a huge responsibility in maintaining the paperwork which authorizes and legitimizes access to and payment for services. Since payment is not guaranteed even if service has been ordered and provided by home care nurses, they spend a great deal of energy worrying about reimbursement.

> It's just too hard. And see, what's happened is no one really looked, especially at this Medical stuff, so things [claims] were rejected. We got rejection after rejection (HC2a, p. 17).

When claims have been denied after services have already been provided, nurses are responsible for making the appeals.

> If someone analyzed how much labor they were spending writing these appeals, I'm sure it would outweigh the reimbursement. And see, that's what's so unfortunate. If you want to really get upset about the whole system, that's what you're paying people to spend their time doing, to give me RN wages to be sitting here reviewing these and writing these appeals (HC2a, p. 27).

This kind of institutional design has exploitation woven into its very fabric and is a matter of ethical concern. This should not surprise us for as Orgel (1983) notes, our "so-called ethical dilemmas can generally be shown to be products of the peculiar ways in which we have organized our social relations...the way we have constructed our social institutions" (p. 123). In the case of health care, the social relations and institutions are organized by a gendered division of labor; the work of nursing is women's work. While nurses comprehend patients in the immediacy of need and suffering, institutions see patients as consumers of services who generate or cost money. These differing perspectives often conflict in determining what work is made a priority. Patients as subjects of need and suffering and the nurses who address that need loose to institutional need. Yet, addressing patient need which concerns the patient as person who has a history and belongs somewhere is not essential work. Not surprisingly, this unessential work is often dubbed caring which is *natural* to women and therefore the expectation is that is will simply be done, regardless of other demands.

> It's not a novel concept, nursing being a feminine thing because there

> mostly have been women in nursing, and the structures that have been set up are structures that build those skills and those roles into the profession. Staffing is based on a certain amount of work officially and a certain amount of work unofficially that nurses will do. There's official work and there's unofficial work. And if nurses really demanded that we be paid for what we do, we couldn't do so much in the hours that we're paid for. The official is to carry out doctors' orders. It's to make a physical assessment and report those findings to the doctor if they're significant. It's to check what patients are doing at home. You might watch what they're doing, their own blood sugars, or teaching, things like that. What we do unofficially, psychological care, dealing with people's cultures is all unofficial. There is no time slotted for that. Unfortunately, the agencies reimburse per visit, not by time. Medicare reimburses per visit and they don't care if your visit is 5 minutes long or 3 hours long. And the private insurers have followed that model, Blue Cross, whoever your private insurer is, Health Net. A visit is a visit is a visit, with a few exceptions (HC4a, p. 37-8, 41).

The same nurse continues.

> Unfortunately, I think, as a group, nurses are not very vocal, and they tend to just absorb a lot. And I've always said, if everyone in that agency wrote down exactly what they did and how long it took to do it, and wasn't paid for the hours that they did, they would have to hire five or six or ten more nurses. We're all doing free work, and I don't think we should. To me, that's kind of basic. But I do it, too because, in the bottom of my heart, I don't consider emotional care to be quite the same as what they're paying me to do. So I take that out of my own hide, out of my lunch hour, or I come home a little late, or do paperwork at night, or something like that. We all do it to some extent (HC4a, p. 43-4).

This creates enormous stress for these home care nurses as they try to attend to both patient need and organizational structure. The stress consists in the sheer physical and emotional effort in trying to accomplish this as well as the burden of coping with exploitation and the consequences that such an ethical wrong can bring.

If home care nurses were subject to the particular hazards of working in the vital yet marginalized space of complex health care delivery systems, both psychiatric and home care nurses were exposed to dangerous staffing patterns as hospital nurses. For these nurses, this was a matter of ethical concern. The same home care nurse tells a chilling story of lethal staffing.

> This is a different story, but when I worked in the pediatric ICU, we were very under staffed. And one night I came to do a 12-hour night shift, that is, from 7 in the evening to 7 in the morning. And, as you probably know, if you accept report on the patients, you are accepting responsibility for their care. I was to be in charge and I saw that I had completely inadequate staffing for the patients and the kind of patients we had. So I refused, I didn't put on my uniform and I said, I'm not accepting this assignment until you find me one other person. And I said, I don't care if it's an LVN or even a nurse's aide, to take vital signs or just watch the kids. As I put it, find an orangutan, but there has to be one other body here. So pull someone or whatever, or I'm going home. I'll wait as long as it takes to find that person (HC4, p. 22-23).

She continues to tell me how angry both nursing administration and her colleagues were with her for taking this stand. That they felt victimized by rather than supportive of her concern speaks to how effectively organizational structures can operate to exploit and silence the gendered labor of nursing work. The harm of such practices, however, can be beyond redemption. She continues.

> This horrible thing happened. Someone had turned off an alarm, and this child who really was very functional and would have been fine, basically choked to death and was brain dead, not killed but brain dead. The staffing had been very poor. It had been, you know, new nurses, the same kind of situation, not experienced nurses, not enough people. There was this little side room where they put kids when there was overflow. It was really tragic. It was a baby whose 2-year-old sibling had stuffed tissue paper down his throat, I guess he was jealous or whatever. The baby was about six months old. He was OK but he had really bad aspiration pneumonia, and he was intubated just so the secretions could be cleared. And someone had turned off the alarms to the cardiac monitors. So, when the secretions clogged--it would have been easy to go in and suction it out but--the alarm was off and no one knew and his heart rate fell and he was anoxic for a long time, and he was a vegetable. It happened very soon after my incident and I always felt both terrified and vindicated. I felt terrified because I easily knew that I could have been the nurse in charge, I could have been the nurse assigned to that patient and just been busy with some other sick baby--vindicated because that was exactly why I didn't take report that night. And the situation comes up in nursing again and again and again (HC4, p. 24-5).

In one final example, a psychiatric nurse tells me the following ethical concern.

> When I first worked at that first psych hospital, I had had three years of nursing school, but technically, I had had only three months, three days a week of psychiatric nursing. And I was hired as a charge nurse on an open adult psych unit, working with a psych tech, who had experience, thank god. But when I think about the lack of knowledge that I had, and the lack of experience, you know--the concerns for the patients. I had a lot of responsibility and a mix of intermediate psych patients. I didn't really know a lot about them and I just didn't have the experience to deal with these people, and no supervision. So that is my concern about the type of practice, or the quality, that I was giving. I mean, I think that somebody should have been supervising me at that point (P9, p. 1).

Temporal Dimensions

The temporal dimensions of having a life manifested themselves in two distinct but related aspects. First, the nurses in this study see human life as constituted by routines of lived experience and secondly, they recognize the inherent temporality of human lives in that lives come to an end--people die. Taken together, these notions of temporality shape their practice and deeply inform their ethical concerns. Because much of the work of nursing practice is concerned with creating and managing routines of lived experience, I turn first to that aspect.

Routines of Lived Experience

By this I mean that one's actions which express their engagement with the world through their connections to others, work, projects, leisure and so forth are temporally structured. The patterns of this structuring have varied with different cultures and historical epochs. As members of Western, industrial culture, we are born into and socialized into a world that is for the most part, a world of mechanical clock time. This particular sense of time orders our activities; for example, we arise at seven a.m., begin work at nine a.m., have dinner with friends at six p.m. and so forth. The repetition of these temporal orderings giving a pattern or rhythm to the activities which constitute our lives is human time. It is not merely an external feature of our lives tacked onto what really matters but itself gives meaning and significance. Both our identity and individuality are partly given by how our activities are temporally structured. When our routines of lived experience are disrupted by disease, injury, or disasters, our subjective sense is that our lives and not merely routines are affected. Indeed, it is the disruption of the routines of lived experience which constitutes the experience of illness (Kleinman, 1988). This disruption in the lives of patients is conveyed in the following passages:

> He has oxygen on 24 hours a day. But if he knows he's going to walk from here to the bedroom, which is 30 feet, maybe, he has to

> take a nitroglycerin to even walk that far, because he knows he's going to have chest pain just from that slight exertion. So he's extremely limited and he is, like I said, on so many medications, extremely high doses, that he's just barely existing. And he says things to me, like, this isn't much of a life. Somehow I keep going on, but, I don't know why (HC6, p. 6).

> When I go out to see some adults, a lot of what you see with them is the totally other spectrum of life, and how do they feel about being where they are now? So often they're depressed because they're seeing how frail they are and that their bodies aren't working the way they used to work. They're upset and they're frustrated about that. And then there's so many other things that they're angry about--the system doesn't work for them anymore the way it did. Things they took for granted, like driving, isn't even an option now (HC7a, p. 28).

For the nurses in this study, the temporal aspect of having a life concerned with routines of lived experience shaped their practice in three major ways: routines as work, temporal knowing which informed that work, and as ethical concerns. Much of the work of nursing consists in a set of activities which are repeated according to a temporal pattern, for example, the administration of medication, changing of dressings, and monitoring of various physiological processes. Even aspects of establishing a relationship and patient teaching encompass elements of routine. The notion of routines can have a negative connotation because routines can become an end in themselves. When this ensues our behaviors and interactions with others are mechanistic, thereby obscuring our vision of the needs of others and numbing our capacity for response. This was not how I saw the routines of nursing work in this study. In contrast, nurses worked with a persistent sensitivity to the fact that their actions were directed towards achieving some outcome for or on someone who is a subject with their own desires, wishes, problems, doubts, and routines of lived experience. For this reason, nurses did not simply impose their own routines on patients but rather, observed and participated in the patient's routines as a way of both preserving and fostering their sense of agency and of understanding what the patient needed. In one example, a home care nurse is trying to arrange hospice care for an elderly woman who has schizophrenia and end stage cancer.

> I think she will accept the service if it comes to her house and if I tell her that they will help her with her pain management a lot better than I would. And not only that, but they're available more, on an on-call basis. And they would also give her in-home support a lot more than we would. So I think, for her, she'd be better off, which is what I'm working on right now. I just talked to the social worker this morning and I got the OK from the doctor last Friday. So, little by little, I don't want to push her (HC9, p. 4).

This nurse recognizes the need for improved pain management, round-the-clock, on-call availability, and more support in terms of personal care and household support. The patient has had some hesitancy about hospice and although the nurse sees this as the best solution to the patient's needs, she remains responsive to the woman's sense of agency by proceeding slowly. In the following excerpt, a psychiatric nurse cares for a profoundly depressed person which involves adapting herself to and entering into the markedly altered temporal rhythm of his depression.

> He had tried to hang himself before, he felt so bad about himself. One time I went in there and I just felt like he might do something. He was looking about as depressed as anybody I'd seen prior to killing themselves. And I went in there and I said, you just look terrible, you're making my heart very sad. I said, would you let me know if you were planning on doing something to yourself? And he looked right at me and he said, yes, I would. So it made me feel a little safer, because I was going and checking on him. And it was when he was having a lot of difficulty with his wife. I said, well, when you feel that you can, [that you] want to talk with me about what's going on, I would love to sit down and talk with you. I said, it doesn't have to be long, it can be short, it can be anything. Sometimes I'd just sit there. See, people would get frustrated with him because he might not say anything for five minutes or so; then he'd start talking and then maybe he wouldn't say anything for another couple of minutes. I'd just sit there and think and be there with him and then he would talk some more. It was like he was just slow around the whole thing. But I just let him have that process. And then, as he started to get better, the sentences got closer

> together and the words got closer together, and they made more sense. So, it was like, if you spent the time with him at the beginning and were patient with him, then... (P3a, p. 8).

Because this nurse is emotionally sensitive to the world of the very depressed, she is able to adapt the routines of her day-to-day work to the temporal structure of this patient. This creates a kind of synchrony through which the patient comes to see that he can still be heard--that despite his altered temporal rhythms, he is still able to petition a response from others. In another interview, this same nurse makes the point in reference to an aphasic patient.

> I'm on a little bit of a crusade with this lady because I want the doctor to spend some time with her. I'm going to talk with him about not just brushing her aside because she's got the stroke. I wrote in her chart that if you take time with her and really listen to her, she does make sense. Then I wrote down the things that she and I talked about so that people could see if they do spend time with her, they will learn to understand her if they can just fill in some of those gaps. Because somebody like her, people just brush off as being--you know, they're aphasic; they can't talk and really she can. It's so desperate for her that just being dismissed or passed over doesn't--is going to make them feel even worse about themselves, that they're less of a person because they've already had this thing happen to them (P3, p. 15).

In another example, a home care nurse must see how the patient has been trying to breast-feed before she can know how to be helpful. The patient has extremely cracked nipples and has been saying she wants to stop.

> I went out just yesterday or the day before with somebody who was going to quit breast-feeding because she said it was so painful. She had nipples that were real cracked. And I said, gee, you know, it's really up to you, what you want to do, but if you're interested in breast-feeding, I really have to see how you're doing it while I'm here, because I can't help you if I can't see what's going on. And she just wasn't even really, I mean it really took a lot of will power on her part to go ahead and try it and show me what she was doing. But luckily, I was able to show her how to put the baby on and how to position herself and position the baby so that the nipple did get

> into the mouth right. And as soon as it was in there right, she was just incredibly relieved. She was so elated. She must have said four times while I was there that she was going to quit, that she wasn't going to do it anymore because it was so painful. And now it was wonderful and this was the best thing that ever happened to her (HC7a, p. 10).

The aim of the routines of nursing work is to contribute to the achievement of some state of good for the patient. Nurses help the patient integrate treatment regimens into the pattern of daily life which is especially important when the disease is chronic. When this is successful, patients can continue to have a life a sense of confidence about managing their lives. Here we see a home care nurse working with an 84 year-old woman who still has a job.

> We were saving money by doing it at home rather than sending her to the hospital. Also, I'm not so sure that I would want her just to lay up in a bed in the hospital; I don't think that's healthy. Leaving her in her own home, her own environment--but for me, it's also, this has to become part of your life. It can't be just for right now we're healing the ulcers. You've got to buy TED hose and you've got to get them before you even go back to work. Here she is, 88, but we're talking about before she goes back to work. And that's her job [volunteer at a Jewish Home]. She's done that for years and years (HC8, p. 4-5).

On those numerous occasions when patients will never be able to maintain or retain what most of us would take to be a meaningful life, the routines of nursing work are directed towards achieving a state of comfort for the patient. In cases where patients are extremely debilitated and demented and no longer able to express verbally their needs, nurses work to achieve a state of synchrony between the patient's bodily expressed needs and their ministrations.

> I would have her help me turn the patient. I would have her help me hold the patient's arm or leg or whatever I was--changing the wound--so we would talk over the patient. I would explain what I was doing, and she would say things like, Mama looks so much better today. And I would have to say, no, your mother's not doing better today. Her wounds are not infected anymore but, I said, we're going to

> make her as comfortable as we can. And that's why you need to give her pain medicine before I come, and as often as when she goes--she'd say things like, well, she doesn't ask for the pain pill. And I would say, well, your mother isn't talking. She can't speak to us. But she does cry out when we turn her. Do you notice when we turn her how she cries, grabs for my hands when I do the dressing changes and she'd shake her head, oh, yeah. And I said, that's pain too, not just asking for it. She can't ask for it (HC1, p. 6).

This was a very complex situation in which an 80 year-old woman with marked Parkinson's disease was caring for her 100 year-old bed-ridden mother. The mother was demented and contracted with multiple bed scores, some of which were gangrenous. Here the nurse must teach the daughter the cues indicating her mother's pain as well as work with her to overcome her fear of addicting her mother! In a similar situation, another home care nurse works with a 104 year-old woman being cared for by her elderly daughter.

Synchrony is important in another way as well. Nurses recognized that a patient must be ready for what the health care system has to offer. This is especially important for those interventions aimed at supporting major life style changes, such as treatment for drug addiction. In these case, the timing of nursing or heath care intervention must be synchronized with a receptivity to learn on the part of the patient.

> The funny thing that I have never been able to explain to a patient or have them explain to me is why it's not right to take psychotropic drugs to help them along, but it's OK to take alcohol or speed or crack or heroin or whatever to take care of it instead. You know, one is the healthy thing to do and the other thing is the unhealthy thing to do, and they pick the unhealthy.

I: How do you get that message across to them?

> Sometimes you don't. Sometimes it's part of their denial about their illness; we can work with them around that. Sometimes we have to have them back three and four times and then, finally, you can say, well look at this pattern. This is how you've been handling what's

> been going on with you and it doesn't seem to be working. With your manic depressive illness, it seems like Lithium would do you a lot more good than going out on an alcohol binge, or going out on a cocaine binge. And then we can get them into some program that will take them with a dual diagnosis, if we're lucky (P3, p. 9).

Embedded in this recognition of the importance of synchrony is a deep appreciation of the patient as a person who still has a sense of agency--a sense of her own desires, expectations, and limits even if the person does not always act in accord with them. This valuation of agency by nurses forms the background for the belief in patients' capacity to change. This is not merely some pollyanna belief that serves to sugar-coat the hard realities of patients' lives or over-inflate what nurses can do. Instead, it is a profound belief reflecting their commitment to the patient's ability to direct their lives in whatever ways possible. This same nurse is poignantly articulate:

> I had a patient who called me all the way from the South to tell me he was in an alcohol treatment program, that he had finally gotten his sobriety together, that he had eight months in, that he was going into a Voc Rehab program, and that he was living in a sober place with other sober people. He was so pleased and he said, you were the one who had faith in me and I just wanted you to know that I really appreciated that. And it made me, it just made me feel good.
>
> I: Actually, you mentioned the sense of possibilities in the last interview. What's involved in the sense of possibilities or having faith in people?
>
> Oh, I don't know. I think it's like that thing I said last time, that I believe that people change at their own rate and they change at their own impetus and stuff. I can maybe nudge them along a little bit, but it's really themselves that do it. Even the most hopeless of people, I have seen changes in. So when people come in, sometimes they say, everybody's given up on me. And I said, well, I haven't given up on you, but you're going to have to make an awful lot of effort to get anywhere, it looks like. And, I said, but that's your option; you can either stay where you are, or you can move either backwards or forwards. So I see things for people. And what I want, what I do with them is, I ask them about their hopes for the future, especially if they're depressed--ask them about their dreams and their hopes for

> the future, even the wildest things they've ever dreamed about. I say, you know, sometimes they come true. I say, that's what keeps people going, their dreams and hopes, that's having something that you have in the back of your mind that you'd like to do (P3a,p. 15-16).

Implicit in all of the nursing practice illustrated above is what might be called, temporal knowing. By this I mean that nurses come to know the routine, expectable outcome of a complex mix of factors and processes. They have knowledge of the body as object, that is as physiology and the temporal rhythms which underlie that physiology; it is knowledge of what is normal versus what is not normal. In addition, they have knowledge of medical interventions and their side effects as well as knowledge of how to manage those side effects. Based on this, they have knowledge of the expectable timetable for repair which provides a framework of expectation for patients. This is illustrated by a maternal-child home care nurse talking about her former NICU experience.

> This is the normal course for respiratory distress syndrome; a kid of this size usually stays on a vent about this amount of time, usually eats at this time, usually goes home about when their due date was. So it's pretty predictable, when it's a straightforward kind of premature baby that just has mild distress or minor bowel problems, something where they need surgery (HC2, p. 10).

Because nurses are primarily concerned with illness, however, and thus with helping patients re-establish routines of lived experience, they are cognizant of the worlds from which patients came and to which they are returning as well as the world of the hospital or health care facility. This knowledge of the differing spatial-temporal realities enables nurses to help patients make decisions effecting their lives. The failure of health care practitioners to appreciate the lived day-to-day experience of patients in their own world and to see how these experiences influenced their health was an ethical concern for the nurses in this study.

> At this point they have to go back. They have to be readmitted. It's too bad, you know. Some of the people who are the least able to handle that kind of burden are the ones who have to do it.
>
> I: In what way the least able to handle it?
>
> Well, I mean, as far as transportation in and out of there and having other kids. What do you do with them while you go see the one that's in the hospital?--things like that (HC7a, p. 5-6).

Here, another maternal-child home care nurse is talking about the logistical hardships that mothers with limited resources face when their newborns must be admitted to the hospital for phototherapy instead of receiving this at home. This represents a change in Medical reimbursement policy which now prohibits the procedure previously done in the home. The nurse's interpretation of the physician who instituted the change is that while his intent is to protect newborns, the result is a class bias which discriminates against and causes hardships for low-income mothers. Furthermore, this nurse emphasizes to me that nurses make assessments all the time of who can successfully carry out a procedure and who can not. This is an example of how medical routines are imposed without regard to the people involved. Failure to recognize this harms the infants and mothers, undermines the integrity of skilled nurses, and contributes to the poor utilization of health care resources. Power lies with those who make the routines (Barnes, 1988) and such an imposition is an exercise in the construction and execution of the negative aspect of power. Because this imposition impacts on patient and nurse agency, I will discuss this further under the section on agency. At this point I want to turn to the second temporal dimension of having a life, that of the inherent finitude of human life.

Death

Human life is biological life and as such is bounded, by birth on one hand and death on the other. To have a life is to exist within these temporal parameters. It is not simply that the reality of death serves as a temporal marker for the ontological description of biological life. This, of course, is true; if we did not die, we would be something other than human, something beyond the biological. Rather, to say that having a life has a temporal parameter is to recognize that there is a time to die, a time when this ontological marker becomes specific--one's own life comes to an end. Recognizing that there is a time for dying is to see that death is appropriate in a given set of circumstances, at a given time. The capacity to acknowledge both the temporal character of life in general and a time for the end of a particular life bespeaks a wisdom handed down at least since Ecclesiastes: "To everything there is a season, and a time to every purpose under the heaven: a time to be born and a time to die." The state of contemporary, *institutionalized* medicine suggests that we have lost that wisdom, in that recognizing a time to die has been vigorously resisted. I give emphasis to *institutionalized* because I want to be clear: I am not saying that every physician has lost this wisdom [or that every nurse possesses the wisdom], but only that organized medicine and the social structures which support it have. At the very least, they have made it difficult to act on such wisdom.

Death serves as a nexus of concerns about human agency, about what counts as meaningful in the universe, about what makes a life not just livable but good. For this reason, a recognition of the wisdom of the appropriateness of death involves a complex web of factors including the physiological condition of the person in the diseased state, available treatment options, research interests, the identity and social status of those vested with the authority to make decisions, the meaning of the disease and illness to the person, and the social and material circumstances of the sick person. To act wisely is to appreciate that treatment must produce outcomes which make a difference to the person's life as lived experience. Yet, there is increasing evidence showing that only those factors relevant to the disease and medicine's investment in that disease are considered. In one potent example, Koenig (1988) demonstrated that residents did not recognize a patient as dying until there was no more technology to try.

The nurses in this study view this *institutionalized* response of medicine as a matter of deep ethical concern. Their reasons are that it causes harm and that it deprives others of scarce health care dollars. Death, for these nurses was not seen as an enemy to be fought no matter what the costs. Rather, death was seen as a fact of human life.

> It's not the way I think life was meant to be. I think that life was meant to be lived and ended, and let's let go (HC8, p. 31).

As the culmination of an individual life, death brings the opportunity to reflect on who one is and how one has lived. Continuing treatment when it no longer makes a difference to the person's capacity to have a life prevents a peaceful death.

> But this man, we knew he was going to [die]. There wasn't anymore treatment available and we weren't going to do respirators, we weren't going to do all that garbage stuff. So the thing was that when this man died, he was going to be able to die right there, on the general medical floor, in that room. And I would just be able to quietly call his doctor, the resident, and say, he's dead now; we weren't going to do anything. Now that, to me, was the way things should go. I always felt really good and peaceful. His daughters got to do some good talking and I talked with him several times. And it was a really good thing, you know.
>
> I: What is good about that?
>
> He was at peace. The thing is that--these are the things I've been able to do in my life and talking about it. These are the things that I've been able to do, and these things aren't going to be possible, and I accept that. I can't do anything else about it. And I've seen people do that. It's when they make that decision that I really am going to die and there's nothing else I can do about that. In my experience it's been a very peaceful kind of death (HC8, p. 16).

When the time for death is appropriate, helping patients achieve a peaceful death becomes the end of nursing. This help can take the form of listening to and talking with those patients who are verbal. The same nurse continues:

> Here is a person that gets to come to terms with their life at the end. Coming to terms with your life is facing the death part, that you are what you are and you've done what you've done, and there's nothing you can do about that. And then being able to look back on--these things were good. These were the good things that happened in my life. These are the things I'm proud of. Rather than not bemoaning--a death of not coming to terms is bemoaning what you couldn't do and those were the bad deaths. Those were the people fighting against it. But those people who were able to be helped into that situation, they were able to look at the things that they had done. They were able to talk about it, sometimes with their family, sometimes just with me. But, they came to terms with their life and therefore, acceptance of their death (HC8, p. 17-18).

When patients were not conscious or could not communicate, the good death was one where the patient was as comfortable as possible, hopefully attended by significant others. In the following, a home care nurse tells about a 100 year-old woman who was being cared for by a daughter in her 80's with advanced Parkinson's Disease.

> What made it get better was the fact that the patient was able to die at home, as she wished, fairly comfortably, because I taught the patient's family how to care for her and got them the help they needed, or as much as they would allow me. So it worked out because of what I did. To walk into something that's chaotic and with people defensive, with care not being done, with patients in pain because their pain is not controlled and to pull it all together is very rewarding. And it worked out well for the patient's family. They were very calm. They called other family members and the patient died with the family around her, hopefully getting as much medicine as she could get--I know, getting a lot more than she was in the beginning which was nothing. That's the rewarding part, that it worked out like that (HC1, p. 11).

When the end of a peaceful death was traded for continued but irrelevant treatment, harm resulted to patients, families, the nurses caring for them, and society. As mentioned, patients were deprived of the opportunity for a peaceful death but they endured another harm as well, the undermining of their agency by coercing treatment. On former ICU nurse describes it this way:

> Oftentimes, patients will tell the nurses, oh, this is awful, I don't want to go on like this, I just want to die. And they go, you tell the doctor. And you go to the nurses' station, there's Dr. Jones and you tell him, and he'll go in and he'll go, oh, Mrs. X, now you know you don't feel that way. This is for your own good. Then Mrs. X will go, Yes, doctor. You know, that kind of thing. It just seems very (tape is inaudible) to me. I mean, I just couldn't do that to her (HC1, p. 17).

As mentioned earlier, agency is the capacity to initiate meaningful action. Protecting and nurturing patient agency is a central feature of nursing work. In home care, elderly patients tell nurses that they do not want to go to the hospital, they do not want invasive procedures. Yet, what frequently happens is that in a physiological crisis, the patient's agency is weakened as a result of both the symptoms and fear; he defers his power for decisions to others, usually the family members. An example of this is the following story which I relate at some length so that the deliberative ethical problem posed for the nurse can be appreciated.

> The first patient I'm thinking of is a gentleman who--I didn't quite feel comfortable with how I handled the situation with him. He was 94. Well, he's still 94. He hasn't passed away. I knew him from two years ago in home care, and then we discharged him, and resumed seeing him again because I think he was referred by his doctor. At any rate, he was very end stage heart failure, congestive heart failure, and severe angina, unstable. The reason I bring up that I knew him two years ago is, he had said to me repeatedly, I don't want to go to the hospital, I'd rather die than go there. The reason I've lived so long is I've stayed away from hospitals and doctors. When I saw him he had a pacemaker inserted and they were trying to convince him to have a bypass--at, well, 92, then (laughs). I'm just telling you the background from what I knew of how he felt about medicine and doctors and that sort of thing. And so he was on very high doses of meds, and that's what he was living on, basically. When I went to see him again, then, two years later, actually, pretty much from the moment I arrived he was in increased congestive failure. He had real shortness of breath, even at rest. He was very weak, and saying that he thought this was it for him, that he was

> going to die. He was in real congestive failure and didn't want to go to the hospital. But his wife did want him to go. She wasn't ready to say, this is it. So I was sort of caught between feeling, well, I know how this patient feels about going to the hospital, and knowing that he was on such high doses of medications, some of them double the dose he'd been on two years before. I was trying to determine, are we going to honor that wish of his to stay home and perhaps get hospice involvement and get him some oxygen at home and just keep him comfortable or--then his wife was sitting there saying, well, I think maybe we should call an ambulance. Maybe he does need to go to the doctor. In the course of all this, I found out that his daughter, who lives in [names distant city], one of his four daughters, but the closest one, was en route to the house at that time. She had spoken to him in the morning, found out how badly he was doing and was coming to be with him. I was also informed that he was kind of the patriarch of the family, and he was adored. It sounded like nobody was ready to say good-by to him, that they were not ready for him to die. So I felt caught right there. I felt like I didn't want to be responsible for saying, well, this is--we're not going to do any more intervention than this. But yet I didn't want to override his decision and call an ambulance (HC6, p. 1-3).

Up until the current crisis, the nurse has been the guardian, the supporter of his agency which was possible because the nurse knew what the patient wanted. However, under the stress of frightening symptoms, the situation has changed and the patient's wishes are no longer transparent. Is the patient unsure of what he now wants or is he too weak to resist the pressure of family who want something other? In deciding what to do, the nurse must balance her knowledge of the past against what she sees as morally relevant in the present. Here is what this nurse does:

> I tried to talk to him privately about it. Let's talk this through. If you go to the hospital, what might they do for you? I know that they could give you some IV Lasix or something to diuresis you. They'd certainly give you oxygen, and that kind of thing, some of which we can do at home anyway. I talked to him privately about it, and then when she came in the room I repeated in front of her. I said, this is what we've been talking about. And he seemed, to me, to be too weak to make a decision. He seemed more willing to defer to other people and say, well, honey, what do you think, and less adamant than he used to be about how I feel about going to the hospital and

> how much intervention will they do. And knowing, or presuming that it sounded like the family wasn't ready to just leave him unattended. I also knew that hospice couldn't start up immediately (HC6, p. 4).

It is in talking with the patient and his family that she sees, what is for her, the morally relevant factor, the patient's fear: "what I was sensing from him was that the emotion was fear" (HC6, p. 25). Fear is a powerful and painful emotional state which can threaten the self and agency; it speaks to one's vulnerability and calls for remediation. Because hospice cannot begin immediately and because of the family's anxiety and inability to be supportive, the nurse makes arrangement for the transfer. She does so even as she realizes that his fear may be hindering his judgement because in going to the hospital where "residents are hot to practice" (HC6, p. 28), he is at risk for coercion into treatment. Indeed, he does undergo an angioplasty which leaves him, if anything, worse off than before and he complains bitterly about it upon his return home. This is exactly what the nurse in her guardianship hoped to prevent. Her inability to do so leaves her wondering if she did the right thing. She asks:

> Some of the dilemma is--what are we promoting here? What kind of lifestyle or level of quality are we promoting? (HC6, p. 6).

It is not simply that the patient has an increase in physical suffering although that would be sufficient in itself, but it is also the absence of what makes life good.

> I do see a lot of elderly people who are just barely making it day-to-day, so fragile and don't have a lot of pleasure or joy or love or anything in their life. A lot of them--they're the only ones left in the family, and they don't have anyone, really, except for maybe hired attendants (HC6, p. 7).

This issue about what kind of life one can have was a repeatedly and passionately raised theme throughout this study. The good of medical treatment must be measured against the relevance to a patient's life. To do otherwise is to do what we do best, not what's best to do.[1] Both groups of nurses are acutely aware of the power of hospitals to undermine patient agency, to increase suffering, and to ignore needs. Nurses were not unmindful of their own power which I will discuss in a later section, but they do recognize that the ends of medicine are not always the ends of nursing. Indeed, the majority of ethical concerns directly concerned with patients are about those occasions when they do not coincide.

Harm to families. Harm to families was most likely to be seen as occurring in those situations when the patient was not responsive and would have died if not for some form of medical intervention. Specific situations included a 100 year-old completely demented and bedridden woman who was contracted with multiple bed scores, some of which were gangrenous, being cared for by her 84 year-old daughter with advanced Parkinson's Disease; a 104 year-old woman demented woman with bed scores being cared for by an elderly daughter; several comatose people being maintained at home via feeding tubes. For the nurses in this study, these people do not have a life. They are not conscious, or barely so, and thus have no agency and no engagement with the world. They do not have routines of lived experience and death has been deterred. They exist in a "non-state". A nurse describes a 98 year-old woman in this "non-state":

> She's not there anymore. There's very little of her left, little of a personal essence. There's not--she'll open her eyes and the other day she said a couple of words. She moans a lot when you turn her. She hurts. Her life is over. She's not going to get better. She's not going to improve. We're just going to prolong this kind of thing. That's not the ending that I foresee for people. And I've watched many, many people die in the hospital--some good, some not--and here I'm in the home now and this lady is terminal. She's not going to get better. She's not going to get back to where she was. She's not going to

---

[1] This phrase is borrowed from Martin Amis' novel, *Time's Arrow*.

> talk again. She's not going to eat again. She's not going to be with her family again. But she requires a huge amount of care to keep her in this non-state (HC8, p. 5).

When in this non-state, families were bound to a deteriorating body but not a person. It is interesting that in our post-Cartesian world, these nurses made a clear distinction between mind and body. The body is a material object which occupies space but is not necessarily identical to a person. While the body is critically important, it is the mind that endows a body with identity, individuality, and meaningful agency. In more philosophical language, a body is a necessary but not sufficient condition for human life. The same nurse continues:

> We're spending all of this money and all of this energy on these last few months of someone's life when it's not even a good important part of their life. Oftentimes they're not even participating in it anymore. The term vegetable sounds crude and rude and I always hated using it, but that's really what they are. They could be a cucumber. They're not themselves anymore. That part of them, whatever part that made them a human being that you related to, it's not there anymore. It's empty. It's empty. It's gone. There's something breathing and stuff, but it's not them. They've gone. They're not there anymore. You can touch a warm something, it's heated but it's not them. You can't get anything. And to spend money on prolonging that is wrong. Sometimes it can be cruel (HC8, p. 23).

The cruelty lies in the paradoxical reality that while those in this non-state receive what they do not need, the living do not receive what they do need. Here I am thinking of Doyle and Gough's (1991) conception of human need as those items which contribute to physical health and autonomy. Autonomy in this sense refers to the capacity to initiate action, what I earlier referred to as agency. Satisfaction of these needs enables one to participate in the life of the community. What is so ethically disturbing for these nurses is that these patients will never be able to participate in such a life. Instead they drain psychological and material resources from the living, from those that are here. Family members decrease their participation in life; adult children caring for parents spend less time with their own children and customary celebratory occasions such as birthdays can be lost to the routines of turning, feeding, changing, and laundering. Resentment can build at the deprivation and depression at the loss of purpose. Grieving is not possible as the body remains but the person is gone in this non-state.

> It's hard to be healthy and move on with your life when you've got this presence that's always there that's not really there (HC8, p. 31).

That these people were not simply being allowed to die, that death continued to be resisted is evidenced by the fact that nurses frequently had to press physicians for No Code orders. In one particularly bizarre situation [the 100 year-old woman with gangrene],

> the doctor chose not to put an NG tube down, which would have just prolonged this life (HC1, p. 1),

and yet, the nurse says she must

> convince the doctor that this patient should be a No Code (HC1, p. 3).

It is difficult to know what to make of such an inconsistency. At the very least it demonstrates our culture's profound ambivalence about death and our power in relation to it.

Harm to society. From the above discourse, we can already see hints of a deep ethical concern about the economics of death in our contemporary health care system. In fact, this study was replete with references to this situation and the resultant harm to society. As previously mentioned, the harm occurs because people do not receive what they need. Having a life requires a certain set of material resources which makes health possible. The focus on high-tech intervention over preventative care is viewed as misguided and there is concern that we should be using our resources to combat poverty as a way of improving health. People who will benefit from treatment, for whom it will make a difference in their capacity to participate in life have a moral claim to those resources. Failure to utilize high-tech resources appropriately is seen as irrational and immoral. Here a nurse tries to articulate the connection she sees between health care economics and her philosophy about life and death.

> They're intertwined and they're separate, but they're the same. The thing is that, see, I was in Thailand, where it was poor. I've seen poverty; I know what that's like. I see it in the Tenderloin all the time. So, for me, I don't think it's OK to take a huge amount of health care dollars and put it on the elderly in their last few months of life when it's not even quality life. It's terrible. It hurts me, and it feels totally immoral to me (HC8, p. 22-23).

The following nurse tells a very passionate story of an elderly, poor woman with glaucoma who is now blind because of what she sees as a misguided uses of resources.

> I have a lady who's got end stage glaucoma because she's poor and didn't understand she needed to have drops, see the doctor, and go. She didn't go, didn't put drops in her eyes, and now she's almost blind. And she got plugged into the [X health care] system recently, and they poured all this money in and the garbage stuff, but the thing is, nobody really is thinking about this patient, and she had no doctor. So I've got this new patient who has no real doctor, and no appointment, nobody really operating with her. And she's had a history of not following through with things. She's uneducated. Her granddaughter is not very smart and not educated but was trying to do the right thing. But really, it was just too complicated for her to hear all these things. She just didn't understand. But if we had spent some money, some of these health care dollars, at an earlier period or even now--can't we spend some time teaching this granddaughter how to take care of her health and her grandmother's right now? There's nobody doing that. We're not doing that. We're going to spend all this money on sending her for all these various tests and all this stuff to try to--I don't know what we're going to try to do, but the lady's blind now. And if she had had some health care earlier, that wouldn't have happened (HC8, p. 25).

One important point this illustrates is that health care in this country is not spatially expansive, particularly in poor areas. It tends to be concentrated in large, tertiary facilities where practitioner interest and responsibility end with the walls of the building. Patient need is interpreted through the context of what the hospital can offer, rather than what the patient will benefit from. From the nurse's perspective, it is senseless, misguided, and tragic that this woman did not receive the right kind of care prior to her blindness. The ultimate absurdity, however, is that this patient was discharged without a physician to follow her. This nurse will spend a significant amount of time trying to convince a physician to take this poor patient.

> I: I don't quite understand why she doesn't have a doctor. You mean she didn't have a doctor before the hospital; something came up and she ended up in the hospital. Of course, then she gets more doctors than one can ever imagine needing. But then...
>
> But none of them were designated as her doctor or will follow her outside. I mean, this is a teaching hospital. We spend huge amounts of money training these medical students to follow all the interesting cases and all that kind of stuff. But we don't designate, this is the person who's going to follow you. If you're not poor, that doesn't happen. Now, if you and I got sick, we would find us a doctor. Or even if we got to the hospital, we would be very articulate and verbal about, now who's going to follow me when? Who am I going to follow with? Are you going to recommend somebody if you're not going to do it? I mean, we wouldn't have come home from the hospital without having anybody. But here's this family--and she doesn't have transportation, either. She lives in [names area of city]--poor. And all these crazy kinds of stuff, where we're putting all this money on these people who really aren't there anymore. And I need some resources allocated to this lady who's still there, before she gets to where they are. If she's not going to take her medicines and she's got high blood pressure, she's going to stroke out and be just where they are. I'd like to intervene earlier, now, when we could make a difference, could make a difference. And I guess that's the reason why I can't take my ethics out of the economic class (HC8, p. 26).

Again and again these nurses stress the inanity of our willingness to pay for high-tech care rather than prevention. This applies to the other end of life as well. A former pediatric surgical nurse tells of a bowel syndrome common in premature infants which is fatal if not treated. The economics are sobering.

> It costs, I think, something like $4,000 for prenatal care at the [X] Clinic for a woman's pregnancy. It may be a total of $8,000 for prenatal and delivery. Whereas these kids who are born premature, cost $10,000 a month just for the total parenteral nutrition. And they end up being hospitalized anywhere from 3 to 12 times a year for infections on their lines (HC9, p. 8).

She continues, talking about a child she has cared for:

> The ones that have more bowel will end up getting predigested formula through night feedings, through a gastrostomy tube. They'll take them off the TPN, because the longer they stay on the TPN, they will have liver failure because of the high concentration of the nutrients that are more than you would eat. So this little boy now is on the liver/bowel transplant list. He's waiting to get a liver and a bowel transplant, because he's already in such bad liver failure. He's yellow. He's going to die unless he gets a liver and a bowel transplant. So, talking about money, you have $8,000 here that our government isn't willing to put out. But yet, here they are, they're willing to put out hundreds of thousands of dollars on the side effect of not having the prenatal care (HC9, p. 9).

We can see that these nurses hold strong convictions that resources be spent on people who are "already here" and for whom treatment will "make a difference" in their ability to participate in meaningful human life at *some level*. I emphasize some level because I want to stress that the ability to participate in human life is not about human perfection. It does not mean that health care resources should not be spent on anyone who cannot return to or achieve some ideal standard of perfect human functioning. Their convictions do not exclude treatment for those with Alzheimer's, for instance, or those otherwise incapacitated elderly who have meaningful lives, or those neonates who can have such a life despite disabilities. Treatment must, however, improve one's ability to be engaged with others, to have interests and concerns, and must decrease not increase suffering. Furthermore, focusing on prevention for everyone rather than on treatment for a few costs less, thereby freeing funds for wider distribution and use, including attention to poverty.

These are ethical beliefs which reflect a vision of the common good but as we shall see in the section on relationship, a central tenet of nursing ethics is a commitment to the support of patient agency. At first glance, there seems to be a conflict between this vision and the strong support these nurses give individual choice regardless of what is chosen.

> I feel like everyone should make those choices for themselves, and it's not my business to make those decisions. I just want to support what they do want. I mean I don't think it's our role to come in there and say what we think--well, you must have this procedure, you must have that done, or not have it done. I think our role is to give them choices and say--just like I did with that man--let's follow each path. If we did this, that might happen. If we did this, that might happen (HC6, p. 18).

In talking about suicide, a psychiatric nurse says:

> I feel that people have the right to end their life if their quality of life is no longer acceptable to them (P1, p. 2).

Yet the apparent conflict between this and a vision of the common good is more complicated for three reasons. First, there is a fairly widespread skepticism about what physicians actually tell patients.

> Are the doctors really telling them what's going to happen when they initially say: Look, you have this and we can do this for you to help you. Are they giving them the long-range plan?--but, in the end, you will only have a year to live--you know, so the patient can make up his mind whether or not they want the treatment. Because, in my opinion, I think they're only telling them half what they need to know. They're telling them, you have cancer and this is what I can do for you. They're not saying, but you only have six months to live (HC9, p. 2).

Implied in the above is that physicians promise more than they can deliver which was actually given as an ethical problem by one nurse. Following from this is the second reason: nurses believe that at least some patients are more accepting of death than most health care practitioners are able to admit. The following is an elderly patient with advanced cancer who also happens to have schizophrenia.

> So we talked about it, how she feels. And she said, well, you know, my feelings about life are that you live and you die and that's it. I'm not afraid to die, she told me. I know that we're all here for a certain amount of time and then, when our time is up, that's it, you know, and I'm ready for it (HC9, p. 3).

Another nurse tells of her experience with elderly patients.

> I've noticed that elderly people in some ways they're resigned to the fact that, yeah, I'm older and yeah, I have health problems, and I know that I'm going to die sometime in the not too distant future. They're more accepting of their illness. Like, well, if you've lived this long, yeah, you're going to have some heart trouble, some arthritis, whatever--versus the people in their 20's and 30's who are dying (HC6, p. 10-11).

Third is a belief in a rationality which provides a wisdom regarding the use of high-tech interventions.

> And he [the speaker's husband] said, how do you know, when somebody gets old, that they're not scared to die, or something else comes up? But I've seen too many deaths, as a nurse working in a university hospital. I've been there. Some of them were planned deaths, some we knew it was going to happen imminently, some of them happened unexpectedly. I worked in the coronary care unit my first nursing job. I saw people saved who had no heart left, essentially. And they were going to go home and vegetate on the couch, after we'd spent hundreds of thousands of dollars. And they didn't feel good. They were scared. Their family was scared. It was just a real horrible thing to put people through--the things that we did in the coronary care unit. I watched a man in the coronary care unit revived three different times, and he was aware of it. He'd open his eyes; he could talk. And here was another man whose heart was gone and we just keep these people who are not going to be OK. I know you can't always know exactly, like when the patient's husband asked me, have you ever seen anybody like this get better? You can't 100% predict. But you can make some kind of rational decision based on experience and expectations about what kind of care should be involved, and how much of it (HC8, p. 6).

The implication in this nurse's comment is that physicians are not being rational in what looks like unreflective use of high-tech interventions. I would suggest, however, that physicians and nurses employ different rationalities reflecting the underlying differences in the logic and structure of their practices. Because nurses watch lives and not merely physiological events, they have a point of view which affords a different kind of knowing, a different rationality. I believe it is a narrative rationality which nurses employ. Recall from an earlier chapter that narrative rationality is concerned with a logic of good reasons. Applied to a life, this logic would examine the facts of the situation, the relevance of any given intervention to the person's life as lived, the consequences to a life for choosing or not choosing a particular intervention, the impact of the intervention on the integrity of the person's life, and the harm that the intervention may do to the patient or others. Medical decisions are seen as decisions based almost exclusively on what can be done in a physiological sense, abstracted from their relevance to a person's day-to-day routines of lived experience. When listening and watching, nurses bear witness to lives that are lived. For this reason, they are more attuned to the significance of treatment to patient's than are physicians. Having a life is more than medical decisions.

> It's their life and their body, and I want to honor whatever their choices are. I mean, I don't think it should just be a medical decision (HC6, p. 17).

The nurse uses the phrase *medical decision* to mean who makes the decision but it could just as easily refer to what is included in the decision. This work does not provide a definitive answer regarding the existence of a conflict between the common good and the rights of the individual in nursing ethics. It does lead us directly, however, to the final harm of our cultural failure to exercise wisdom in the face of death which was expressed in this study, and that is, the harm to nurses themselves.

Harm to nurses. Even if economic resources were infinite, the prolongation of dying is deeply troublesome to these nurses.

> I: Is there a tension in your thinking about, on the one hand, if the resources were infinite, people could do this... (respondent interrupts with)
>
> If they choose to but I wouldn't choose to be the nurse. If you want to do it, you have the right to make your own decisions about what you think is right. But I also get to make my decisions (HCB, p. 29, 31).

Death sets limits on life. When we try to deny that reality though medical intervention which prolongs dying and extends physiological processes at the expense of meaningful social life, we harm nurses. This harm arises from two aspects of the work of practice; bearing witness to the patient's suffering and the doing of procedures which contribute to that suffering. To witness suffering is to suffer oneself. To suffer through witnessing another is to participate in that suffering through empathy and imagination. Such an event is possible because we share both the experience of a body and the participation in a given social world. Only those who are disturbed in profound ways cannot do so. The suffering of the observer is not necessarily a suffering of identity in kind nor proportion. Parents keeping vigil at the bedside of a traumatically injured child may share in the physical suffering to some degree but they may suffer in other ways such as guilt and rage over not being able to protect their child. Suffering is not only an empathy with the various forms that physical suffering can take but extends to emotions as well.

> I remember one baby who just went through this whole stage before it died--got bloated up like about five times its weight, and then his skin started cracking because of the edema. So it was just breaking out everywhere. The parents wanted everything done. And so it was a little different, because it was sadder watching them have to go through the pain of dealing with what we all knew would be the outcome. But see, sometimes you have to just sit back and just wait for them. So then it was really hard to be the nurse. First it was hard to be at the bedside, mainly because you had to take care of this baby who was getting so atrocious (HC2, p. 28).

Nurses are in the peculiar position of "causing" much of the suffering of their patients through the carrying out of various procedures. There are a few ways to cope with this. One is to objectify the patient, transform the patient from a subject with desires, wishes, and feelings to a passive object on whom one performs certain tasks. There is little to no engagement with the person and therefore little empathy. Here I am using empathy to refer to the capacity to understand the experiences of the other through the imaginative use of self. Empathy is a way of knowing. Obviously, the lack of engagement is made easier when the patient is unconscious. Respondents note:

> Intensive Care Nurses do not like to talk to patients. They don't (P7a, p. 11).
>
> In fact, I remember one nurse once said -a patient started coming out of a coma and started talking--and she goes, time to get him off the unit; he's asking for things (P1, p. 17).

Another way to cope is to justify the infliction of pain or whatever in terms of the outcome it is intended to produce. Pain is inflicted and endured with relatively little problem when the outcome is cure or significant improvement. Here the point of the practice remains intact and there is a relevant and appropriate means/end relationship. Nevertheless, when the end of cure or significant improvement does not occur the treatment frequently continues. In such cases, there is a rupture in the means/end relationship and nurses ask, "why are we doing this?" At this point some rationale must be given and seen as legitimate. Two types of rationale were given in this study. If families wanted "everything" done, this was seen as an understandable and legitimate rationale even though nurses disagreed with the continuation of treatment and thought it was wrong. This can be seen in the excerpt above which I repeat here.

> The parents wanted everything done. And so it was a little different, because it was sadder watching them have to go through the pain of dealing with what we all knew would be the outcome. But see,

> sometimes you have to just sit back and just wait for them. So then it was really hard to be the nurse (HC2, p. 28).

Another type of rationale is one that rests on the presumed superiority and objectivity of medical knowledge. The thinking is roughly like this: maybe medicine really does know something leading to cure or improvement that we don't.

> Well, as long as they say, OK, this is what the family wants, or something, so there's a rationale for their decision to keep going or not to keep going. You know, then the doctor will say, listen, this is--or--we've read the latest literature and this is documented. Maybe they have some information that we don't have, and if it's just shared with the staff, so that--listen, kids with this kind of anomaly can live quite well or these are the statistics or something. And then it's like presented in some sort of way (HC2, p. 22-23).

But even these rationales will fail in the face of suffering and the continuing advance of death. "Why are we doing this?" is raised again. The following example is one of several in this study. I chose it because it is complex and particularly interesting in that it illuminates both the issue of engagement with the patient as well as the goal or end of practice.

> The patient arrives in the Intensive Care Unit in poor shape. The patient, hopefully, will leave the Intensive Care Unit in better shape and, hopefully, somewhere down the road, they will be able to see the little kid that they took care of in the Intensive Care Unit that's getting better, looks healthy, has sort of been brought back to life--is awake, talkative, cute, whatever. Now, you go to the Bone Marrow Transplant Unit, you have a kid that walks in healthy looking, cute, talkative. You get a little bond going. And then you start these procedures--whether it's starting with the chemotherapy or whatever you're doing. And the kid starts going downhill. So you essentially bring them down into a critical state, but now the problem is, you've formed a relationship with them, and so that the cuter that they are and the more interactive that they are, it throws into your world of nursing something that you're not used to dealing with. They've watched the kid become gangrenous and its skin sloughs off. And these kids, when they go, they've become little monsters in bed. They have ascites, I mean their body starts rejecting whatever organs it is. So, if their skin is involved, they start, I mean literally, it's like

> shedding layers there, and then they're down raw. The skin starts coming off. So it's horrible. It's really horrible. So this is like, from the cute to this versus the other way around. And those are the times when I have seen nurses--if it's a patient that everybody has loved--finally sit and have to question, is this really worth it? Is this really worth it, meaning is this bone marrow transplant really worth it. If I had a kid, I'd never do this to them. If I had to make that decision for myself, I wouldn't do it (P7a, p. 11, 13).

This nurse points out an interesting contrast between pediatric ICU practice and pediatric bone marrow transplant practice. The former patients are admitted unconscious and intubated and usually have relatively short stays. Nurses do not have a relationship prior to treatment, the expectation of which is improvement even if remote in time. In contrast, the bone marrow transplant patients walk in and nurses establish relationships with these children who are in relatively good health prior to the procedure. The ultimate goal is cure or remission but the procedure itself makes these children mortally ill. When the transplant does not take, the end of their practice is called glaringly into question. The relationship, the empathy with the child which helped one know and provide excellent, skillful care is now a source of deep pain for the nurse. Her connection to the child clearly enables her to appreciate the child's profound pain and suffering. But I would suggest that the effect of the relationship goes further and calls attention to and into question the nurses' agency in producing continued pain and suffering to no end. At this point, no rationale would seem to work as a substitute for the end of cure or remission. To continue is to violate the nurse's integrity and the integrity of nursing practice. It leaves nurses with the knowledge of causing suffering to no end. This is a harm to nurses.

The silencing of nursing's voice. Another harm related to the loss of integrity is the silencing of nursing's voice. As we saw from many stories so far, nurses bear witness to suffering, to the body's deterioration, and to lives. In preserving agency, in attending to the temporal and spatial realities of existence, nurses come to know the patient as a subject; they know the patient where disease intersects illness. This knowing comes through watching and listening to patients and nurses can come to know their wishes, intentions, and limits. Patients frequently tell nurses that they have reached the limits of their endurance for treatment and wish to stop rather than tell the physicians who, likely to be caught in the technological imperative, cannot hear. Nurses speak for their patients to physicians regarding their desires to end treatment.

> listen, this is what the mother's telling me when you're not around (HC2, p. 23),

Nurses are not simply messengers, however, but also speak for themselves when treatment is extended beyond any hope of making a difference:

> this is going too far (HC2, p. 21).

Bearing witness is a means of gaining access to knowledge and thus evidence. Testimony involves the telling of that knowledge (Coady, 1992; Felman and Laub, 1992). The knowledge these nurses have is the knowledge of the spatial and temporal dimensions of what it means to have a life. It is also knowledge, built over long experience, of who is likely to benefit from extensive treatment.

> I've done this long enough to know that they'll just give up, no matter what you do. They have very resilient little hearts, and they keep going and going and going. But there's kids that just ultimately--it's like an internal thing that happens with an ICU nurse if you're there a long time. You just know who's a real little fighter and who isn't, and who's going to make it (HC2, p. 10).

Anspach (1993), who has studied decision-making in the neonatal intensive care unit, corroborates this nurse's claim. Yet this knowledge is not recognized as valid nor seen as relevant to treatment decisions. Since the authorial status of the one giving testimony is of crucial import, the testimony of nurses can be readily disregarded by a health care system which defines someone as dying only when there is no more technology to try (Koenig, 1988). This devaluation and dismissal is echoed in nurses' self-doubts about their ability to articulate their positions.

> This is wrong. Definitely I feel this is wrong but I don't know if I would have been able to back it up. I think it would have been just more like a gut feeling which, I think a lot of us did at the time--this kid's just too small--without any real--looking at the long term, you know. It was just more like--it just seemed so ridiculous (HC2, p. 27).
>
> Everybody would just be like, this is ridiculous. You know, how people come on and in that kind of setting, you work very very closely with people. When they would come on shift, you'd say things like, this is ridiculous or what are we doing with this kid? But then you kind of network with each other, but it's like the peons just voicing disgruntlement; it doesn't really go anywhere, you know, because it's not really effective. It's not an effective strategy because it's just grumbling amongst each other. I think it's effective only in the way that it probably makes you feel better to have some peer support (HC2, p. 17).

Self-doubt and a long history of not being heard lead to the silence. The harm of silence is experienced in two ways. In the first way, the inability to have a meaningful say which contributes to the mutual construction of mutual ends reduces nurses to the status of artificial persons (Wolgast, 1992). An artificial person is a person who acts on the decisions made by others. Artificial persons lie in a merely instrumental relation to those determining the ends of action. The possibility for this situation is partially given by the nature of nursing work which includes the monitoring of patients for the effectiveness of treatment regimens (Benner, 1984). Nurses extend the perceptual capabilities of physicians through time and space.

> So, I'll be like the eyes and ears for the doctor and just report to him. But again, we're doing one more thing for this patient (HC6, p. 34).
>
> Even still, I mean, we call the physician to get the order; that's the way we do it. We do the assessment. We're the eyes. And we just call them and if we think, gee, this baby looks really yellow, we think it's a good idea [obtaining an order for lab work] (HC7, p. 11).

In this way, nurses *act for* physicians in a certain sense which can have both positive and negative consequences. In the first excerpt above, the nurse is speaking of a elderly, very compromised cardiac patient who is decompensating further and does not want to go to the hospital or even to the physician's office. This is a positive instance of *acting for* in that the patient is able to remain at home although the nurse continues to have concerns about yet another treatment. In most instances, however, nurses are treated merely as passive receptors of perceptual information. The second example I see as negative because the nurse is not seen as being able to judge the need for and therefore order a lab test on a jaundiced newborn. By treating her or him solely as the extension of the perceptual faculties of the physician and by de-legitimating the nurse's ability to act, the present health care system fragments care, continues bureaucratic control, and is the source of a constant but subtle assault on nursing judgement. Nevertheless, the practice of *acting for* physicians ordinarily is not experienced by nurses as harmful. It is only when nurses must act for physicians in situations where the ends of medicine come into conflict with and override the ends of nursing and about which nurses have no say that *acting for* is harmful.

> What became hard was to be at the bedside and not be part of the decision making--just be there and have to supply all this physical and emotional care (HC2, p. 23).
>
> What was hard for me is that there was a disgruntlement amongst a few of us. We felt like, we're the ones that have to sit and listen to her gasp. Other people can come and go but we were the people who were directly right next to the bedside of this baby, who had to really see her go through these physical changes of her gasping (HC2, p. 16).

With longevity and experience, nurses learn the system, learn how to exert pressure, and on whom in order to have their views heard.

> As a new nurse, you don't speak up. Or you do, and you're not heard, or not listened to as much as when you're there 10 years. When you're there 10 years, you push a little harder, and you know who to push. And you know the right ways to go (HC2, p. 21-22).

> He's the one that makes the ultimate decision about who gets reimbursed and who doesn't, about the visits that do. And he just came up with this policy in the last couple of weeks that, from now on, we won't do phototherapy at home. So, now, what's going to end up happening is we'll have to get our pediatrician in the nursery to talk to him and see if there isn't some way to work it out. And there is a way to deal (HC7, p. 10).

However useful experience proved to be in ultimately having their voices heard, not a single nurse reported an instance where treatment was stopped on their account. Thus, the illusion that nurses are heard may be just that, an illusion. The voice of nursing is silent.

The second harm that nurses experienced in relation to their silence is what has been called, bearing witness to the witness (Felman and Laub, 1992). Those who bear witness to significant human ventures also need to be heard for as we saw, to witness suffering is also to suffer. Giving testimony to what one has seen and participated in is a way to make sense of the events. This is true for nurses even in those instances when the ends of nursing and the ends of medicine were shared. At those times when the common end was to permit someone to die, there was the customary pain of watching suffering. Perhaps, more profound though, was the confrontation with the power of one's own agency. The goodness of the act of withdrawing treatment or of treating pain which would lead to death does not protect thoughtful, responsible nurses from the recognition of their power to occasion the finality of death.

> I: I guess one of the things I'm trying to get at is a sense of what that was like for you. You didn't object on moral grounds. I mean, you thought that this was the best thing to do for the baby. The baby wasn't going to get better.

> Right. But there's always that underlying sort of, I guess it's the power of doing something like that because you're really the one administrating something, so it doesn't matter. There's still, I think, some personal beliefs and some objection that comes up. Even though intellectually and verbally I could definitely say this is the right thing to do (HC2, p. 8).

In this situation a decision had been made to stop treating a very ill newborn. While this nurse strongly believed that this was the most ethical thing to do for this baby, the nurse objected to the way in which it was done. Here is the nurse's reasoning.

> We at least started to withdraw the support by just not responding, we just sort of stopped treatment. We didn't treat the acidosis as we had earlier. We started, it was just dialing somebody down. It felt like you're just choking somebody, you know. That's just not the way that it's done, that you just dial down their oxygen because, of course, they're going to start to decompensate. So we were like manipulating the external treatment rather than, like, if some babies are really ready to die, you just make a decision that they're going to code, you don't code them, and then they code and then you withdraw support. It's much more clear now than it was then, and it's still a real fuzzy subject (HC2, p. 4).

The method of treatment withdrawal places the nurse in a more proximal relation to the baby's death thereby confronting the nurse's sense of agency in a way that simply removing life support would not have. Moreover, this method was seen to cause the baby more distress.

In another situation, a long-time patient of renal dialysis has made the decision to stop treatment. This patient is in severe pain and morphine is being used knowing that it will occasion her death.

> The resident was standing there, it was his patient. And he said, do you want to give it to her or do you want me to? And I just looked at him and I said, no, she's my patient. She's my patient, and I will give it to her. And that was the first time I had thought about that I was the person that gave her the morphine. And when I gave her the morphine, she died (HC8, p. 14).

The witnessing of suffering, the confrontation with and acceptance of responsibility for one's agency demands to be spoken as testimony. Testimony is a speech act and not merely a propositional statement. To testify is to speak the truth about what one knows, that is, "to take responsibility for truth" through the telling, it is "an appeal to community" (Felman and Laub, 1992, p. 204). For these nurses, the desire to speak is itself a moral act, a desire to speak the truth about the patient's suffering as well as to take responsibility for their agency. It is also an appeal to be understood.

> So I really didn't go through the channels, where I think I would do things different, like really call a meeting with the doctors and head nurse and say, this is just stupid. Let's either treat or not treat, or let's just have some sort of outlet for how it was to take care of this baby. So I think that was hard for me (HC2, p. 16).

I: You look sad as you...

> Well, because it was sad, it is sad. And it's sad that there's no outlet or I didn't create that outlet. Maybe it just was where I was, where my level of maturity was because later I became a head nurse in that unit. I became clinical coordinator on several shifts, and I would have been able to see that in other people. But somehow, my manager didn't at that time, or I didn't seek it out. Maybe they felt like it was fine (HC2, p. 16).

And here again:

> I guess what I felt really sad about was that there was really no outlet. Maybe now that I talk about it, I guess what made me so sad is that I felt like there was no place to go with it. So it's something that I just held inside for a long, long time, until right now. It's funny that I just even brought it up (HC2, p. 18).

This plea for an outlet suggests the lack of an adequate cultural response to our late twentieth-century manner of dying. Having an outlet offers the possibility to testify, to speak the truth. It is a call for legitimacy, for understanding, and for support which fosters social connection and decreases isolation. Testimony submits the situation to moral evaluation. Perhaps it is similar to the deathbed testimonies given in the Middle Ages (Aries, 1974) where people spoke the truth of their lives and left words for the future.

The call for an outlet is seen as the responsibility of all those involved although the nurse mitigates her own responsibility somewhat by appealing to her youth and inexperience.

> I was so naive then. I don't know. I didn't speak up very much (HC2, p. 27).

Burn-out. Regardless of how the responsibility is negotiated, it is essential that nurses be able to speak to their bearing witness. The failure to do so is likely to lead to what has been called burn-out.

> And that was just the beginning of [the technology]. It was, this is the nature of the game. This is what we're doing. This is how the technology is, this is what it's becoming. So I feel personally, I had to deal with a lot of that. It was years--because I went back and forth. Like I said, I'd either not take care of those kinds of kids for a while and that was a luxury of that kind of unit, the way that we did staffing. We did later have support where you could just take a break. Your managers or your leaders would listen to you and say, OK, you sound really burned-out (HC2, p. 20).

The nurse compares the support from this manager to the time when she first started in the unit, when:

> There was a big turnover of some staff at that point in time. They left because of keeping these small babies alive (HC2, p. 20).

Burn-out, as referred to by most of these nurses, is more than disengagement and lack of caring (Benner and Wrubel, 1989). While the effect certainly involves the emotional distancing from one's practice, it seems to be a physical and emotional response that is the final common pathway when four conditions which I have just discussed coincide. These are: a profound questioning of the ends of medicine; conflict over these ends with a loss of one's own or nursing's ends; a denial of voice in setting the ends; and, reduction to artificial personhood. The distancing that results occurs because the nurse ceases to know what she is doing. Of course, this is not in the literal, moment by moment sense; she knows she is suctioning a patient, medicating a patient in restraints, and so forth. But she no longer has a grasp of the point of her practice. It is as if the practice falls away leaving merely a succession of tasks carried out in robot-like fashion.

This conception of burn-out contrasts with another conception in which the self is seen as containing a given amount of fuel called caring. When the caring has been depleted through doing too much for the patient, one is burned-out. In the following story, a home care nurse tells of her work with a family where there is a child on total parenteral nutrition (hereafter referred to as TPN). Because of what she does for the patient, she is warned about burn-out.

> I followed her at home. For a year I did daily visits, twice a day, because she was getting admitted 7 to 11 times a year for infections. She was living in the ghetto so I'd make sure that she got the proper housing from the Housing Authority. I actually helped them move. I got my dad's truck and helped them move and set them up in this nice house. And which is something--you know people were telling me, you're going to burn out. But I did it for them. And I hooked her up and I unhooked her [TPN lines]. And during the whole year that I was there, she was never admitted for infection (HC9, p. 13).
>
> I: I'm curious, as people told you you're going to get burned out, what is that all about?
>
> Well, they wanted me to go in there and prevent line sepsis, you know, Broviac infections. If that's what they wanted me to do, then they would have to be in an environment that would promote that. And when I went into the house and I saw that the toilet was stuffed up, it wasn't draining properly, the refrigerator was freezing the TPN, the house was filthy, I knew that the reason why she was getting line infections was because of her environment. It had nothing to do with the line care. In my opinion, she needed to be in a clean environment. So I changed it so she could have a clean environment (HC9, p. 17).

I: Is this unusual, that home care or public health people will go to these (respondent answers)

It's unusual. I went out of my way. I went out of my way, just because I feel that if I'm going to do a job, it has to be done correctly. You have to complete the loop and that's one of the things that I feel is wrong with medical care. They don't do the complete loop. They just do part of it and then they forget about all these other things that play a role (HC9, p. 18).

I: When people told you that you were burning out, what was your answer to them?

Well, I think I didn't really answer them because I didn't really understand what they meant. I mean, I knew what they meant. I knew what they meant is that this is something that they, as nurses, would not do. But, in my own mind, I was thinking: I'm not them. This is what I want to do and this is what I'm going to do (HC9, p. 19-20).

I: What does burn out mean to you?

Well, that means basically you just can't handle it anymore and you don't even want to deal with that situation anymore. In other words, here's that patient that you put yourself out for and finally, they're still at stage one. You haven't progressed to stage two or stage three of their independence or whatever it is that you're trying to achieve, your goals for that patient. And then you'll just cut them off and say, OK, I quit. That's burnout. You can't deal with it anymore. You haven't gone anywhere. But, in reality, I don't think that's burnout. I think, in my opinion, I have patients like that where I've said, my goals with you were these. We haven't met those goals, and we've tried to do it three different ways, so that's as much as I can do for you. I'm discharging you from my care and referring you back to your MD, and hopefully they can find another nurse that can deal with you more effectively because I've tried everything I know how to do and it hasn't worked (HC9, p. 20).

I: And that's not burnout to you, that's just the way it is?

Yeah. You try problem solving, and sometimes you don't solve them. You know, you have accomplished, not accomplished. So it's not really burn-out (HC9, p. 20).

In this story, the nurse does not see herself as having a limited amount of caring which might exhaust itself. Instead, they view themselves as determining what needs to be done and doing it. At no time, is the nurse reduced to an artificial person. The nurse's agency initiates the needed changes to bring about the shared end of sepsis prevention. It is worth noting, of course, that the end is not controversial for the nurse. Failure to achieve the end after several tries is the result of a mismatch between patient and nurse which is interpreted as failed problem-solving on both sides. This does not lead to the nurse's withdrawal and interpretation of non-caring and burn-out.

Resisting the denial of death. The nurses in this study resisted the dominant practice in health care, expressed so succinctly by a home care nurse:

> Right now in health care, you have to make a decision for prolonging life. You just have to (HC8, p. 19).

They resisted by leaving the places where the refusal to acknowledge the appropriateness of death is most conspicuous, that is, medical-surgical units and specifically, intensive care units (hereafter referred to as ICU). Several of the home care nurses in this study were former ICU nurses and the director of the agency informed me that the majority of nurses she hires are former ICU nurses. Medical-surgical units, and to an even greater extent, intensive care units, are socially structured spaces where the end of care is the monitoring and correction of disordered physiological rhythms by a variety of technological means. Sometimes the impressive array of machinery, procedures, and drugs is effective in restoring the physiological state to the extent that the patient can resume their lives to some degree, if not completely. Yet very often it can not, and in these cases it serves merely to sustain the minimum amount of physiological activity compatible with being alive. Over time, with repeated exposure to such failures, nurses increasingly questioned the point of such practices--why are we doing this? The end of care is no longer shared by medicine and nursing. The ethical problem is that while the end of nursing care has shifted to that of helping the patient die, they may not act in accordance with that end. In their own words:

> The reason why I left the ICU was because I was beginning to feel that if somebody brought a pork chop into the Emergency Room, we'd try and keep it alive in the ICU. So, I was having trouble. I didn't see that there was a lot of viable individuals. It's very far and few between that we'd have patients that really had a prognosis by the time they left, if they didn't die in the ICU (HC3, p. 20).
>
> I started out in ICU just loving it. I mean, I just loved it. You have to to stay in there. And towards the end, as I was getting older, and more the age of the patients that were coming in, and then having to deal with my own mortality and what I would want as a patient, and looking around and saying, I would never want this for me. I used to wear a necklace, a little gold necklace that said "No Code" on it. When I turned 40, I got it from my girlfriend. And I just couldn't, I just couldn't do it to somebody else who didn't want to be there (HC1, p. 16).
>
> Early on, as a nurse, when I worked in the coronary care unit, we talked about having a tatoo: Do Not Resuscitate. And I was pretty clear. I never want that to happen to me, ever. I don't want to have a feeding tube. I don't want any of that stuff. When my time comes, if I can't eat myself, leave it alone, unless my mind is clear and I'm able to think and have some quality of life. But if I can't think and I can't make that decision and I can't say, please let somebody make that for me because I can't say it anymore. That's not what I want for my body and soul (HC8, p. 19).

Although these departures were far more common with the home care nurses, they were not limited to them. Here a psychiatric nurse tells why she left medicine:

> That's one of the things that I couldn't take about medicine, definitely, without a doubt, to me it was black and white. In medicine I didn't feel they discussed the quality of life at all. And sometimes I just really couldn't believe the people that they kept alive. I mean, they were going to keep them alive to put them in a nursing home. And young kids, this is one of the reasons I left, young kids in motorcycle accidents who were 16 years old and who hardly had any brain tissue left, they were keeping alive. You know, the tubes everywhere, people on ventilators. I just thought it was really

> outrageous. And nobody ever discussed the quality of life; all you discussed was what their potassium level was, or sodium level, how much blood do they need--never the quality of life--it never was an issue (P1, p. 16).

Thus, although leaving was a way of resisting the denial of death, it was something positive as well--it was an affirmation of living a life.

Acting For

The patient requires help with health problems about which the nurse can do something. This ability to do something depends on the nurse's skills and preexisting knowledge as well as on knowing certain things about this particular patient. The patient's needs and desires for help in combination with the nurse's knowledge and skills set up this capacity for action in which the nurse, literally, must act for the patient in numerous circumstances. Acting for is not a new idea even if the term is; Virginia Henderson's (1966) definition of nursing is meeting those needs which the patient would be able to meet if they had the physical capability, knowledge or will. Yet inherent in acting for another are the possibilities of an instrumental relationship between the nurse and patient. It is precisely the potential for instrumentality that renders the notion of acting for as ethically significant. We have seen that for these participants, the end of nursing is helping the patient have a life. Of course, what matters is not simply that nurses help patients have *any* life but rather that they help them have a *particular* life, a life that the patient can claim as one's own, that is, as *my* life. In the previous section, I briefly discussed agency as a central feature of having a life; through our agency, we construct our engagement with the world. In acting for patients, however, nurses risk misappropriating this agency and therefore the notion is a matter of deep ethical concern. In this section I discuss the ethical significance of acting for and how it was revealed in this study.

Ethical significance of acting for

When nurses act for a patient, an interesting phenomenon occurs: the nurse becomes the instrument or agent which acts to achieve some end supportive of the patient's sense of having a life which, as we saw, the nurses in this study take as the ethical point of their practice. In this way the means/end relationship is no longer located within one subject which is to say that the nurse is, for whatever time necessary, the means for obtaining the patient's end. The ethical significance of acting for in nursing practice lies at the center of three linked concerns: the significance of the domain in which the need of acting for arises; the vulnerability of the patient; and, the potential for the abuse of power.

By domain, I mean that nurses and patients meet in the context of the patients' having some health care need which they can not resolve satisfactorily on their own. The matter of health is not a trivial one. It is important as an end in itself simply because people feel *good* when they are healthy and *bad* when they are not. Beyond this, however, health is significant because it assumes a decisive role in the kind of life we can lead. Both of these consequences of health contribute to human flourishing. Thus, by reason of the seriousness of the concept, health is rendered ethically meaningful of its own accord.

Likewise, the notion of the vulnerability of people is ethically significant in its own right. Vulnerability refers to the fact that people are inherently vulnerable, that is, capable of being injured. Good health does not efface our status as vulnerable beings since regardless of the extent and duration of good health, we are mortal and will die. Furthermore, injury can and does occur in other domains of human experience besides health. Thus vulnerability creates a demand that people, their social systems, and cultures find ways to cope with this inherent threat. Martha Nussbaum (1988) has referred to similar phenomena which she discusses in a slightly different but relevant context as 'grounding experiences'. These grounding experiences, because they are based on our being biological creatures, are universal to all people and thereby bind us together in a human community.

Nurses are members of the human community not only as individuals but also as people, conferred by society, with a special status to respond to a given type of vulnerability. The vulnerability associated with threats to one's health is the primary vulnerability with which nurses deal. Injury or damage and a patient's response to them occasion needs that frequently will require a nurse to act for them. The state of one's health is particularly sensitive and vital for reasons noted above. Acting for by nurses in the context of health need brings them face to face with the experienced reality of vulnerability both in themselves as responders and in the injured party as sufferers.

Acting For in Realms of Experience

As we see in nursing theories, it is a commonplace understanding that nurses act for patients. This study reveals two features of acting for: it demonstrates that nurses act for patients in three realms of experience: physical, psychological, and what I call the integrity of the self; second, it discloses the nature of the ethical concerns nurses experienced in this aspect of nursing practice.

Physical

In this study, nurses acted for patients in a physical sense in two ways; they differed according to whether the nurse acted on the body of the patient or on the environment. The first is plain enough. Nurses act on the body any time they perform physical care as the following shows.

> I have a patient, an elderly lady who is 100 years old being cared for by her daughter who was in her 80's. The patient had asked, when she got older, not to have to be put in a rest home; she wanted to be taken care of in her home. It was a flat where the daughter was upstairs. She had Parkinson's disease and--very disabled--could hardly get around herself. The mother lived in the lower flat. Towards the end, the mother was completely demented--bed pan, of course. Contracted with multiple bed sores--very painful--some of them were gangrenous and weren't healing because she was not eating or drinking, and the doctor chose not to put an NG tube down which would have just prolonged this life. And what I was doing, I was going in daily and doing wound care, because the daughter, with her Parkinson's tremors, couldn't do the wound care (HC1, p. 1).

> And then that whole issue of, well, if there's a fire, how do we get the patient out of the home? Who rescues the patient? So you call

> the Fire Department and you let them know that there's a debilitated patient in this flat, and they put a little sticker on the door, and they have a list. So if there's an earthquake or a fire, they can go to these homes and get the people out. They don't walk away and say, well, everyone's out. So we have to do all that. Actually, you know, it's really very rewarding, but at the same time it's very draining. There's a lot of these shady issues that you don't have to deal with in the hospitals (HC1, p. 7).

Nurses also take over agency for the patient in those situations where the action is directed towards the environment, frequently, some aspect of the health care system. In the following excerpt, a psychiatric nurse has been caring for a woman who underwent an abortion because she had cancer and required a radiation implant. Although she had agreed to the abortion, the woman was clearly distressed by it. The nurse reported that the surgeon's treatment of the woman had been quite callous throughout. Here is the situation post abortion in which the nurse by virtue of her position in the hospital as well as by her personal strengths can accomplish what the patient could not.

> Several days after the abortion was when the real dilemma came, when she came to see me and said that she was having a difficult time with it still. I saw her also the moment after she came out of anesthesia from the abortion. And she wanted to find out if she could get these remains of this fetus and bury it. She talked it over with her husband and they felt that that would really help them get through this time. So I contacted the surgeon to find out how that would be possible, and he basically said, look, you people over in psychiatry, just drop this. It's over. It's done with. Just forget it. You know, don't upset her with this any more. They really saw it as us prodding her to do this. So it finally happened. We finally got these remains.

I: How did you negotiate that?

> Well, I had to, I can't remember to tell you the truth. But I had to make a lot of phone calls, finally got the people in pathology, the lab where this was, and thank god it hadn't been destroyed because, usually--they also told her it would be burned. So the images that set off for her were just unbearable. First of all she was having a terrible time with the fact that she'd had an abortion, and she felt very

> guilty about that. But then, the thought of them burning her fetus was just--She wasn't sleeping, she was totally depressed, she was crying constantly. So, it took a lot of phone calls, but we finally located...
>
> I: How did you learn the system even to trace where the fetus might be?
>
> It was all by trial and error at that point. I mean, I'd been in the system, at that point, for six years. This was a new job but I just got on the phone and started calling. I think I first called the Same Day Surgery Center where she'd had the abortion, and they gave me some telephone numbers. And I called them and finally found the exact specimen with the name on it, so I knew I had it located. And it was very lucky because they usually do destroy these fairly quickly (P6, p.4).

Psychological

By acting for in the sense of psychological experience, I mean that nurses frequently structure the environment and direct the patient so as to modulate stimuli and the patient's response to it. The goal is to support and or strengthen the patient's sense of self so that they can act on their own. Such a commitment to patient agency is reflected in these narratives of nursing practice as well as nursing theory practice and is consistent with contemporary views of the self and agency (E. Wolf, 1988).

> We had a fellow. His name was S. This is many years ago now. He came in and he was in the midst of the catatonic process. He was either so catatonic or he was so depressed that he was not able to do anything for himself. And I used to have to stand with him in the bathroom and tell him to continue to brush his teeth because he'd get in there and he'd just start and then the brush would stop. And you'd have to tell him to go back and forth, and back and forth. And even to take a shower or anything, you had to give him step by step instructions because he would just stop in mid thing and just stand there. And eating was a problem for him. And one time he was so bad--he never did this with me, and I don't think he did it with any of the nursing staff, but he did it with a couple of the patients--that he had to go to the bathroom and he couldn't unzip his pants to go to the bathroom. And a couple of the male patients actually helped him unzip his pants and aim himself towards the toilet (P3a, p. 1-2).

> I saw a patient who came into the Emergency Room specifically requesting a prescription for psychiatric medications. And this was a young man who was discharged from X hospital. He had had a brief hospital stay several months back, had been referred through Psychiatric Emergency Service at another hospital. And, I think he had engaged in some high risk behaviors which resulted in his becoming HIV positive. But he was not made aware of that at the time that he was discharged from X hospital because the plan was for him to return to X city. And so when I called the Community Mental Health's Clinic he had actually not made contact with them. So, here's a young man who probably engaged in prostitution, but also had been in jail as well, and I think, because he was so fragile psychiatrically, that he might very well have been taken advantage of in jail. So, in that setting [psychiatric emergency service], where you don't have a relationship with the patient per se except for the interaction you've had leading up to--but he obviously needed to have some follow up care. And so to just let him go, saying well, here's a number and I want you to call this and I want you to get yourself set up, I think, was very difficult for me. To just let him--I mean, he left and I think about him a lot, and think about, could I have done something differently. Could I have intervened more aggressively in sort of taking him by the hand and taking him to X clinic or wherever he could get set up, because I think that he just didn't have the capacity to do that (P4, p. 3-4).

In some cases, the aim may be to help keep the self intact whether or not there is any hope of the patient's capability to act on their own. For example, in terminal illness a patient literally may be overwhelmed by various symptoms to the point where any meaningful sense of self is obliterated. Even though the patient will not recover so that they can act on their own, they may experience a coherent sense of self from adequate symptom control. In cases such as these, a nurse may be acting for the patient in both the physical and psychological realm of experience.

Integrity of the self

The third realm in which nurses act for patients I call integrity of the self. Since one meaning of integrity is wholeness or intactness, aspects of the psychological realm of experience could be taken in this way. Yet I have something different in mind in using this phrase which is in the sense of faithfulness or fidelity to one's identity and values. Integrity is a matter of the continuity with having lived one's life in a certain way. Consider the following two stories:

> The first patient I'm thinking of is a gentleman who--I didn't quite feel comfortable with how I handled the situation with him. He's 94 and I knew him from two years ago in home care, and then we discharged him, and resumed seeing him again, because he has very end stage heart failure, congestive heart failure, and severe angina, unstable. The reason I bring up that I knew him two years ago is, he had said to me repeatedly, I don't want to go to the hospital. I'd rather die than go there. The reason I've lived so long is I've stayed away from hospitals and doctors. When I saw him he had a pacemaker inserted and they were trying to convince him to have a bypass at, well, 92, then. I'm just telling you the background from what I knew of how he felt about medicine and doctors and that sort of thing. And so he was on very high doses of meds, and that's what he was living on, basically. When I went to see him again, then, two years later, actually, pretty much from the moment I arrived he was in increased congestive failure. I mean, he couldn't--he had real shortness of breath, even at rest. He was very weak, and saying that he thought this was it for him, that he was going to die. He was in real congestive failure and didn't want to go to the hospital. But his wife did want him to go. She wasn't ready to say, this is it. And he didn't have oxygen in the home at the time. And I can't remember when but it had been quite some time since he'd seen the doctor. We got a call from the head nurse at the clinic saying, would you please go see him because he didn't want to come in. The doctor didn't make home visits, so we were the first ones evaluating him. So I was sort of caught between feeling, well, I know how this patient feels about going to the hospital, and knowing that he was on such high doses of medications, some of them double the dose he'd been on two years before--I was trying to determine--are we going to honor that wish of his to stay home and perhaps get hospice involvement and get him some oxygen at home and just keep him comfortable or--then his wife was sitting there saying, well, I think maybe we should call an ambulance. It sounded like nobody was ready to say good-by to him, they were not ready for him to die. So I felt caught right there. I felt like I didn't want to be responsible for saying, well, this is--we're not going to do any more intervention than this. But yet I didn't want to override his decision and call an ambulance. (HC6, p. 1-3).

The dilemma for the nurse is not so much that the wife and husband seemingly disagree although that would be problematic in its own right but rather, that the patient, who has been adamant until now, defers to his wife. The most significant discrepancy does not lie between the person of the wife and the person of the husband but within the past and present person of the husband. Here again is the nurse:

> The wife, didn't seem to be accepting that this could even possibly be the end, that there must be something we could do, or--he's going to be OK, isn't he? I tried to talk to him privately about it. Let's talk this through. If you go to the hospital, what might they do for you? I know that they could give you some IV Lasix or something to diurese you. They'd certainly give you oxygen, and that kind of thing, some of which we can do at home anyway. I talked to him privately about it, and then when she came in the room I repeated it in front of her. I said, this is what we've been talking about. And he seemed, to me, to be too weak to make a decision. He seemed more willing to defer to other people and say, well, honey, what do you think, and less adamant than he used to be about how he felt about going to the hospital and how much intervention they would do. It seemed like she was trying to feel him out for how's he going to respond to that. So it wasn't really something she was insisting on (HC6, p. 3-4).

For two years the nurse has stood in guardianship of the patient's wishes not to return to the hospital. The nurse understands herself as having a fiduciary commitment to act for the patient on these wishes. The question, however, is which point in time represents the wishes which would best serve the good for the patient--the past two years or now. I will return to this narrative but for the moment, I want to present another.

> I'll start telling you the story. Something happened to me about a year ago. I was seeing a patient, an older woman, about 75, who lived alone. I'm not sure of her origin but she was European Jewish and her family had mostly been decimated in the Holocaust, which was very important in terms of her paranoia and her fears and how that feeds into my actions. She was a diabetic, very brittle, and she'd also had a couple of strokes, which made her memory kind of in and out, and she was really very marginally able to take care of herself. She would

> show me photo albums, show me little girls that she'd grown up with, and they were all dead. Her sister was dead, her sister's husband, her sister's children were dead, her father were dead, her aunts were--everyone was dead. And she had all these pictures. And she had really been one of the lone survivors. And she was still very alone and still living very much in that world, because... (HC4, p. 1, 5).

The nurse is called one day by the home health aide who asks her to come immediately because the woman is grossly confused and disoriented. Her blood glucose is extremely elevated, the nurse does what needs immediately to be done and calls the physician who wants the patient hospitalized. At mention of this, the patient becomes increasingly agitated, screaming she will not go and demanding the nurse leave her house. Several hours go by as the nurse contacts the daughter in a distant city but this does not help. The nurse wants a psychiatrist to come to the house but the agency does not provide this and does not help the nurse explore other psychiatric avenues. Some how the nurse learns that she can have the patient committed against her will but, given this patient's background, this is not entirely satisfactory to the nurse. She continues:

> She said, get out of my house. I want you out of here. And she was starting to clear a little bit more mentally, I guess because her insulin kicked in and she'd had a piece of bread or something. So I really didn't know what to do. She'd say, I'm asking you to get out of my house. Please get out of my house right now. And, you know, shaking and trying her hardest to concentrate, and all the time kind of weaving like she was going to fall down again. So I really didn't know what to do, because I didn't feel that she was very oriented, and I felt that if the paramedics came and forced her into this ambulance, that it would be sort of like when her family was carted off to the death chambers (HC4, p. 4).

This is a very difficult situation in which the nurse is trying to weigh a variety of factors including the woman's current physical condition, her psychological state, and the agency's "bottom-line" policy of safety first--all of this against the woman's history, the integrity which marked her life and constituted her very identity. Here is what the nurse does--and why.

> You know, I'm Catholic and I was born after the war, but it's always been a big part of my personal mythology, if you will. My parents talked about the Holocaust a lot, and I don't know why, but it's just--well, of course it's a very horrifying thing, but it's always seemed very real to me. And just some of the nuts and bolts of it, the children being separated from their parents. If you just think about people taking little children away from their mothers and just the terror, the terror. I hate, I hate to see people in terror. You know this little boy that was kidnapped recently, people say, they took his life, he's young, how could they take his life? But all I can think about is the terror of that child between the time he was kidnapped and the time he was dead. So I didn't like to see her terrified. I think that's the horror of it. And that's why I had left, because I--that was the best thing I could think of to do (HC4, p. 13-14, 7).

The exploration of the nurses' reasoning continues in dialogue with the interviewer.

> I: It sounds like and tell me if this is a fair characterization, that, for you, a central ethical grounding of your practice is this issue about terror and what you as a nurse can do to intervene and prevent that.
>
> Right. Because I feel that the mental suffering that people have because of their physical problems is the central suffering. And second, I would say, it's the moral precept, if you will, of somebody's right to choose their own fate, even if ostensibly they don't have quite the equipment to do it. No one should be forced to accept medical treatment.
>
> I: Even if that means it will have a tragic outcome?
>
> Sometimes. [Here the nurse discusses her experiences as an emergency room nurse in a famous county hospital of a major East Coast city which further illustrates her point.]
>
> I: One of the things that strikes me about this story as you tell it is that you were committed to a lot of things. You were committed to her health and committed to her safety. But beyond that, you were committed to, kind of, the integrity of her life. And, I mean... (respondent interrupts)
>
> Exactly. That is actually exactly it. Yes. I mean, in a sense, what I did was put the integrity of her life and her sense of herself and her need to be in that house where her husband had lived and where all her things from Europe were, etc.,--that was more important than her

> physical safety, even if she fell down and broke her hip or fell into a coma. That was more important. That's how she wanted to live and die, and that was her decision (HC4, p. 16-17).

This nurse, like the previous nurse, sees herself as having a fiduciary commitment to the patient; likewise, this commitment to the patient's integrity is taken to include not only the present reality or set of circumstances but also the past. The past can not be ignored because it lays a claim to who we are, to our characters. Indeed, acting for in the realm of personal integrity requires that we consider the agentic, temporal, and spatial dimensions of having a life as relevant because it is these factors which make a life a particular life. Yet attention to these aspects obviously complicate our perception of need and the demand for response which present themselves so potently in the immediacy of the here and now. By this I mean that if we take into account only those needs which are immediately present to us, the possibilities for appropriate actions are limited thereby making our response straightforward. On the other hand, when these needs are seen against the background of the person's life and values, the end at which our actions should aim is not always so clear. These nurses illustrate that if nurses are to act for patients in such a way so as to preserve the integrity of their lives, they must pause at exactly those times which most call forth a routinized response. In both of these situations, that response would have been to call the ambulance immediately.

Narratives of acting for in the realm of integrity reveal the complexity of nursing practice. They reveal that people do not always fit smoothly into the disease driven interventionist rationality that dominates our health care system. To be concerned with the integrity of the self is to be concerned with our identity, with who we are as people. In the introductory notes to *Young Men and Fire*, the publisher quotes from some of Maclean's notes:

> The problem of self-identity is not just a problem for the young. It is a problem all the time. Perhaps the problem. It should haunt old age,

> and when it no longer does it should tell you that you are dead
> (p. vii).

In old age and approaching death, we encounter again through memory all the lives we have lived. We ask who we are, what we have stood for, and what we have stood against. It is a time for moral accounting with ourselves as we examine our causes, projects, and connections to others. In the words of sociologist Robert Fulton (1976), death asks us for our identity. In acting for the integrity of the patient's self, these nurses were seeking to preserve the patient's identity and their agency by acting in a way consistent with that identity.

Such action by nurses is, however, not without difficulties; I see two major problems. First is the problem of knowledge; how does a nurse know what actions are in keeping with the patient's integrity of self. The issue of knowledge is central to the concept of relationship in nursing but because I discuss this in the next major section, I will leave this until then. For now, it is sufficient to say that knowing the patient in this way requires entrance into their world which is occasioned by a narrative rationality in contrast to a disease oriented procedural rationality. Second, assuming the nurse does know, she or he, in acting for the patient, will frequently place themselves at risk for institutional reprimand. This is likely because health care institutions are structured to address disease rather than illness. Disease is understood as objective and universal and therefore amenable to standardized procedures. I am not arguing that this is not the case with disease but only that attention to the person's experience of illness does not lend itself to such an approach. When something outside the standardized procedures is done, monitors of institutional policy are likely to question the offender's knowledge and capability. With this kind of rationality, there is little or no room for what Pellegrino and Thomasma (1981) have called discretionary space in professional judgement.

Yet judgement is exactly what these nurses exercised. Both of these stories are what I call deliberative moral narratives, that is, they are stories about the possibilities for action or, in other words, about what to do. What these nurses do not do is apply some rote procedure to the situation but rather, appraise it in terms of the particularities of the context. In so doing, they are acting on their judgement, a judgement that Aristotle would have recognized as practical wisdom or knowledge. Although I have discussed Aristotle earlier, I think it helpful to return to him again in the context of these narratives of practice. Because it is concerned with the contingencies of day-to-day life rather than with the unchanging laws or universals in the world, practical wisdom is the essence of ethics. It involves both moral and intellectual virtue. Moral virtue is a matter of perception which tells us what is relevant in the situation. It is worth repeating Aristotle's words,

> practical wisdom is concerned with the ultimate particular, which is the object not of scientific knowledge but of perception (p. 148).

Perception tells us that the situation is one demanding a given action and not another type of situation demanding another action. Perception consists in a certain attitude of openness to factors which contribute to the significance of the particular situation in question. In the above narratives, both nurses recognized that they were confronting situations in which more was at stake than merely instituting the correct response to a medical problem. What was at stake in both these stories was the integrity and identity of the patients should the medical response be initiated. The nurses' sensitivity lay in their apprehension of this and in their ability to understand what it meant for their particular patient to have a life. We see this very clearly in the second narrative where the nurse, given the patient's present terror and past history, empathizes with the patient as willing to suffer an adverse outcome and even death rather than be hospitalized. In the first narrative, given that the wife does not insist the nurse call an ambulance, we may ask why the nurse does. Like the other nurse, she also attends to the salient emotional factors.

> What I was sensing from him was that the emotion was fear, and that that maybe hampered his judgment, or something. I think, in some ways when we make decisions about how invasive we would want our care to be,--well, I'm probably speaking for myself, but--I'm assuming that we're all hoping that it will just happen, and we won't actually have to be faced with, do I do this one thing or not, or do I just die of a heart attack or something. Does it just happen to me, or do I have to actually refuse surgery and make an active choice to say this is really it for me? I think a lot of people feel that that's the difficult decision. When it comes right down to the wire, we can talk abstractly about not wanting certain procedures or whatever, but when it comes right down to it, do you really want to refuse treatment? That's where I think some people can't make that decision for themselves. I don't know if it's that they're not ready or if they would ever be ready. I don't really know (HC6, p. 25).

Aspects besides the patient's fear inform her reasoning as well. The nurse cannot get hospice stat in which case the patient would have been assured of more assistance, both in terms of personnel and symptom management. Furthermore, the nurse spoke with the daughter who did not seem at all ready for her father's death. If both of these had been otherwise, it is likely that the nurse would have felt she could address the patient's fear and support him adequately. As it was, she could not. Unfortunately, the story does not have a happy ending and thus, the nurse's moral distress and deliberation. Once in the hospital, the patient undergoes the invasive procedures he had been saying for two years that he did not want. The same forces are at work in the hospital as at home only magnified for now the patient finds himself in the very space where the disease interventionist rationality is at its most powerful. The procedure may have thwarted death yet again but experientially the patient is improved not at all.

> He's just barely existing. And he says things to me like, this isn't much of a life. Somehow I keep going on but I don't know why (HC6, p. 6).

In stating, "this isn't much of a life", the patient is echoing the fundamental ethical concern for this nurse and that is, the worthiness of the end of medical care. This returns us directly to practical wisdom which is the intellectual virtue concerned with the good for man. Recall that for Aristotle, practical wisdom is the "knowledge of how to secure the ends of human life" (p. 142) and the achievement of practical wisdom requires deliberation. Once our perceptive and desiring faculties have given us knowledge of a good state of affairs, practical wisdom enables us to deliberate not only about the means by which to obtain the end but also about the worthiness of the end to be an end in view of the ever changing contingencies of human life. It is worth noting again, however, that there is not simply one good in these narratives. Health and medical care are goods, they simply are not the *only* goods, nor necessarily, even the most important (Jameton, 1984; von Wright, 1963).

The moral excellence of these nurses lay in their practical wisdom; they were able to discern the most important good for the particular patient given these particular circumstances. Perhaps this was made easier for them because they were never seriously in conflict with the ends itself. In the first narrative, although the nurse questions the cultural end of treating as long as their is something to treat, she never doubted that it was good to respond to the patient's fear. The nurse in the second narrative is concerned with institutional and legal repercussions should anything happen to the patient; nonetheless she believes strongly in the good of supporting the patient's integrity and identity.

This study revealed another deliberative narrative in which there is intense conflict between the nurse and the family member regarding the good for the patient. The situation involves a 104 year-old woman who is being cared for at home by her elderly daughter. The daughter is highly educated, holding a doctorate in public health and is assertive regarding her mother's care. The mother is demented and incontinent with several decubitus ulcers and requires total care. The care is rendered more difficult because the woman is large and not easily turned. Getting her out of bed requires a Hoyer lift. Let's hear the nurse in her own words.

> It was her choice to keep her mother at home and not put her in a skilled nursing facility (SNF), which I admire. But one of the problems that I'm having with her is that she's developed a lot of decubs everywhere. She has a huge sacral decub now that 's like 13 by 8 cm. So I make recommendations to turn her and just do everything you do for a bed bound person, watching their skin, changing their diaper frequently, immediately upon saturation, that sort of thing. And she's not heeding my advice. She likes to know all the details and then she makes her mind up, even if she doesn't have the medical expertise to make that decision. So now she continues to get her mother up into a wheelchair, having her sit on this sacral decub for four hours at a time. I confronted her about it last week and I told her, I really recommend that you don't do that because that's the very thing that caused that decub and it's never going to heal. Well, she didn't want to hear anything about that. She has her reasons for getting her mother up in the wheelchair which are valid, you know. She feels that her mother is a lot less demented when she's in the wheelchair. She feels she's more alert, she eats better. And probably all of the above are true but as far as I'm concerned, those things come second to the healing of that wound and I'm not sure it will ever heal. The ethical issue is, is this ethically right to allow her to continue doing this? I've talked to several people, social workers, other nurses, and they say, well, god, that sounds like a case for the Adult Protective Services--that it's neglect. But I don't think I have a case against her because in all other ways she's showing that she is giving her mother good care. And I can't convince myself that she would get better care in a SNF. I mean, she's certainly a candidate for a SNF but I think her daughter is giving her adequate care. This one issue that I have with her about turning her mother and changing her diaper as soon as it gets wet. I'm not quite sure what to do about that. I don't think there is anything that I can do about that. I can talk until I'm blue in the face and I don't think she's going to take my advice for whatever reasons. And so I'm stuck with, ok, so I'm going to continue to see her mother. Right now I'm seeing her twice a day, probably for weeks and weeks and weeks, maybe months, until this thing heals. So I think, god, is this a good use of resources? Should I just say, look, I've made my recommendations and you're not heeding them. Therefore, I'm going to discharge you for noncompliance (HC10, p. 1-3).

I found this a very challenging and complex narrative, one worthy of a separate analysis in another work. That this situation was profoundly troubling for this nurse is evidenced by the fact that she spent the entire two interviews talking about it. Certainly it is a deliberative narrative in that she is struggling with what to do on several levels. At one level she is struggling with whether or not to report the daughter to Adult Protective Services although she speaks to the fact that she doesn't really have a case. Indeed, this is highlighted in several places where the nurse talks about how attentive the daughter is to the mother's care, dressing her in pretty street clothes, putting on make-up, and doing her hair. At another level, the nurse feels truly at a loss for how to work with someone who repeatedly rejects and refutes what the nurse knows and takes to be best. In one example, the daughter says she will get an egg crate mattress to help relieve the pressure. The nurse tells her that while it will be a comfort measure, it will not relieve any actual pressure; the daughter rejects this. The nurse tells me:

> I mean I don't know what to say to a person like that who flat out denies something when she really doesn't know for sure (HC10, p.7).

What I find so absorbing is the nurse's response to this situation:

> I wonder what I'm doing out there. What am I doing? (HC10, p. 7)

and again,

> So, what am I doing? You know, what am I doing here? (HC10, p. 25).

Of course she *knows* what she is doing in terms of tasks and techniques. But what she does not know is the overall aim or purpose of her work and such a state is profoundly disconcerting. The deliberation of practical wisdom is about the worthiness of the ends to be ends and the means to achieve that end. When we are certain of the worthiness of the ends, we never need ask, what am I doing? This questioning of ends is not unique to this nurse as the following nurse also shares a similar concern.

> You see things that you just don't see in the hospital. You know, people constantly urinate on their leg ulcers or they fall. I have a

> patient like that, they just don't heal, because of the circumstances in their house. You can't control it. For me that's OK; you have to work with what's going on with the patient. But then you have to look at, well, then, are my visits OK? Because, what am I doing here? Sometimes you have to let them fail. That's hard (HC2, p. 48).

But the heart of this deep, painful conflict between nurse and daughter is exactly the nature and worthiness of the end. Listen as the nurse is finally able to articulate this contest of ends.

> I: Is that ever an ethical issue, when you have different agendas?
>
> Definitely. In this situation it certainly is because my agenda has the physical part first. And the daughter's agenda, or so she claims, has her mother's whole being as her first priority. But the fact that she gets her up into the wheelchair and has her sitting on her butt bone that's just bare to the world, and has her doing it for four hours at a time is the worst thing. But her response to my telling her that that is extremely detrimental to her mother's health is that, my mother is more than these wounds and she feels better when she's sitting up in a chair and she is more alert and she eats better and she's just more alive when she's in the chair. I could argue with her, how does your Mom feel having a huge wound on her bottom that's not healing? I mean, does that make her feel more human? You can't begin to think of a person as a whole until you have gotten these other problems resolved. Then start talking to me about her spirituality and how she feels on a day-to-day basis and that sort of thing. But when she's at risk for getting an infection, for sepsis, for further breakdown, for pain and discomfort, it's just misplaced attention. In fact, I used to think, before she got the skin breakdown, this is a really great thing. I used to admire her for this because I thought, no one I know would put that extra effort into doing this. But now she's got a different problem, and I think she should be shifting her attention elsewhere. It's sort of like Maslow's triangle, you have to take care of those very basic needs first and then start moving up the triangle and talking about feeling like a whole person and having your spirituality intact and so forth and so on. But it's hard to be concerned about those things when you're in pain and I think her mother is in pain. She must be in pain, she flinches when I do the dressing change. She groans. I don't see how you could not feel that wound when it's that deep. I mean, it's down to her bone. When you're in pain, you don't have the energy to expend on spiritual things or, how am I feeling as a whole person, or do I feel like eating today? When you've taken care of your food and your shelter and your clothing and your bodily integrity and you're not in pain, then you can start working on those other things (HC10a, p. 23-26).

Because people are different and because nursing work deals with some of the most profound of human issues, conflict over the worthiness of ends and the means to obtain them will always exist on a spectrum between possibility and reality. I am deeply saddened by the strife of this narrative. Both parties felt manipulated and treated poorly by the other and, in a sense, both feared being reduced to an artificial person. In the absence of a shared, worthy end, it is, for the nurse, as if her practice falls away, leaving only technique, a series of disjointed and unconnected tasks. We can only speculate as to what this must seem to the daughter but I suspect she views health care providers as cold, unhelpful, and punitive as when, for example, the nurse tells her that staff can no longer help her use the Hoyer lift to get her mother out of bed. We can sense the daughter's loving commitment to the care that supports the integrity of her mother's personhood yet such care is beyond what an elderly woman can single-handedly do. What the nurse can do is also quite limited and she is acutely aware of it and so both are frustrated. The tragedy of this situation is social and it is complicated. As we have seen in other narratives, we have elderly children taking care of very elderly parents with very little support, either physical or psychological. It would seem that as a society, we have, as yet, neither the emotional and moral commitment nor adequate resources to do otherwise.

> I'm very conscious of, is my visit making a difference? Should I discharge this patient or do they really need me to be here? So I don't make frivolous visits. If I go to someone's home and they really don't need me or I don't have any goals there, then I'll discharge them. Or, if they're able to get their needs met in, say, an outpatient department setting, then I'll discharge them. I have discharged patients who have thought, oh, I still need you to come, I still you to check on me. And from my perception as a nurse, I may say, no you don't need me anymore. I don't tell patients this, but psychologically, it's difficult for you to realize that I'm not going to be coming anymore. My coming here doesn't really make much of a difference except in your psyche. It makes you feel better because I've taken your vital signs, looked over your medications, or whatever. And now, I'm setting you free. That's scary for a lot of patients. I've had

> numerous patients just shocked--oh my god, you're not coming anymore! What am I going to do? Well, I've decreased my visits; maybe I started coming once a week, and then I was coming every two weeks, and maybe now it's gotten to the point where I'm only coming once a month. And in that once a month, I'm only doing maybe a vital sign check and checking to make sure that they're taking the correct medicines. Not a whole lot, like a 15 minute visit and then I'm gone. But to them, it's a reassurance that they're doing ok. But Medicare's not going to pay for that and understandably so. So to them it's a shock, but to me it's not. I've decreased my visits and medically you don't need me anymore, although psychologically, it would be nice if I could come and just let you know every month or so that you're doing ok. But, as I said, we can't do that. It would be great if there was enough money to go around where we could do that sort of thing, but there isn't (HC10, p. 25-6).

Ethical concerns in acting for

The ethical issues of acting for arise from the linked aspects of domain, vulnerability, and power which endow the nursing work of acting for with ethical significance. As we have seen, the nurses in this study are committed to the patient's sense of having a life which necessitates an appreciation of and nurturance of the patient's agency. Yet, the vulnerability of people whose health is threatened frequently calls for the intervention of nurses. The lived experience of vulnerability is largely one of compromised agency and an unequal power relationship, thereby introducing related notions of skill, competence, responsibility, and trust. All of these are ethical notions in the context of unequal relationships in which considerable power can be exercised and in which the stakes are high. The danger of the simultaneous occurrences of compromised agency and unequal power lies in the ease with which the patient's agency can be misappropriated. So in addition to the ethical significance of health and membership in the human community, acting for introduces us to the moral complexity of inequitable power relationships and the inherent potential for abuse of that power.

Nurses in this study recognized the enormous power they could implement to ensure that a patient would or would not do something. This power does not reside solely in the nurse qua individual agent but rather, in the nurse by virtue of their ties or access to institutionalized mechanisms of control. Nurses in this study understood that institutional control extends over a range of human life, from behavior,

> I think she was too psychotic to realize that this was OK and this was *not* OK, and that this is what she needed to do to stay out of seclusion. And she wasn't listening. She wasn't hearing me. One of the things was that she was really testing me by calling me names to see if I was going to back down. And I didn't. And I think, again, that that was important for her, somehow. I think, too, when somebody's testing me, not backing down becomes very important for me and not just out of a macho thing but out of a real therapeutic sense that, if you give them the upper hand, then it's just going to ante the system up a little bit more until finally the staff gets control of the situation. I'll sit down and tell people that. I just say, hey, we've got the power over this. We rigged the deck. This is not a level playing field, you know, we're in control here. I would like to think that people, when they come in, somehow it is more of a level playing field. I wish I didn't have to [keep people under control]. Here I am the enforcement tool of large university hospital (P5, p. 16-17).

to the body,

> In the hospital, you have total control over what goes on, or as total as you can. I mean, we check their blood sugar, we decide how much insulin they get, we give it to them, we see what they eat or don't eat. You don't have any control over that at home (HC6a, p. 14).

to the manner of death as we saw in an earlier section, to access to goods and services, and to life itself. In the following example, a psychiatric liaison nurse must help to decide if an emotionally disturbed child will be able to tolerate a bone marrow transplant for leukemia.

> That's what I said, in essence, at this Ethics Committee. But prior to my going to this committee, it was a preoccupation of mine, thinking about how people were going to ask me, and that, in essence, the dilemma was the way in which my opinion would be weighed, which would be high. My opinion was going to weigh into the whole picture

> of what was going to be decided. That was hard; it was hard to even think about that. To know, for example, that there's a list the committee goes over, the list of people who are up for a transplant, and essentially decide who's going to get one and who's not. It isn't like everyone's going to get one. It doesn't work that way (P7, 8-9).

The work that nurses do takes them inside the space and temporal rhythm of their patients' lives where the ends of the patient and those of the nurse may not always coincide. Yet for these nurses, moral excellence in acting for their patients was possible precisely because of the recognition that the life in which they intervene is, in fact, the patient's life and this recognition requires a commitment to the patient's agency.

> It gets to a point where you've got to give the patient back their life. They bring it to us, sometimes, broken and say, help me, fix me, get me back in line. And sometimes they're brought in with their broken lives and they don't want help or can't accept help or we see it as broken and they don't. It was working perfectly fine for them (P8, p. 18).

> My focus is to respect their autonomy and their wishes and the way they want to live (HC6a, p. 17).

> We're talking about patient's lives, you know. Up here on the hill, we think we know better than everybody else. We know how you can live your life better. You must measure up to this standard in order to be happy. We've decided this. But there are lots of different ways to be in life, and there's lots of different ways to be happy. And until the point that they're unhappy with their lives and want to move on, that's when it's going to work and that's when I can help them. We can work together to make that better. But that's a shared goal. Otherwise you're trying to live somebody's life for them (P8, p. 19-20).

When this moral sensitivity to agency and to having a life is combined with the skills of assessment, interpretation, and shared goal setting, we have moral excellence in acting for.

> In her case, it was a combination of assessing it and getting her treated. She didn't say, I don't care if my leg is swollen and I'm having trouble breathing, I'm going to die and that's what I want.

> She wanted treatment and she got it. For me, it's a combination of the two. I want to feel that I have the skills that I can assess their physical status and do it thoroughly and then tell them, well this is what it looks like to me. You're having real trouble breathing. This is not going to get better at home with these medications you're on; they're not doing their job anymore. What are we going to do about this? I think we should call the doctor, or do you want to go to the doctor, or do you want to go the hospital? I want to honor their wishes once I have assessed what's going on. That's how I feel that I did the best that I could (HC6a, p. 42).

Moral excellence in acting for, however, demands that nurses know their patients which can occur only to the extent that there is a relationship between nurse and patient. This relationship is the vehicle through which the work of nursing is carried out. In the following section, I examine what is involved in this relationship as revealed in this study.

Relationship

Relationship assumes a central position in these narratives for two reasons. First, this study reveals that the relationship between patient and nurse is the vehicle for the work of nursing. A patient and nurse have a relationship by virtue of the fact that they share a connection or set of circumstances which bring them together. Specifically, these circumstances are that the patient requires help with health problems about which the nurse can do something. Moreover, the specifics of this particular circumstance are structured by a whole host of societal sanctions and prohibitions which govern the practices of health care in this country. An example revealed in this study is that health care is generally organized in certain geographical spaces. In turn, these spaces can dictate how relationships obtain among people. We saw, for example, that the structure of hospitals frequently leads to coercion of patients to undergo what is considered the best and latest of therapies. Home care nurses, as former hospital nurses, repeatedly demonstrated their awareness of the difference between hospital and home in making such statements as, "you have to meet them on their terms" (HC2a, p. 49) and "you can't be as bossy, for one thing" (HC1, p. 13).

The second reason for the centrality of relationship in the ethical concerns of these nurses is precisely because the relationship is not an end in itself but is instrumental; like a fulcrum, it "supplies capability for action" (Webster, p. 464). It is the instrumentality which renders the notion of relationship as ethically significant (Wolgast, 1992). For these participants, the end of nursing is helping the patient "have a life" but, of course, what matters is not simply that nurses help patients have *any* life but rather that they help them have a *particular* life, a life that the patient can claim as one's own, that is, as *my* life. In the previous section, I briefly discussed agency as a central feature of having a life; through our agency, we construct our engagement with the world. Because nurses frequently act for patients, thereby taking over their agency, the proper relationship to the patient is a matter of deep ethical concern. These nurses were very concerned to take over patient's agency when necessary but not their lives. This could be accomplished only through knowing the patient and through obtaining the proper relationship. The latter was characterized by the right distance and level of engagement with the patient; securing the proper relationship can affect significantly how well the work of nursing is done and therefore the good done the patient. Danger lies in not achieving a balance between connectedness and distancing, imposing on the patient and not intervening enough. The nurses referred to the proper relationship as a matter of boundaries. In this section, I discuss those aspects of relationship revealed as ethically significant by these nurses.

Knowing

Once a health problem brings patient and nurse together, relationship legitimizes work that can be done. Part of this legitimation involves the specification of knowledge needed to accomplish the work. For example, the knowledge required by a carpenter in a business dealing is different from that required by a lawyer and so forth. Knowing and knowledge are extremely complex concepts with a complicated history in Western philosophy. For the purposes of this work, to know means to perceive or understand some aspects of the patient's reality which is relevant to the nurse's work with that patient. The specifics of any set of circumstances will set up what kind of knowing is necessary for any given action. As we have just seen, a significant feature of the work of nursing involves acting for another in three domains, physical, psychological, and integrity of the self. The nurses in this study were largely concerned with knowing the self or person. Given that these nurses understand the heart of their work to be preserving patient agency, the priority of knowing the person is a logical necessity. To know a person is to appreciate the individual as a subject which is to say as the holder of certain interests, moral ideals, beliefs, desires, and capacities to act in and on the world. If the reader were to look back through this work, they would find that they have already seen numerous examples of knowing the person. There is, for instance, the home care nurse who knows how difficult it will be for low-income women with small children to see their newborn in the hospital for phototherapy. There is the psychiatric nurse visiting the dying AIDS patient in a hospice who knows the important people and causes in the patient's life. Knowing the individual as a subject is to know something about their life, their world, it is to see from their perspective. It is to appreciate what is significant in their lives. It is:

> to understand where they're coming from (HC7a, p. 34).

Such an understanding requires time for a history of interactions to have occurred.

> I hang out with people, just sit down and start chatting. It's not really coming in as a person in a position of authority and sitting down, I'm the nurse; you're the patient. Let's get to the bottom of this. I just try and see what their world is like, just sort of enter into it, not ask them formal questions, but see what it is that they're interested in. Like there's one guy on the unit now who's really into motorcycles, and so we talk motorcycles. And I don't know that much about motorcycles, but boy, he shows me pictures and we talk motorcycles, and I've become more interested in motorcycles. But then, after we talk motorcycles for a while, we start talking about some other stuff, too. I try and see what people are interested in and, so we get people to start talking (P5, p. 26-27).

Notice how this nurse calls our attention to the distinction between the nurse as a bearer of institutional authority and the nurse as a subject in their own right, someone who meets the subjectivity of the patient with their own subjectivity.

> It would make you be able to empathize with a patient in whatever circumstance. It would make you let your ego go enough to consider their needs and enough, also, to collaborate with other disciplines, which is important when you're working in health care. If you're a good person, I think you're more likely to be able to communicate at

> a level or in a way that anyone else can understand. If you're a good person, then you can cross cultural and educational boundaries in a way that lets you do good education and help people. And those are all things that are important to practice of any kind, health care practice. And then, to add to that, giving of yourself. Not just going and listening to somebody's lungs and asking them about their medication, but giving some of your time to listen to them, or to reflecting on what they're saying, or somehow giving psychological care. You need to enter, somehow you have to enter something of yourself to do that. Maybe psychologists and psychiatrists would argue with that and say, no, that's not true. You can, in fact, you have to be objective to give good psychological care. But I've never felt that that was true. I've always felt that, in order to understand what someone was saying, I had to--maybe this shows how primitive I am--but relate it to something in my own experience, some loss, some hurt, some fear, some crisis. Otherwise, how can you in any way understand what they're saying. Somehow making a bridge (HC4a, p. 28).

When this nurse doubts the knowledge her emotions give by saying it shows how primitive she is, she is only reflecting the long history of the devaluation of emotions in Western thought, particularly as expressed by women. She has been well socialized and her comment saddens me especially because she is correct to note that empathy is a bridge which facilitates knowledge of people as subjects rather than objects. As a fellow home care nurse who has worked in a variety of different practice areas notes,

> Having worked in all these different places, I feel like I've taken some of all of those experiences to get to where I am today, and it makes me a little bit better. It's just more things in your bag, or something to work with (HC7a, p. 34).

Empathy, however, need not depend on our actually having had the same experience but it does require an openness to possibilities and a willingness to explore that possibility through imagination. Earlier, we heard a psychiatric liaison nurse talk about how difficult it was to have to contribute to a decision determining if an emotionally disturbed boy should receive a bone marrow transplant. Among other things, she is asked if the child will be able to tolerate the grueling procedure. In an attempt to answer the question with its profound implications, the nurse goes into the space the child must occupy for up to seven weeks and uses her imagination to visualize what it would be like. Here is her story.

> I had actually gone to stand in one of these rooms that the child would be in post-transplant and I visualized what it would be like for *anybody* (emphasis is respondent's) to be in that kind of an isolated situation. And in the rooms that they have, there's a lot of equipment. [She goes on to describe the room and equipment.] So in the process of being isolated, it's also being stimulated by a lot of things that, as a kid, you could pull, you could grab, you could whatever. The problem is, though, that these kids are so sick that they can barely move. But they don't leave this room for up to at least six or seven weeks, at all. To sort of visualize I went and stood in one of these rooms, to get a feel for myself, what are we talking about?
>
> I: How did you come to do that?
>
> I decided that on my own accord because the question was, what would it be like for a kid like this, with all these behavioral problems, what would it be like? So I wanted to know, well, what are we talking about in terms of the room? Because, even in the larger hospital rooms, the kid managed to be able to throw things, grab things, pull things, whatever. I decided I needed to know, what would this kid's experience be like? I mean, when the question is posed, what do you think it would be like for a kid to be in this room and there's going to be all this equipment and whatever and what's the guarantee that he could be controlled in that environment? Well, I don't know, and I first would like to see the environment so then I get a sense of what we're talking about. And I'm thinking, there's no way in hell that this kid, unless he's basically completely tranquilized--now, granted, there's a period where the kids are so sick that you could have a train going around the room and they're not even going to know what's happening. But when they feel a little better--a kid who's dealing and coping with the fact that he knows he's sick. He's very precocious. People talk to him as though he's a 13 year-old. He's very bright and is, I'm sure, well aware of the fact that he's very very sick and could die. What would it be like when a child like that who's feeling terrible, who has to be stuck and has to constantly be intruded upon in one way or another--if they even have the least bit of energy and if a kid who deals with his feelings in a very action-oriented way which is kicking, hitting, cursing, doing that kind of stuff--what would it be like? And I thought, no way (P7, p. 5-7).

To return to the issue of authority, nurse P5 is acutely aware that they cannot disassociate themselves entirely from institutional power (nor should they necessarily) as it is this nurse who earlier said, "I am the enforcement tool of a large university hospital" (P5, p. 17). Precisely because this nurse is acutely aware of the institutional context in which they carry out their work, there is a commitment to know the patient as a subject. Such knowing contrasts sharply with knowing someone as an object where subjectivity is silenced or ignored and some aspect of the self (or body) is taken reductively and is thought sufficient in standing for the whole person. Indeed, this nurse implies that knowing the person as a subject offers a protection against the authoritarian objectification that is the frequent consequence of engagement with institutions.

> I have no qualms at all about sitting down and serving in the function of a teacher, and really working with people from a position of authority, and a position of being well enculturated in our society. I like that role. But what I don't like to do is to not have their cooperation and to be forced into that role, because then I become the punitive parent as opposed to being the guiding parent, and I think that that parental role is something that I really like in nursing and in psychiatry. I feel comfortable with that. I don't feel as though it's a bad role to have, it's a good role to have. But you need the patient's cooperation. That's really what I work with. It's like, when I first walk in to meet a new patient that's been assaultive, I want to make friends with them. And it's not so much that I'm afraid, oh, please like me, please. It's that, if we can form some kind of a relationship, whether or not they're my patient, then as they start to escalate, maybe there's something there that we can work with (P5, p. 12).

Knowing the patient as a subject is not merely some instrumental technique to get them to do something but is a deep commitment to patient agency and to the recognition of the life that agency can bring about. In the following excerpt, a very skilled psychiatric nurse tries to help a patient see the importance of knowing how their co-workers feel about a situation. What is at stake is nothing less than the patient's well-being.

> She's manic depressive, and she had gotten really depressed, and cut herself at work. One of her co-workers brought her in. She had a hard time talking about what brought her in, and then she started talking about being depressed. Then I started getting her to talk about how it must have been for other people to see her cut herself there. Her boss and supervisor never came in to see her and there was some talk about her losing her job. And I said, well, you need to talk with your boss about this. Anyway, she had finally worked out some things and I told her, I said, you need to have some things prepared to tell people when you go back to work so that they won't feel so anxious around you. Different people had come in to visit her and we talked about the people who didn't, and what they might feel. And I said, you'd better have some things prepared to tell people so that they'll feel comfortable with you, because it would be very scary to work with somebody who just all of a sudden does something like this to themselves. And I made her see it from the side of the other people (P3a, p. 10).

Listening

In this study, knowing the person was attained largely through listening. An object can be read, deciphered, or decoded in some way but a subject must be listened to. This is not to deny the linguistic reality that language must also be decoded. The point I want to make, however, is that listening implies a subject who speaks. For these nurses, listening is a matter of moral import because it is only in listening and attending that the nurse can ascertain the patient as person thereby enabling the nurse to act for the patient in ways which preserve their agency and their integrity. Here is one nurse's words about why listening to patients is an ethical matter. We have heard these words before but they are worthy of another hearing.

> Because it's their life and their body and I want to honor whatever their choices are. I mean, I don't think it should just be a medical decision to make. I think it should be their decision as much as possible (HC6, p. 17).

In the following a nurse has been talking about the importance of empathy and shares what they understand empathy to be.

> The willingness to listen and I mean listen, not just hear somebody talk. But listen for what they are saying and take into account what impact any therapy or non-therapy may have on a patient, and how it may impact their health. So, willingness to look at what the impact is going to be (HC3a, p. 30).

Even in those situations where patient agency is compromised, constrained, or overridden, listening to patients has intrinsic merit as the following narrative shows.

> A lot of times it's attention. I mean, it's just that positive affinity, that sense of empathy. It's that sense of, I'm sitting here, I'm listening, sure, I like you--that is so tremendously healing for people. I really believe that that can be more healing than medications. To sit down and let somebody know that you like them, that you think they're OK, that they have some crazy stuff going on or some real manipulative stuff, but that... (P5, p. 31).
>
> Just the other day, we have what we call Reese hearings on the unit, where people are deemed either competent or incompetent to refuse psychoactive medication. And the woman had been admitted, who'd been to us once or twice before, and was refusing medication, but obviously needed them. The only way she was maintaining was because of the structure of the unit; if she were out on the streets, forget about it, she'd be in trouble. She'd be beaten up; she'd beat somebody up, I guess. She took her medications; we had to go in there and do a show of force--you take the medications and you take the syringe and, it's your choice. She took it but she was indignant and was angry. And there was all this delusional stuff that was coming out, her anger was being voiced in the terms of delusions. And I said to this woman: so and so, I want you to know that I hear you saying that you hate this, that this stinks, that you don't want the medication. I want you to know that I hear what you're saying. And I didn't add, but we feel that--this was not the time for that. She had just been overridden, overpowered, whatever in this Reese hearing and it was so weird because she stopped and tears started welling up in her eyes. I do believe that it is very important to be heard, not always to be right, not always to be the one in power or in control, but just to be heard (P8, p. 25-26).

Listening will figure importantly again with the discussion of boundaries which is where I turn now.

Boundaries

So far, we have seen that a relationship is constituted by the relative positions that people hold in a given set of circumstances. Linde refers to this as the "self in space" or the position of the self in relation to others (Linde, 1990, p. 10). This space is not the literal space of bodily closeness as nursing care necessitates this physical proximity. Instead the space is interpersonal space which pertains to the type and intensity of engagement with the patient. The nurses in this study did not speak of relationship but did speak of connection and boundaries. These terms reflect their concern with achieving the correct space between patients and themselves. Recall that the ethical significance of acting for in nursing practice lies at the center of three linked concerns: the significance of the domain in which the need of acting for arises; the vulnerability of the patient; and, the potential for the abuse of power. Such a situation often leaves only a small space in which to balance these intricately linked but opposing demands. For the nurses in this study, achieving this balance was a matter of getting the boundaries between patient and nurse right and the right boundaries were a matter of moral urgency. Indeed, I was surprised with the frequency with which boundaries arose and that the concern was common to both psychiatric and home care nurses. Although I expected concern with the issue of boundaries among psychiatric nurses (Liaschenko, 1989), especially given their familiarity with the concepts of transference and countertransference, I was amazed that home care nurses also raised the same issues.

Although these nurses did not use the term relationship, the relationship of correctness which they sought might be described as one of 'bounded connection'. Through connection or engagement with the patient, the nurse is able to know the patient as a subject which is essential should the nurse's work require she or he act for the patient particularly in ways which touch upon the integrity of the self. Boundaries, on the other hand, serve to protect both the patient and the nurse by delimiting certain areas and ways of engagement. What exactly is being protected? The answer as revealed by this study is self, world, and influence. In the lived experience of day-to-day life these are, of course, not independent categories as fluctuations in one will effect changes in the others. In fact, the ultimate function of boundaries is to preserve patient agency which is protected when self, world, and influence are supported in disease and illness and in dealing with the institution of health delivery systems.

Self. Nurses' sensitivity to the temporal dimensions of patients' need for active intervention is one way in which the self is bounded and agency preserved.

> When they're really, really sick and they're really psychotic, you end up doing more things for them. But then, let go and let them do more for themselves as they get better. Some people have difficulty with that, of letting the person take over and do more things as they get better. And so, what I do is I ask the person. I do it in such a way that they can get irritated with me around doing it. I get obnoxiously pushy. And they say, I don't like that, and I say, oh, does that mean that you want to start doing some of these things yourself?--Well, yeah--And I go, well, that's great! Then they get mad at me because I got them angry and then I say, this is great, this is good. These are feelings that you're having and there's nothing wrong with them. This means you're feeling better. And I point these things out to them and let them get back into some of their own autonomy. So if you miss the cue and you keep doing these things, then sometimes the patients will tell you. Then I go, oh, was I still doing that? And I say, gee, you're in a much better space now, aren't you? And they go, yeah, yeah (P3, p. 27).

This nurse's practice was characterized by her cognizance of and sensitivity to issues around patient agency. While sensitive to the vulnerability of patients, particularly in institutional contexts,

> I'm one of those people who roots for the underdog and patients, a lot of the time, are underdogs. So I'm one of those people who helps them see that they have rights (P3, p. 4),

she nonetheless maintains a constant vigilance against overstepping boundaries which she takes as doing the work for the patient.

> Now, if I realize that I'm really getting on a crusade, then I realize there's something wrong; I shouldn't be doing the work, the patient should be doing the work (P3, p. 5).

For this nurse, doing the work when the patient is capable of it is a danger signal that the nurse is meeting her own need to be 'a savior'. Such a situation is harmful to the patient because it prevents the patient from once again taking up the rhythm of their life. In another situation, a home care nurse talks of a physician who overstepped their boundaries in treating a patient with AIDS. From the nurse's perspective, the harm to the patient was an overly optimistic prognosis, which, for this nurse, is an ethical wrong.

> I believe that caregivers, when you're a licensed person and you have a specific role to fill, I don't believe that it's correct not to set some sort of a limit or boundaries, and I don't think you can be an objective caregiver if you become personally involved with the client to the point where it may influence your decisions, and that sort of thing. I saw the physician tell the client things that I don't believe were true such as that he could live a much longer life. This was somebody with wasting syndrome who had multiple and secondary infections and tumors (HC3, p. 4).

Objective is a complicated word with many nuances and we can not be completely certain as to how this nurse is using the term. When applied to interpersonal relationships, the word is taken frequently, but misleadingly, to mean a cold, detached approach to someone. I believe, however, that this is not what this nurse has in mind. Instead, I believe he is implying the conviction that in a professional relationship, the patient's well-being is primary. The psychiatric nurse working with the emotionally disturbed child who needs a bone marrow transplant gives an example.

> Their subjectivity gets introduced into how the patients are dealt with, and so there become different approaches. And at the time, I think there was some conflict between the head nurse and the clinical nurse specialist on the Oncology Unit, and that sort of got

> played out all the way down to the nursing staff, in which there were different approaches in how to set limits with this boy, even before these more serious ethical issues even came into play. In fact, one nurse who, as I came to find out in talking with her, had a brother who died of leukemia, was the one nurse who constantly asked for this patient. The kid would say, you're not so and so and you can't take care of me. So she got singled out as the only one that could take care of the boy. In fact, her need which was to relive an experience that she had had with her brother who had been younger but not as young as this little boy, really played into a lot of her own psychological issues. And she got major ego gratification to be the only one (P7a, p. 2).

This nurse works with the staff to help them see the necessity of providing a consistent, firm approach so that there exists the possibility the child may benefit from the external structure. In those situations where one's competence is questionable, appropriate boundaries or limits help support a sense of self and agency. In another example, a nurse has been telling me about his work with a very disturbed patient. Much of this work involved the setting and enforcement of limits with the patient in an attempt to help her stay out of seclusion.

> Anyway, to end this story, about a day after that, she really started being very positive with me. A couple of times when I was working on the other unit, I was called over to give her her meds because the other nurses couldn't get her to take them. And she and I had somehow, in this psychotic way, developed a relationship because I had been willing not only to let her out, but also to say, these are the limits that are going to keep you out and to be real firm with that and make sure that she agreed to it. And somehow, that worked for her (P5, p. 15).

The correct relationship prevents the nurse from becoming a friend because patients and nurses can rarely meet each other's needs. In friendship there is a mutuality which permits both parties to make claims on the other. Some of the nurses in this study voiced their concern with having made friends of patients with the result that both parties felt hurt at the inevitable disappointment.

<u>World and Influence</u>. The idea that space is a major aspect determining the context of one's

life has been evident throughout this work. The place we occupy affords or restricts our access to certain privileges and social resources as well as determines what conduct is appropriate. Our ability to act and to have influence in the spaces we inhabit result from these factors. For example, we have already encountered numerous examples from home care nurses noting exactly this point. Their frequent counsel that a bossy, professional approach is inappropriate in the patient's home is a matter of boundaries. This is likely to seem obvious to us to here. Yet, all the examples under the section Ethical Concerns in Acting For are also examples of violating the patient's world. These included not honoring patients' wishes, coercing treatment irrespective of our good intentions, and assuming we can live their lives are instances of wrongly bounded relationships and a matter of deep ethical concern for the nurses in this study. Boundaries, however, protect the nurse and her or his world as well. Nursing is not always a matter of our fully engaged selves rendering exquisite care to an ever cooperative and grateful patient. The following nurse points to the potential differences between the world of the nurse and the world of the patient and the security that familiarity engenders.

> I've noticed a real difference in home care versus the hospital, especially working with poorer patients in worse areas. When you're in the hospital, no matter how grungy and hellish the environment of the ER, and how much the street culture comes into it, you are a representative of this larger system, and you can be kind because you are in a position of safety. This is your world. This is your territory. You've walked this hallway a thousand times. They come in and you're nice to them because you're a nice person. But when you go to their home, you're in their territory and something is needed beyond your nice, white, liberal girl stuff. Something is needed. It's needed that you understand their whole environment (HC4, p. 35).

As we saw in comments like, "this is not a level playing field, we've rigged the deck, we're in control here", these nurses were aware of their ability to access sources of institutional control. Although the nurses in this study most often found themselves intervening to protect patients against this power, when personally menaced they could invoke institutional power in all its potency. At another time and place the same nurse tells of a very stressful situation when, while pregnant and near delivery, a patient with a history of criminal behavior threatened to kick her and kill her baby.

> I said, well, if you ever did, I would arrest you for assault and battery. What I would want to say is, I know you didn't mean it, I won't let you hurt my baby, I wouldn't let you, or something. But what I said was, if you ever tried, I would have you arrested for assault and battery. She was a tough street kid, and my relationship with her was well--I'm from a poor family, I'm from a working class family, I'm tough. I'm from [the famous county hospitals of two major cities]. I know my way around or at least your kind of person is not unknown to me. I think when I said it, I meant it to sound like, well, if you ever do, I'll stick your butt in jail, girl, or something. But the way it came out, it was very serious. It was interesting, because my rapport with her had been, well, you're outside the system and I accept that. You're cool. I'm cool. But by saying that, using that terminology--assault and battery--and invoking the system of authority, I was saying, this is my world, I can bring the system to bear against you--not, I'll kill you, I didn't say I'll strangle you or I'll get you back. I said assault and battery to frighten her with the powers that be. I was very aware, when I said that term, that I was saying, I live in another world and I can cream you with that world (HC4, p. 34-6).

This is a very interesting passage for two reasons. First, we can see the tension between what the nurse wants to say and what she actually does day. Saying, "I won't let you hurt my baby" is a response of a therapeutic genre that nurses typically use in working with potentially dangerous patients. The genre may be used most commonly in psychiatry where nurses work with seriously disturbed patients who have difficulty discriminating between reality and their hallucinations. Implicit in such a therapeutic approach, however, is the nurse's understanding that the patient as person does, in fact, not intend harm but is struggling with impulses over which they have little control. Although I can not say definitively since I did not follow this point specifically, the nurse in this case seems to be attributing more deliberate intention to the patient. Deliberation is a critical element in any ethical discussion because it involves questions of moral culpability, deserved blame, and just responses. If the reader had access to the entire narrative, they would see that this nurse continually reflects on what it is to preserve moral ideals and actions under serious threat. A passage from early in the first interview shows this clear enough.

> Well, I think what's always been fascinating about it, or frightening, to me is, I really believe that any human being in a certain environment will, can react in a horrible way. You can be, I could be a Nazi. That's what I think, I could have been a Nazi--that but for an accident of birth, having the parents that I had. But who knows, if I was threatened, if someone said, we will kill your child if you don't, whatever. You know that experiment, that torture experiment where they're not really electrocuted, I really wonder what I would do [referring to the Milgram experiments] (HC4, p. 15).

Second, to have responded to the patient in an equally threatening manner would have been to enter the patient's world where the nurse would no longer have the same force of access to the power of institutional protection. Perhaps even more important from the perspective of moral self-evaluation, to have retaliated in kind, the nurse would have shown herself as willing (at least in theory) to reduce herself to the level of the patient's moral world. This brings us directly to the last ethical concern regarding nurse-patient relationships which was raised by these nurses. It is, I believe, the profoundly important but rarely discussed (at least publicly) issue of working with patients one does not like.

Not-Liking the Patient

Not-liking is, however, a misleading term in that it conveys triviality. In spite of this I have, nonetheless, retained the word for three reasons. First, respondents and I actually used the term. Second, another term has failed to suggest itself. Third, as mentioned, this is a rarely discussed topic within nursing and in informal discussions with colleagues, I have found that the term kindles dialogue. When we think of the categories of things we typically describe as not-liking, we most commonly think of those things which fail to give us pleasure of some kind but that are insignificant in contributing to the moral tenor of our lives or to our stature as moral agents. For example, we may not like red hair, romantic, sentimental movies, classical music, MTV, french fries and so forth but these things can hardly be said to figure prominently in the moral fabric of day-to-day life. For the nurses in this study, not-liking a patient was not a matter equivalent to rejecting their patients' preferences of consumer products. On the contrary, not-liking refers to the difficulty in establishing and maintaining some relationship of 'bounded connection' in the face of patients who engender strong negative responses from nurses for serious reasons. The patients included those who rejected and sabotaged the nurse's care, who endangered others, who made threats to nurses, and who were guilty of morally reprehensible acts such as child abuse.

> I try and talk with people. I mean, lord knows, sometimes some pretty nasty stuff comes up and it's really hard to like some of these people (P5, p. 13).
>
> All of my adult life and all of the work I've done, all the nursing settings I've been in, I have worked with people on the edge. There's people that piss me off terribly and that I can't stand. Patients, that's true too, because a lot of my patients are not nice people. They're personality disordered people, manipulators, all of those tags. And then working in psych, one doesn't always come from your patient assignment saying, oh, they're my favorite people! For a good looking, nice, charming, courageous, articulate and witty patient, that's pretty damn easy! That's easy to make those visits. It's a pleasant thing to take care of that person. Just to give good care, to be a really good nurse and to do good nursing, is initially easier with someone who is attractive in the large sense of that word. Someone who responds to you. Someone that, when you teach them something, they learn it, or it obviously makes a difference in their life. Or they thank you for it, or they have donuts for you. You know what that is, those things--a little bit easier to make the connection. (HC5, p. 11-12, 31).
>
> There was that tension between us for a while but I had to go every day. I used to just pull up in front of that house and go, I don't want to go in this house (HC1, p. 5).

In this study, the demands of establishing a *bounded connection* with patients in trying and exhausting situations was a matter of deep ethical concern. Such situations bring into sharp relief concerns with one's character in a world in which brutalizing conditions can narrow possibilities for action to raw force.

> I feel that human beings are incredibly plastic in terms of the acts that we can come to do. It's just a matter of circumstances, almost, that form us in ways that we think we could or could not act a certain way. I feel I probably could act in ways that right now I'd say I couldn't act, but I could. I could torture somebody. People often ask me, well, you're opposed to the death penalty, what if somebody killed your child? Well, my response is, I could rip them limb from limb, but I'm still opposed to the death penalty as something that is administrated by the government. What I'm saying is, I couldn't rip someone limb from limb but it's possible that something could happen to me that would make me able to do that. And I find that very frightening. I feel that we think that we know who we are, and we think we know what we could do, what we couldn't do, and what our morals are and what our boundaries are and what's holding us back from being bestial or brutal. But I don't think we really know that. That's something that's very frightening to me.
>
> I: How does this perspective on people and morality influence what you do as a nurse?
>
> I think it makes me more aware of the decisions that I make, and it makes me a little more deliberate in my decision making. Because I don't want to just react and find myself doing something that--I did something brutal once. I was in the Emergency Room and this man, who was very drunk, I don't know what his injury was or why he was there but he slugs me. [The nurse interrupts this story to tell another one in which a colleague was stabbed with a needle from an AIDS patient when she refused to allow him to inject heroin.] So anyhow, this guy slugged me and I called the security guard. He bound him really tightly, ostensibly so he couldn't assault anyone again, right? But he stayed tied up like that for a long time; his hands were losing some circulation. He was begging me to untie him. And for a long time I wouldn't untie him. I told him it was because I'm afraid you'll hit me again. But, really, I was getting back at him, you know. So, you can feel yourself turning into this role--being one of us and one of them (HC4a, p. 59-61).

Most instances of nursing work are, fortunately, not a matter of us and them and therefore, making a connection with patients comes effortlessly. For the most part, nurses' perception of vulnerability, need, distress, and suffering and their desires to be of help find welcome acceptance in appreciative patients.

> I basically like the people on the locked unit, I like these people. I think that it's interesting. I'm interested in alternative realities and different consciousness and to meet psychotic people or meet people that are very depressed or to meet people that are having some kind of a crisis. They are in a position that I find very interesting. That's one part, the interest. And also, for some reason, I don't know why it is, but I like them. That might be my strongest asset, that positive regard for the person. And a lot of times they just sense that--that it's not phony--that it's not something that I've put on (P5, p. 13).

> I think it's because I came from such a troubled family myself, that I always look at people to see what's going on that made them the way they are, and I'm fascinated by people. I'm fascinated by their stories. I never just look and become instantly prejudiced. I look at people and think, well, what occurred to them that they've reached this point and this is what they've settled for or what happened to them? People are a lot more complex than they look on the surface (P3, p. 16).

Yet, establishing and maintaining a relationship with a patient that one did not like is a skill. As the nurse above implies and as the following nurse suggests, one must look for the connection with patients one does not like precisely because it is not obvious.

> Where a lot of that comes from or where a lot of the skill that I've developed comes from is the eight years in my previous job. You get lots of people that you don't like. It's pretty easy not to like someone who has just sexually abused five little kids. A little hard, although it's easier than you might think to find the common connection, too and to like a person like that (HC5, p. 25).

Skill in this sense is not merely the technical execution of some physical task; it is not procedural. Rather, skill is the final common pathway, occurring over time, for certain desires, knowledge, and actions, a final common pathway contributing to the self-identity of the nurse as a moral agent. The desires are the desires of wanting to do one's best in attaining some good state of affairs for the patient in spite of the obstacles the situation presents. For these nurses, the knowledge is essentially the belief that underneath the patient's difficult exterior is a core of humanity, which is to say, I recognize you as similar to me. Underlying this is an understanding of human nature and development which maintains that the human being requires an environment of physical and psychological nurturance and support, the absence of which can deform the individual's capacity to initiate, sustain, and accept attachment to others.

> I have had a hard time with patients I didn't like. I'm going to have to think about this, because I haven't thought about it very much. It's hard for me to articulate it. First of all, I try to like everybody because I know that will be easier--if I really like them. Even if I feel that I don't, I will try to like them.
>
> I: How do you do that?
>
> I listen to them. I look at them and I look in their eyes and I listen to them.
>
> I: And what are you listening to, or for?
>
> I'm trying to hear that they're human, that they're vulnerable, that they may be nasty but they're not all bad. I try to think about what made them that way (HC4, p. 31-32).

> I lead a group for people with AIDS, it's an ongoing group. And there's this guy that's been real real difficult; it's been real hard for me to develop an empathic relationship. He was talking about being beaten by his stepfather at five years old, and it was like, god, how else could he be? This is a sense of acceptance, I can understand then (P5, p. 32).

Both of these excerpts indicate the essential role of understanding to making a connection. The understanding comes from a story that makes sense of the patient and their world; it provides, in Fisher's words, "a logic of good reasons". When self and other are not seen as alien there exists the possibility that the patient might be open to the nurse's desires to help. Both desires and beliefs are rooted in the nurses' concept of themselves as moral agents.

> I revert to a very professional sort of persona and distance myself from them. It's an issue for me. I think that if I'm working with the patient, then it is--I hate to say required--the word doesn't quite come out--expected--that my own moral prerogatives say that I should work in a positive way with this patient. I should give them my time and my attention and, hopefully, some positive regard. That that is part of being in that professional environment for me, and being a person, I guess, when I'm interfacing with another person, and not just to shut them down and see them as someone I'm not going to like and try and distance myself from them. It becomes a moral issue for me to try and maintain a positive regard for them, to encourage that, to enhance that (P5, p. 24-5).

The above is interesting in that the nurse is beginning to articulate a distinction between the required of the nursing role and the desired of their self image as a person with moral ideals. For these nurses, their identity as moral agents is prior to their identity as nurses and is a matter of moral education originating in early family life. I believe this is significant for two reasons. First, it locates moral motivation in the desires of the nurse to be a certain kind of person and therefore, makes it possible to be a certain kind of nurse. It is these desires and not some required role of nursing that accounts for the nurse's moral actions. Second, this is related to a philosophical concept called practical necessity and may explain why there was no mention of duty by the nurses in this study except in response to my questions. This same nurse a few pages later provides a very clear example of practical necessity but it may be helpful first to see how it is understood philosophically. The concept concerns the relation between one's desires and one's will. The will is the Kantian will which is completely separated from any desires and is an instrument of reason for seeing moral truth and acting in accordance with it. Von Wright (1963) puts it this way:

> We could say: the wider the gap between the *must* and the *want to*, the more prominent the *must*; and if there is no gap at all--meaning that we do the act from sheer inclination--then there is no autonomous necessitation of the will either (p. 172, emphasis is the author's).

I take von Wright to be saying that both desires and will or duty can lead to action but will comes in only to the extent that desire does not. These lie on a continuum between must and want to. Let's return to the nurse's discussion on the professional persona they sometimes employ when working with patients they don't like.

> It's almost as if there's the shell of me as opposed to all of me being there. And there's, what is it? There's, I want to say spirit. Maybe it's spirit. I mean, maybe it's an emotional involvement, but it even goes beyond that, because even in a professional capacity you have an emotional involvement with the person, but it's much less rich. But there's something about that spark that sometimes just happens, there's a sense of caring. There's a sense of relationship, I guess.
>
> I: Would you ever find yourself in the professional persona saying, it's my duty to do this, I've got to do this, it's my duty?
>
> Sure.
>
> I: And do you ever find yourself doing that in the other case?
>
> I don't think so. No, because it just comes. Of course it's not only my duty, but it's also what I want to be doing, there's not that split. Whereas, on the one hand, this is my duty but I'd rather not be doing it, whereas with the empathic kind, there's no split between those two. It's not only my duty; it's also what I want to be doing (P5, p. 35-6).

Notice that it is not the nurse who introduces duty; although this nurse admits to appealing to it in practice, no other nurse in the study mentioned duty. We have already encountered, however, what they do appeal to and that is, the belief that the patient is understandable. With such a belief, a space for the possibility of the experience of understanding and empathy is created. I will come back to this idea of the appeal but first I want to return to the specific actions which partially constitute the skill of working with a difficult patient.

The actions are of two sorts, communication skills and those cognitive and affective capacities which permit of self-monitoring and self-evaluation. Central to the former are listening and attending which, as we have seen, hold a prominent place in the story of these nurses. Listening is constitutive of the relationship between nurse and patient and generally occurs without much reflection. When working with a difficult patient, however, listening, like connection, is a deliberate strategy. These nurses mentioned several times the importance of listening to the patients' stories.

> There's a lot of watching. There's a lot of watching and a lot of listening to their experiences and listening to their stories (HC7, p. 28).

> Just try and see what their world is like, just sort of enter into it. Begin to just--not ask them formal questions but see what it is that they're interested in (P5, p. 26-7).

As this nurse indicates, we can not enter another's world through formal, technical discourse; it is stories which give us access to the patient's world. Through stories, we can connect the past with the present, thus realizing an understanding of the patient. Together, past and present may offer the nurse some vision of a future which they can help the patient to see. Stories offer the possibility of connection. The nurses in this study looked in the stories of their patients for some aspect in which they could share--some experience or interest, a joke, perhaps.

> The thing that I found in common was we had both lived in [names the city]. When I don't like someone, I try to look for something, something we can talk about, something that will make that connection. And for us, about the only thing was geography. But it

> was something where we could do that. I could get him to reminisce about growing up in [names the city] and it allowed me to see him a little bit more as a human being who was suffering and dying and losing a lot. It's usually not that hard to see with someone in his circumstance, but he made it hard to see (HC5, p. 29).

> Maybe some difficulties they've had. Maybe things that we enjoy in common. I can think of one man that was there about a month ago. He was so obnoxious, but he had some redeeming sides of him. He was quite bright; he was very interested in books. And, for some reason, someone took him up to the roof which is like a patio for the patients and he found several shelves of books there. And he was just in heaven. He really could get into that. And he was just being himself in those moments, instead of trying to get something or pull the wool over somebody. Now, I love books. And so, I could use that kind of interaction as a bridge later on (P2a, p. 17).

Self-monitoring skills presuppose a self-knowledge through which the nurse is aware that a given patient is distressing to them in a certain way. Self-monitoring then involves the ability of the nurse to modulate their responses to the patient.

> What I think you're doing is examining your own feelings, like for me, what kind of issues do I have--that maybe this problem would get in the way of helping this person? And you're also reminding yourself that you have to ask them, what is it like for you?, because it may not be what it's like for me in the same situation (P9, p. 33).

Anger is the emotional response most frequently elicited by the difficult patient. These patients are often extremely critical, even abusive of both the nurse and others even as they demand more and more from them. In the following excerpt, a nurse has been telling me a story about a patient dying from AIDS who is very abusive to his lover and primary caretaker. Although the abuse was directed primarily to the lover, it was nonetheless painful to the nurse.

> It was painful because it was one of those situations that made me recall my own personal experience, and that's where these alarm bells went off for me, not to do that, not to make comparisons, not to jump to conclusions. But it was one of those things where I think I was aware of that because of my experiences in my previous job. I

> got really good at doing personal inventory in terms of which chain of mine this person is yanking and how hard. When you do that kind of work in psych, you learn where your chains are and which ones. And that's when it happened, because I looked and I thought, it was just bringing up all this personal stuff (HC5, p. 27).

In addition to self-knowledge, self-monitoring and self-evaluation are constituted by an honesty and maturity in relation to one's work and judgements.

> A nurse needs to be really stable to work in the field. She has to be able to be honest enough with yourself to know how to use supervision instead of covering up something that maybe you thought was not such good judgment, but being able to go back and say, this happened to me, what do you think I should do and what could I have done? Rather than try to cover it (P2a, p. 15).

The notions of self-monitoring and self-evaluation, in particular, extend beyond the goal of a flawless performance of nursing interventions with difficult patients. The desires to do one's best for the patient are constitutive of the nurse's moral identity as a nurse and as a person.

> I'm talking about ideals here that I work toward most of the time. I don't want to say that this is always the way I am (P5, p. 25).

The following excerpt occurred in the context of what makes a good nurse.

> Liking people, I suppose. Being compassionate and like, someone can grow up and say, oh god, I can't stand druggers. But, if you're going to work in psych, you're going to be working with them. And if you can go beneath that and look at who the person is and maybe find something in addition to the drug stuff that makes that person somewhat redeemable--if that's something you don't like. Or the alcoholic (P2a, p. 15).

These desires are the result of a moral education that preceded nursing. As in all moral education, however, desires are shaped and fine-tuned by experience. This was especially so for nurses caring for patients they did not like. They learned the significance of their own responses and how to cope with them as well as ways to foster connection.

Respect

Earlier I said that in these situations nurses make a conscious appeal to something other than duty to help them sustain their desires to do their best by the patient. Although this appeal is the idea that the reasons for the patient's behavior can be understood, the appeal is sometimes made in terms of the moral concept of respect.

> [Making a connection with a difficult patient] It demands work. It demands work to respect that person. We had a patient that we accepted to the office that apparently is persona non grata in every health care agency, including every hospital, certainly in this city, perhaps west of the Mississippi. I mean, honest to god, he's got suits flying against all of these different physicians. A couple of physicians have suits against him. I mean, it's just this horrid, hideous case. He has AIDS. He lives in a hotel down on Market Street in just this hideous kind of situation. He is diagnosed with a personality disorder. He is obnoxious. He's probably got lice. He won't listen to what you have to say; it's not a pleasant visit. This isn't the guy who's got donuts for you or says thank you for everything you're doing. This is the guy who says, what the fuck are you here for. I know how to fucking do this because they taught me; I was an EMT and they taught me in medical school. And you're scratching because you're looking around the apartment, and it smells, and you want to lose breakfast and that isn't pleasant. That's not easy. But he's deserving of respect. If I have a bottom line belief, I believe that it's the assholes that need respect. Most people tend to get it. It's those hard ones that really need a conscious effort at respect, a conscious effort of taking the time, a conscious effort to figure out how--if you can make a connection with them, how you can do it. And sometimes you can't (HC5, p. 31-32).

Respect is a composite term for a variety of attitudes and strategies that support the possibility of making a connection. It is a self-conscious work that, by giving time, seeks to understand a difficult patient, thereby validating their experience. In the words of the above nurse:

> It's not judging people. It's giving people time. It's validating people. I've worked and work with people who are in enormous crisis. They're dying of cancer or AIDS or in a psychotic break, being restrained. It's true. I deal with people professionally at these really

> enormously vulnerable times and that vulnerability needs to be validated. I'm still back on what does respect mean to me (HC5, p. 13, 14).

Ultimately, respect seems to be a way of assuring that the patient's needs are met in the face of serious, perhaps impossible, interpersonal difficulties. It functions to remind the nurse that the patient's behavior is potentially understandable. Yet the nurses in this study most certainly were not pollyannish in their beliefs that a bridge could always be made. Indeed, sometimes a connection could not be fashioned.

> And I can agree that the system is certainly not fair. I think everybody gets handed whatever they get handed, and it's up to you to decide how you're going to deal with what you have. But you can't make everybody have a wonderful experience with their life. I guess that's pretty much the way I handle it. And I don't take it home and try to work it out, try to solve their problems for them. I can't really do that. I've had a whole different set of experiences than even my husband has had, and so I can't solve someone else's problems for them. I struggle along and do the best I can with my own (HC7, p. 16).

> When I walk on the unit, I don't feel that it's realistic, nor do I particularly want to suppress the emotions that a patient generates in me. That if somebody comes onto me with anger, I am going to feel angry, and if I didn't, somehow I feel that that would not be being true to my person. I don't think that I can be this Mother Theresa figure or whatever her myth is, so that if someone becomes very angry at me, I can say, yes, child, I forgive you, now let's get on (P5, p. 9).

> Sometimes you can't make that connection. And that's the kind of thing that I was laughing about. Sometimes you think, this person's just really an asshole. I've done all of the assessment and my assessment comes down to that bottom line--this really is piss poor protoplasm we've got here (HC5, p. 25).

But even if a connection can not be made, the patient must still be cared for. Sometimes the patient could be transferred to another nurse but in those cases where that is not possible, two things occurred in this study. First, there was an emotional distancing from the patient and situation; second, there is a self-conscious effort not to short-change the patient in terms of time and services.

> I kind of detach myself and I put on a professional personal manner, and I just go with that, without really feeling. As I say, when I try and get to like somebody, and those times when it just doesn't really work, then I feel as though it's just not happening, then I become sort of detached, and I try and become a very good professional nurse. Or I think I just do that, my soul's not there, I guess. I try to be very good at that, probably one wouldn't even know that I'm not there because in a way I'm trying to be there, too. It's like, by going through all the motions, I'm trying to create a situation where I am going to be there. It's sort of like rehearsing, if you don't have the affect, at least get the behavior down and maybe the affect will follow the behavior (P5, p. 22).

> The only way that you can do your job is to tell yourself, it's OK to hate them, but I'm just going to work twice as hard to make sure that I'm not working half as much (HC5, p. 25).

In this way, the nurses appeal to their own images of themselves as a moral agent with ideals. They develop strategies to self-monitor and keep in check any retaliatory responses which, understandably, they might experience. And we saw that sometimes nurses do act from frustration and rage. What impressed me about the nurse who "did something brutal once" was their recognition of just how damaging brutality is--it makes things us and them.

Testimony

Advocacy

The nurses in this study frequently spoke of the importance of being an advocate for patients. Advocacy brings us full circle in terms of this investigation because for these nurses, advocacy entails a cluster of dimensions which reflects the concerns arising from their work, many of which we have already seen. What the notion of advocacy emphasizes is speaking for patients. Advocacy is, for these nurses, another kind of work; it is the act of speaking for patients on a matter of import.

> That is something that I see in my role as a nurse--I am a patient advocate. I may not always agree with what a patient says, but I support their god-given right to say whatever to whomever when they're in the hospital, when it has to do with their care. It's their bodies, it's their lives. We are not in charge of it. We are the temporary caretakers, the grounds keepers so to speak, but it is their lives. And that's very important to me, to express the concerns of the patient.
>
> I: So, advocate, for you, means...
>
> Passing on their concerns (P8, p. 14).

I have touched briefly on its converse when I discussed the harm to nurses when their voice is silenced. As it appears in the narratives of these nurses, advocacy is consistent with theoretical work on the concepts of bearing witness and testimony (Coady, 1992; Felman & Laub, 1992) which, I believe, can potentially expand our understanding and appreciation of nursing ethics in two ways. First, such theorizing offers the possibility for a new language and thus, for another way of understanding the moral work of nursing practice. Second, it helps us to see more clearly why the moral voice of nursing is so often silent and silenced within the gendered space that nursing occupies within the health care system.

Let us look at advocacy in the narratives of these nurses as it appears through the language of testimony. The contexts in which the topic arose were similar across respondents and are illustrative of the aspects of advocacy as understood by these nurses. Here are three examples of context. In the first excerpt, a home care nurse has been talking about the needs of the patients which are not covered by current reimbursement. These needs are visible to the nurse and invisible to the health care system as a whole and they are needs for things like child-care assistance. I want to see this nurse's vision of an alternative system of care and so I ask:

> I: Suppose nurses were in charge of deciding what got reimbursed or not reimbursed. Do you think...
>
> (Interrupts laughing) Oh, I think it would be great. I think nurses could run the health care system a lot better than it's being run. I think nurses are good at deciding what needs to be done and what doesn't need to be done, and if nurses were in charge of human services, I bet that things would be a lot better. I think the whole thing about our training, our background--maybe that's why a person becomes a nurse. I'm not saying that every nurse is a very sensitive person, but I'm just saying the type of training that we've gotten throughout our schooling has always been focused towards being a patient *advocate* and really being able to understand the patient's needs, and read more than just what they're saying, but see what they're doing and see other things that are going on. I mean, I haven't gone to medical school, so I don't know what kind of training doctors get. But I know that we spend more than 15 minutes with the person, and lots of times the doctors don't. They're more procedure oriented and more physical oriented, and we're more oriented to everything else besides, as well as the physical. That's why I think we would be so much better at trying to administer a health care system, because we have a better understanding of the whole picture (HC7, p. 20-1).

In the next example, a psychiatric nurse has been working with a young woman who has a tumor requiring radium implants. Since the woman was pregnant, an abortion was advised which she did undergo but only at great emotional distress. The surgeon's treatment of the patient was callous and cruel. In this excerpt, the nurse, who is still actively working with the woman, is working in another hospital and walking through the waiting room, sees the woman and her husband. They have brought a sick child to be seen.

> And I saw her and I went over, her kid was there and her husband was there, and she was in another world. She was so depressed, she was tearful and she wasn't worried about the kid, she was still dealing with this other stuff. So I did a suicide assessment there in the Medical Emergency Room, when I wasn't even supposed to be dealing with her, I just happened to see her there. I got her to contract that she'll be OK until Monday and when she came in on Monday she was so severely depressed and suicidal at that point that that's when we hospitalized her. So I got a chance to meet her husband and I saw how very much he did not want the patient to be dealing with us. He was very rude to me and said very unsupportive things like, oh, she just needs to snap out of it. This whole thing's not that big a deal and she just needs to snap out of it. So, here's a person with no support at home, no support with her primary medical provider, and I think that's why I felt like we need to be an *advocate* to help her through all this (P6, p. 13).

In the following, a nurse is responding to my initial research question.

> One ethical concern I have is that there be a respect for a patient's individuality in regards to ethnic origin, sexuality, religious basis, that they be respected and acknowledged throughout the care of the patient. That's mostly what I'm concerned about. I find, sometimes, that the medical system or the treatment team would like to homogenize people and put a kind of white middle class value on people as the standard by which to measure people and make their judgments about the patient on that. Or they diagnose patients, especially in psychiatry. They'll diagnose certain behavior based on this kind of white middle class value system that may or may not work for every patient. So that's one thing that I'm mostly concerned about. Another thing is patients' confidentiality. Oftentimes, information about them is just disseminated freely, without people thinking about what they're saying or who they're saying it to. I mean, anybody could call up and say, well, I'm so-and-so's lawyer and I need to know this information about them. Or I'm so and so's mother or wife or whatever, and get information about them. So I'm very concerned about being an *advocate* for the patient and disseminating the information that they want disseminated, and to whom (P8, p. 1-2).

Audience

One of the features of the theory of testimony is the idea of audience. By definition, to advocate is to speak to another but of course, implicit in this is that there is someone to whom one speaks. Each of these narratives show that the demands of the situation require the nurse to move beyond the nurse patient dyad and plead the patient's case to some other, some audience. Perhaps, this is most explicit in the third narrative where the nurse clearly identifies themselves as speaking to others on behalf of the patient. There is also, however, an implied case of speaking for in that the nurse's ethical concern regarding the individuality of the patient necessitates that the nurse speak of this to the treatment team. We have met the nurse in the second narrative before. This is the nurse who locates the fetal remains of an abortion so that the young mother can bury them. Earlier this narrative was used to illustrate acting for the patient but on the environment as opposed to the body. The acting for in this case, however, clearly is occasioned by an act of speech as the continuation of the above narrative shows.

> [Being an advocate] is helping her get her needs meet. And in the system, once it was decided that she wanted to go back and bury this fetus, then she didn't know how to figure all of that out. And I didn't really either. I mean, it was really just pick up the phone and see what I can do (P6, p. 13).

Even in the first story where nurses would be in charge of determining what services are reimbursed, nurses still would be compelled to speak to the funding agencies. The nurses in these narratives speak for some matter of import which brings us to the second aspect of testimony theory.

Issue

I have stated that in this study, advocacy entails a cluster of dimensions which reflects the concerns arising from their work. Central in this cluster is the concept of needs which is the defining and organizing feature of advocacy for these nurses.

> I: What does being an advocate mean to you?
>
> Well, being able to *see* what the patients' needs are, what their problems are, and being able to help them resolve whatever they are, so that they can have activities of daily living to their best capacity (HC9, p. 19).

Another respondent replies to the same query:

> I think being a patient advocate is being able to *see* what the patient's experiencing and being able to relay that into medical terms that you can get things done for them that they need, get them things that they need that they don't even know how to ask for (HC7, p. 21).

Because research with such a broad design can easily become a matter of infinite regress, there was no attempt on my part to have the respondents articulate their understanding of needs. I assumed a mutual understanding but we can see even in these two brief excerpts that needs are the defining and organizing feature of advocacy. While the issues or needs are always relevant to the patient's good, they nonetheless vary. Therefore, nurses speak for patients to obtain a variety of ends. The most significant issue in this study was the reduction of the patient to a passive object and their subjection to the goals of treatment by a system which inherently weakens agency. Put another way, these nurses challenged the worthiness of the very ends of medicine itself. The following narrative illustrates as much. It is a very complicated situation involving a man in his late 30's or early 40's who is entering end stage AIDS and has been admitted to a psychiatric hospital on an involuntary hold with the diagnosis of psychotic depression. The man is well aware of his AIDS, having lived with it for quite some time. Furthermore, he has been depressed much of his life and has a history of alcohol and substance abuse. From the very beginning of this story, the nurse points to *institutionalized* medicine's limited perspective manifested in their inability to see beyond symptoms and pathology. The nurse goes further, however, in suggesting that such a limited focus protects providers from facing the existential reality of death.

> He had what we thought were delusions and hallucinations and so, in a way, thank god, it gave everybody something to hook on to, to treat. I mean, he was getting his medical care, of course, from all the consults coming over and treating him medically. But it took a long while for us to get into the discussion of, hey, wait a minute, this is a patient's right to refuse treatment for an incurable disease. So we gave him meds for the depression and tried to get him more organized and get the delusions under control, organize his thinking, get him more, I guess we were saying, more involved in his life, more motivated, and he wasn't responding. He was not responding and got to the point of being considered for electroconvulsive therapy (ECT). And his statement along the way was I'm going to die. I want to die. And instead of looking at the whole picture and saying, OK, this is a man with disease who wants to die--his thought processes by that time were clear. He was making coherent decisions. He was not delusional. He was not hallucinating. But we were of the school of thought where, well, he's depressed, and that's why he's not thinking clearly; the depression is clouding his decision making process. Somehow we were going to convince him that it was important to live. It was important to fight this disease. Instead of having death with dignity and taking some kind of control back in his life where he's felt he had no control his whole life. He was saying, I want to die and we were going to make him better. We were going to make him want to live. At certain times it seemed it was just a power struggle. At other times it moved past that to us having our own difficulties about dying. The medical system letting somebody go who wants to let go and whose prognosis is not good, is not good at all. I mean, he didn't have the mental fortitude, nor the physical fortitude, to fight this. And he didn't want to fight it. He wanted to let it progress and to go and that's where my concern comes in. We need to really listen to what the patient wants. The attitude was, you are not going to be depressed, you are going to become one of these dynamic AIDS patients that fights to the very end and learns from your death experiences and prospers from this experience until the end. And this was not going to happen with this guy. Somehow we were going to convince him that it was important to live (P8, p. 3-6).

In the theory of testimony, the issue is some unresolved question or matter in dispute; it is not a routine, taken-for-granted affair accepted by the community or culture. Felman & Laub are more exacting in their description; for them, the issue must be an accident, that is, something unexpected. In these terms, it could be argued that the issue at stake is precisely the definition of the issue. Is it AIDS, depression, or *institutionalized* medicine's [and our cultural] response to death that is the accident? No one in this situation would disagree that AIDS is a human tragedy, that is unexpected and therefore an accident. But whereas, *institutionalized* medicine would have all death a tragedy, this nurse does not. For this nurse, the idea that death is never appropriate, that it can and should be forestalled indefinitely simply is untenable and patently ridiculous. This is the issue against which the nurse speaks. He challenges the worthiness of the forced ECT to be an end at all. He challenges the powerful but not invulnerable cultural defense of *institutionalized* medicine which continues to try and keep repressed the awareness that we will die. Borrowing from the work of Kuhns (1991), I would suggest that *institutionalized* medicine continues the enlightenment's elevation of reason and scientism, thereby repressing tragedy. Moreover, his challenge is also a warning about the harms our medical system inflicts on people in the name of saving them from death.

This nurse does not remain a solo voice in the challenge but is joined by most of nursing. The narrative continues:

> I: Where was this particular view [to persist with ECT] coming from?
>
> A lot from attendings, from consult service, from discussion just within the nursing staff. They wanted to see him accept our care, be grateful for it, and move on you know. It was just that there was that push, that push, that push to get him to accept treatment, accept treatment, accept treatment, accept treatment. And it was like pounding your head against a brick wall and wondering, why don't you hear what the patient is saying? Listen to what the patient is saying.
>
> I: How would you see this attitude in nursing conferences and nursing staff?

> Actually, when it would happen is when we started getting a little bit more realistic in our discussions in the change of shift reports when there weren't attendings or there weren't formal meetings or the Clinical Nurse IVs weren't around. You know, saying, come on, talking in basic, let's get real, language. I mean, we're not going to perform a miracle here. We can't perform a miracle. This is what the guy is saying. And questioning ourselves. It got people to look inside themselves, like, how would you feel if you were in this man's position. And seeing all the signs from him that he'd had a problem with depression through his life, with drugs and alcohol. We weren't going to change the quality of his life for him. (P8, p. 6-8).

Particularly interesting in this passage is the reference to the basic, "let's get real language" nurses use when among themselves, specifically at change-of-shift report. The nurse explicitly mentioned during this story that this language contrasted with the language used in interdisciplinary meetings. This is a most intriguing topic which, unfortunately, could not be explored further at the time these narratives were collected. Others, however, have examined the phenomenon. Briefly, "let's get real language" is illustrative of nursing's oral culture (O'Brien and Pearson, 1993; Street, 1992; Wolf, 1988). Street provides a particularly cogent critique of this oral tradition, arguing that while it is an understandable response to nursing's history of being silenced and devalued, it, nonetheless, reinforces our oppression. O'Brien and Pearson, on the other hand, are far more positive about the impact on our practice of this oral culture. Either way, this privatized language reflects the differences in status and perceived competence of nurses in comparison with the other disciplines, especially medicine. The voice of nursing is ignored not only because of gendered speakers but also because the wisdom of nurses is about having a life which, by and large, is irrelevant to *institutionalized* medicine. Since status and competence are aspects of the theory of testimony, there will be more to say about it but first it is necessary to look at the concept of evidence.

Evidence

To give testimony is to present oral evidence (Coady, 1993; Rembar, 1980); it is to speak to the truth of some phenomena. In advocating for patients, nurses are speaking to the truth of some aspect relevant to the patient's care. As this study has demonstrated repeatedly, what is relevant for these nurses extends beyond the mere technical capabilities of *institutionalized* medicine to include the recognition of the patient as a subject, the routines of lived experience, the universal reality of death, and the acknowledgement of the vulnerabilities patients face as a matter of the social and political space they occupy. I maintain that these are domains of knowledge accessible to the nurse. Patients present with some problem with which they need assistance. This gives rise to the relationship through which the nurse then comes to know the patient and the situation. Depending on the circumstances, the nurse will know more or less of the above domains.

I: How do you come to know what a patient needs?

> There's the expression on their face, ***watching*** their body mechanics. There's ***what they say*** and there's ***what you see*** around. I mean that's where I think that home care has just ***opened my eyes*** so much more towards what the patient needs. When I was in the hospital ***I didn't see*** a lot of stuff that ***I see* now**, because ***I can see*** the home they come from. ***I can see*** the type of--***I can tell*** a lot about the type of person that they are just by the way they have their dishes out of the sink, or the way the house looks perfect when you go in there, and it really shouldn't look perfect. They shouldn't be worrying so much about everything else around them when they're at a point when they need to be taking more care of themselves. There's just a lot of things that go into what a person needs besides just what they say they need (HC7, p. 21).

The knowledge this nurse has of this patient and their needs is not the propositional knowledge, if a, then b which, because it is general and holds across the specifics of particular cases, can explain disease. Instead, the knowledge is a narrative knowledge which, because it is particular, permits of understanding meanings, values, intentions, and actions. The root of relationship is, of course, relate, meaning to tell or narrate and evidence obtained through relationship is narrative knowledge acquired through careful discernment of the particulars of the situation. The nurses in this study evaluated the universal reality of life and the merely technical ends of *institutionalized* medicine against the evidence from the occupied social space and the routines of lived experience which constitute the patient's life. In this way, they ascertained the worthiness of the ends of medicine and gave testimony.

> That's what happens sometimes, we think we're going to change the quality of this person's life. Well, no, we discharge them from the hospital and they go back to their same apartment, their same isolated social situation, the same difficulty getting around in day-to-day life, doing ADLs (activities of daily living), getting to doctors' appointments, dealing with taking public transportation when there's been an uprise in gay bashing on buses, with people with AIDS. That's where we have to take all that into consideration and oftentimes we don't, we don't. The big picture doesn't get looked at. And I think that that's where, as a nurse, I feel, ethically, I need to bring that up and say, hey, wait a minute, let's look at this. The bottom line is, what are we trying to accomplish by forcing all this stuff. Why are we giving this man who is dying, of a legitimate physiologic disease--in his case, it was not a treatable disease. He was dying in front of our eyes. Why were we going to be doing ECT on somebody like this? (P8, p. 8).

Competence

Within the theory of testimony, the idea of competence is concerned to answer two questions: what counts as evidence, and who is competent to give it. This study demonstrated that the biomedical model is the only perspective from which evidence is considered legitimate, a finding consistent with Flynn's (1991) work. When nurses served as the instrumental extension of 'the gaze of medicine', which is to say, when monitoring disease, and when they were in agreement with the overall ends of *institutionalized* medicine, their evidence was accepted and nurses deemed competent. It is noteworthy, however, that although the evidence was collected and evaluated by nurses, they nonetheless did not have and could not exercise the authority to remedy the situation. For example, the following nurse is telling me about seeing patients who have been discharged from the psychiatric hospital but present on off-hours and likely need re-admission. The nurse is talking as if she actually admits them and so I ask for clarification. She responds:

> Actually, it [the decision to admit] has to be made by a physician, but the evidence is usually from the nursing staff (P9, p. 21)

When these nurses did propose an end of health care that differed from the biomedical approach to disease, they were discounted. This reveals that the 'bigger picture' with which nurses are so frequently engaged is not a legitimate domain and sometimes, cannot even be introduced.

> It's not a collaborative thing. It's not people sharing information, people sharing. The patient is not getting the best care because you have one person's opinion. You have your medical model, and you have everybody else following suit, trying not to ruffle feathers. But you don't have what's best for the patient in input from everyone, in a creative, free-floating way (P9, p. 8).

The ending to the story of the psychiatric nurse and the AIDS patient is illustrative in this regard. I ask the nurse if the patient receives ECT.

> I think what happened is, it wasn't so much the nursing staff's message that they got--it was, they finally got the patient's message but the nurses were the voice of the patient. We became the patient's advocate. It's like, look at him, listen to what he's telling us. They couldn't hear the patient because we know better than the patient. We're going to make you better. We're going to fix you whether you want to be fixed or not. But they had a specialist who does ECT come in and he said, wait a minute, what are you doing? (P8, p. 12).

The nurse attributes the attending's change of mind to hearing the patient's message. I think what happened is that they heard the consultant's message. It was not until Hermes came in the sartorial splendor of physician status and power that the message could be heard. Even though the consultant disagreed with the end of medicine in this case, his shared participation in the culture of contemporary medicine grants him an authority simply not available to nurses, no matter how good their ends, how wise their vision. This patient was lucky.

The legal and epistemological theory of competence in testimony is concerned with the questions of what counts as reliable evidence and who is competent to give it. Granting that these are legitimate and important questions in any domain in which testimony is given, we might ask what would grant nurses the authority to speak for patients if help in having a life were viewed as a legitimate end in health care? The theory of testimony, albeit that drawn from different sources, was also helpful in enabling me to see an answer in this study. In their study of testimony from the perspectives of literary theory and psychoanalysis, particularly as relevant to the Holocaust, Felman & Laub (1992) argue that the authority to bear witness and give testimony stems from communal knowledge and shared vulnerability to death. The nurses in this study understand both of these. They were very aware that they as well as patients shared a common existence--not the particulars, of course, not those occurrences which make life recognizable as someone's life but the general life of routines of lived experience, the occupation of social and political space, the recognition of the universality of death. These nurses know that their lives are constituted by routines, they occupy a certain space, and they too will die.

> I felt he was more spiritually aware or in tune with where he was going and what was going to happen with him, and very peaceful. And that's far beyond where I am. I'm frightened of death and feel like if I were told I had a terminal disease, it would take me a long time to get to where he was.
>
> I: But not too frightened to listen to patients talk about it?
>
> No, I am frightened and it's hard but if you don't remain open and try to work through that yourself, then it blocks your patient from being

> able to talk about it. So I'm open to talking. I want to learn. I learn from my patients how to work through, especially patients who have worked through things like death. So it's helpful. If I see that they've worked through these issues, then I learned how that happened for them. I want to know how they got to that point and that helps me. Maybe that's the way I would like to work through. I would love to become as peaceful as he was in the end. I mean, I just have this sense that I'm going to be fighting and struggling the whole way, and I don't want to die and I don't want to leave and I've got a baby and I've got a husband and I've got a life and oh it's so hard. I don't know that I learned how to do that through him, but I learned it can be done. But it's hard, these memories are tough, too hard for me. But no, I mean it's painful and it's hard but these things are important to me and I learn something from all my patients, especially those patients. It's hard. And you know, it's become harder for me since I've been a mother, because for some reason when I think about these people dying and death, I think about either myself dying, leaving my baby or my baby dying or my husband dying and leaving me and the baby. So, it's harder, I think, to become prepared, for all those reasons (P6, p. 31-34).

The work of nursing does not lend itself to the cult of a technical ideology promising ever greater mastery and control, a cult which divides the world into us and them.

> It's ethical that--we're all in life together, you know. It's not us and them. It's not like, I'm a nurse and I'm in charge here and I'm in control of your life. No, that's not what its about (P8, p. 21).

That nurses virtually have no say in setting the ends of health care is itself an ethical issue. It is hoped that this work will be a voice added to the chorus of existing work speaking for a more ethical health care.

CHAPTER SIX

SUMMARY AND DISCUSSION

Having encountered the findings, we are left with the task of making sense of this project. What can be made of my rendering of these nurses' stories? The goal of this chapter is to answer this question against the two presuppositions which structured this research. The first is that nursing practice has embedded within it, a morality which is derived from the very activity of that practice. Second is that our ethical experience is comprised of virtue or character, duty or obligation, and cultural ethos. This study was concerned to show how these were revealed in an actual morality of two groups of working nurses. Therefore the tasks of this chapter are sevenfold: 1) a summary of the ethics embedded in the work of practice; 2) a summary of the ethical concerns emanating from that practice; 3) discussion of nursing ethics; 4) a discussion of virtue, duty, and cultural ethos as revealed in these narratives; 5) the limitations and contributions of this research; 6) implications for education, practice, and research; and, 7) future research.

Summary of Nursing Ethics and the Work of Practice

In essence, this research showed nursing ethics to be comprised of the four aspects which constitute the moral work of practice: having a life, acting for, relationship, and testimony. To paraphrase one respondent, the work of nursing is about giving the patients back their lives (P8, p. 18). For the nurses in this study, helping patients to have a life lay at the moral heart of their practice. It was the aim towards which their work was directed. To have a life is to have a sense of agency, to occupy social and political space, to live a temporally structured existence, and to die. When there was no meaningful life to give back or make better, these nurses did not see death as an enemy and their work eased the passage from this life. The work of nursing inevitably necessitated that these nurses act for their patients in one to three domains; physical, psychological, and self-integrity. Because of their commitment to the patient's sense of agency, these nurses were acutely aware of the potential for abuse of power. This danger was offset by knowing the patient. Helping patients to have a life, particularly when acting for them in terms of self-integrity required a sense of knowing the patient in their world and the moral appreciation of that knowing. Knowing the patient was made possible through the relationship between nurse and patient, specifically by listening and entering the patient's world. Indeed, relationship was the vehicle through which the work of nursing both was made possible and accomplished. Somewhat surprisingly, however, the term was rarely used by participants, instead, they spoke of connection to patients. Entering the patient's world implied the crossing of spatial boundaries either literally or more symbolically through understanding and imagination. Boundaries were a significant and complex matter for these nurses. Because their function was the protection of both the patient and the nurse, it was important that the boundaries be correct. The significance of having a life lay in the pointed distinction between the knowing of the patient as a person in her world and the knowing of the patient as an object of biomedical science. These epistemologies and the values which underlie them frequently collided head on in the day-to-day realities of health care. When this happened, nurses advocated for their patients. Advocacy was part of the telling work of relationship. For a nurse to advocate in instances of these differing epistemologies was to speak out and question the ends or goals of biomedical medicine and the means employed to achieve them. Such challenges were always raised against the background of what a given intervention would mean for the patient in her world. For this reason, I have preferred to substitute the concept of bearing witness and giving testimony for that of advocacy.

Summary of Ethical Concerns

The ethical concerns given voice by these nurses reflect their practice as they see it. Central to all their concerns was their commitment to fostering patient agency and their sensitivity to patient need. These nurses were aware of the increased vulnerability to loss of this agency in the face of disease, illness, and the insensitivity of both providers and hospitals. As a consequence, these nurses were vigilant regarding an abuse of power and arrogation of patient agency. Need was not seen solely in terms of a biomedical model of altered physiology but was conceived broadly to include those things which helped the individual to initiate or re-establish routines of lived experience and to cope with the settings in which they found themselves. Such things might include child care for mothers with children or transportation for the elderly. In this view, need was relative to the realities of the patient's day-to-day life. It was an ethical concern for these nurses when these needs were not or could not be addressed. Examples of this included the reversal of a reimbursement policy which mandated that all newborns with jaundice be treated in the hospital and the fragmentation of services which frequently presented obstacles so daunting as to be impossible to overcome. The social and political space people occupy assumes concrete expression in poverty, race, and gender, thereby magnifying the potential for abuse of power and inattention to need. These nurses were particularly aware of their access to institutional power to control patients. It is important to note that such power was not always seen as a negative entity; at times it was deemed necessary and invoked to protect both patient and nurse.

Institutionalized medicine's inability to comprehend the limits of their technology, the exhaustion of the human body, the weariness of spirit, the inevitability and appropriateness of death, and the relief that appropriate death can bring was seen as causing harm to patients, families, nurses, and society at large. Patients endured pointless suffering, families could not mourn and get on with their lives, resources were used unwisely and distributed unfairly, the aims of medicine clashed with the aims of nursing, nurses had to cause pain and suffering to no end, the integrity of their practice was violated.

Establishing and maintaining the optimum space between nurse and patient was sometimes a challenge and always a matter of ethical significance. Relationship, or connection as these nurses preferred, was essential to the work of nursing. It was the vehicle through which the work could be done and it was the means for knowing the patient as a subject in contrast to knowing her as a biomedical object. By listening and watching, these nurses were able to attend to the patient as a subject with desires, concerns, intentions, and limits. They could enter the patient's world and see those aspects of life that made it the patient's life. Knowing the patient as a subject in a particular life was essential in those situations where these nurses had to act for the patient in the domain of integrity of self. Connection, however, was not always easy or successful. There were times when these nurses did not like the patient but this was never for a trivial reason; patients could be mean and hurtful, reject or sabotage care, make impossible demands, have committed some morally reprehensible act. When these nurses did have this response, they appealed to their belief that the patient was understandable, that a reason could be found to explain the patient's behavior. This belief served as a bridge linking the nurse to the patient until the nurse experienced empathy in response to the explanation for the patient's objectionable behavior. At times, this belief was contained in the notion of respect. Even this, however, did not always produce the desired affective engagement and nurses were then exceedingly self-conscious of their work with the patient. As one nurse expressed it so clearly; "I work twice as hard to make sure I'm not working half as much" (HC5, p. 25).

Through their commitment to personal agency, their attentiveness to the routines of lived experience, their recognition of the inevitability of death, and the constraints and privileges extant in the social and political space patients occupy, nurses bear witness to a life. Witnessing is storied or narrative knowledge obtained through hearing and watching the patient. Sometimes, helping patients demanded that nurses speak for them, telling their lives. Telling lives was usually a matter of challenging the ends of medicine and the means employed to obtain them. Serious situations warranted this testimony yet these nurses saw their concerns dismissed as silly or irrelevant to the ends of biomedicine. When such testimony was ignored, patients became mere objects to be acted upon and nurses were reduced to artificial persons.

Discussion of Nursing Ethics

I have listened intently to these nurses' stories, engaged in conversation, and worked to see and understand their concerns. The result of my labor is a rendering of nursing ethics as a four-fold account of having a life, acting for, relationship, and testimony. In my view, these concepts convey the values of these nurses and the work in which they are embedded. I have shared with the reader two of my biases: that I think principle-based ethics as they exist at the present are inadequate in reflecting a morality of nursing practice and that I was (and remain) not well disposed towards a description of nursing ethics as an ethic of care. Nonetheless, I have tried to be open to seeing and hearing both in my understanding of these nurses' stories. I have mentioned that the actual words suggestive of these two ethical approaches were mentioned but rarely and I believe the reader's review of the extensive narratives will confirm as much. This does, however, lead to a methodological point which has social, political, and ethical implications. The methodological point is that in the absence of a language (and sometimes even in its presence), understanding what a story is about "is an investigative problem" to use Mishler's words. He puts it thus: [understanding the point of a story];

> is not an observable piece of behavior and requires inference and interpretation on the analyst's part. Nor can it always be expressed in the narrator's own words (Mishler, 1986b, p. 236).

Studies of practice using a narrative methodology have interpreted the ethical dimensions of practice as a matter of caring.[1] I would suggest, however, that the concepts of having a life, acting for, relationship, and testimony, provide a more fruitful means of understanding nursing ethics. My reason is that caring is a vague and nebulous concept which does more to obscure than illuminate the values and moral work of nursing practice. It is true that the language of care speaks to nurses, bolstering self-esteem against their experience of devalued women's work and this is terribly important. But the question I would have us ask is: what else does the concept of care provide for a nursing ethics? The major problem I find with care is that it is without content. When nurses care, what are they caring about? This study revealed an answer: these nurses cared about personal agency and what it means to have a life, about the routines of lived experience and about dying. They cared about the social and political space that people occupy and how that sentences people to a certain existence. They cared about the frequently misguided aims of *institutionalized* medicine and the enormous potential for the abuse of power by themselves as well as others. I would argue that these are critically important to the goods of human life and to the kind of life an individual can have. By virtue of this importance, they should be thought about, articulated, discussed, studied, and carried out to the extent that they improve human life.

Both an ethic of care and a principle-based ethic are inadequate. On one hand, we have the caring proponents conveying that if only everyone cared enough, we could meet all our ethical

---

[1] Here I am thinking of Benner's work as well as that by Cooper. I specifically did not review Benner's work because she has studied practice primarily in terms of clinical reasoning. Nevertheless, approaching a phenomenon from a practice perspective will yield ethical dimensions.

challenges; on the other hand, the patrons of principle-based ethics would have us believe that a procedural approach to our moral experience enriches our lives. The ethical concepts revealed in this study offer the potential for thick descriptions across the variety of contexts to which they are relevant. Such an approach would link the personal of character with the convention of duty and the reality of social, political, and economic organization. Human flourishing depends on all of these.

Virtue, Duty, Cultural Ethos

Virtue

In this section, I address how I see virtue ethics as being relevant to nursing. While I am very supportive of virtue theory, it is not unproblematic. A valuable aspect of classical virtue ethics is that it presupposes some political and social organization of life and the goods of human life stand in relation to this organization. For the classical world to have included the political aspect is an outstanding contribution which we frequently have discounted as irrelevant to ethical experience in the contemporary world. And yet those who enjoyed the fruits of the political system were the citizens--only free men, not women and, of course, not slaves. That this is so is deeply troubling and has raised important criticisms of virtue theory, particularly, that of relativism. This is to say that the notions of ethical goodness are local and can not be critiqued by any standard outside of a given set of customs (Nussbaum, 1988). Without meaning to defend slavery or the ancient world's treatment of women, I think one could argue that the history of ethics is the history of our conceptualization and treatment of "the other". At this point in human history, we consider slavery a moral abomination although our treatment of women remains a moral challenge. Expanding our view of the other is not an easy task for it involves confrontations with our security--material, psychological and cultural. And yet, when we exercise our moral imagination to envision the other as really not so different from ourselves, we resist the ethical paralysis given in the us/them dichotomy.

In a very important analysis, Nussbaum (1988) contends that there is a non-relative virtue theory and thus the possibility of critique does exist within a virtue ethics. Nussbaum, specifically referring to an Aristotelian account of virtue, points out that those aspects of human life with which Aristotle was concerned are relevant to human existence anywhere. She calls these "grounding experiences" because they relate to spheres of human existence common to all people. They include the following:

> 1) fear of important damages, especially death; 2) bodily appetites and there pleasures; 3) distribution of limited resources; 4) management of one's personal property where others are concerned; 5) management of personal property where hospitality is concerned; 6) attitudes and actions with respect to one's own worth; 7) attitudes to slights and damages; 8) association and living together and the fellowship of words and actions; 9) attitude to the good and ill fortune of others; 10) intellectual life (this is not limited to knowledge but includes cognitive capacities such as perception); and 11), the planning of one's life and conduct (p. 35-36).

These grounding experiences are relevant to a nursing ethics because of their similarity to the concepts of having a life, acting for, relationship, and testimony. That people exercise personal agency, have routines of lived experience which constitute their lives, die, occupy a social and political space, act towards and for others, and speak to and for others are the experiences which are likely to bring nurses and patients together regardless of locale. There is also some similarity between these experiences and Doyle and Gouph's (1991) conceptualizations of human need. The concepts of nursing ethics revealed in this study are sufficiently large to encompass the central concepts of flourishing, self-evaluation, our moral sensitivities, and the relation of the moral agent to the community.

Virtue ethics is only beginning to be discussed in the nursing literature and there are advocates (Brody, 1988; Knowlden, 1990) as well as opponents (Salsberry, 1992). Both sides, however, make the same error in assuming that caring is a virtue. Interestingly, one reason Salsberry gives for her rejection is that there is no way to know what virtues should be cultivated by the discipline. I find this puzzling on two counts. First, she does not ask the same question of caring: that is, why should caring be cultivated? That it should be simply is given. Second, are we to believe that we, as nurses, really do not know what virtues we should nurture in each other? I am always deeply troubled to hear this because I fear it means we do not know what is most valuable about our practice. I know what virtues I want in a nurse when I need one; someone open to and capable of understanding my experience, someone who exercises sound judgement and has the courage for appropriate risk-taking, someone compassionate, someone trustworthy. If we were to give up caring as the virtue of nursing and examine such virtues as trustworthiness in practice, we would have a much richer moral vocabulary--a vocabulary more suited to the critique of individual moral agents as well as of our institutional and political settings.

Duty

Duty belongs to what Williams (1985) has called the morality system, that is, that part of our ethical system emphasizing obligation as conceived by those theorists of which Kant is the prototype. Three aspects commonly associated with the morality system which are relevant to this study are respect, dilemmas, and autonomy. The ethical concerns raised by the nurses in this study were not understood as duties. In this sense also, these nurses demonstrated their resemblance to classical ethics where duties were important as social convention and law but not ethics. This is not to say that these nurses did not have duties but only that they were not seen as moral. An example illustrating this that was not presented in the findings concerns euthanasia. The topic arose several times with nurses indicating they were not opposed categorically to physician (or nurse) assisted suicide, a topic in the media at the time of this data collection. Having registered their non-opposition, however, they did indicate that they would be hard pressed to act on it because of the legal constraints. Here nurses were in fact making a distinction between the morality of helping someone end their suffering and their duty to the convention of law. And as we witnessed, not even in those case where nurses were faced with abusive or rejecting patients did they appeal to duty. Instead, they appealed to the notion of respect which is a subtle concept and philosophically, is used in very technical ways (See Kleinig, 1991, for a brief but helpful overview of the concept). In this study, respect represented a kind of psychological understanding of the nature of humanity. It is an understanding more in keeping with the opening lines of Graham Swift's novel, *Waterland*, than it is with Kant's notion of an autonomous law-giver. Against the background of the novel, these lines can be read is an admonition to remember that while human beings and human existence can be unforgiving and tragic, we nonetheless share a common beginning. And in the vulnerability of this beginning lay both the hope for understanding and the possibility of redemption.

> 'And don't forget,' my father would say, as if he expected me at any moment to up and leave to seek my fortune in the wide world, 'whatever you learn about people, however bad they turn out, each one of them has a heart, and each one of them was once a tiny baby sucking his mother's milk...' (p. 1).

This study confirms my thoughts on the function of respect in nursing practice presented in chapter three. There I suggested that the notion of respect, conceptualized in this study as the potential understandability of the patient, may enable a nurse to care for a patient in the absence of caring about them.

In deontological theories, ethical issues are most commonly a matter of conflicting duties to opposing principles, otherwise known as dilemmas. Dilemmas are about *what to do* in the face of equally competing claims. Nurses in this study did not experience their concerns as dilemmas. In fact, I found it fascinating that all but three of the narratives were a kind of moral commentary on the world of health care. It is as if these nurses stood at the boundary of contemporary health care and peered in, witnessing the lived world of medical treatment and the working of institutions. Their perspective offered a view which illuminated certain salient aspects such that what they saw was not conceived as a dilemma; what to do was clear. The three exceptions were what I have called deliberative narratives. Each has been discussed in the previous chapter and they are: the narrative about the patient who is 94 years old and is deteriorating and facing the possibility of hospitalization (page 205); the story of the woman whose family was killed in the Holocaust (page 206); and the story of the old woman being cared for by her elderly daughter who is not following the nurse's recommendations (page 214). In these stories, nurses were deliberating but not about what to do in the face of competing claims. Rather, they were deliberating about the ends or best state of affairs, in other words, about what was best for the patient. Deliberating, for these nurses, was about doing the best one could.

Because protecting personal agency as a dimension of having a life clearly was the bedrock of the ethics of nursing in this study, I want to conclude this section in re-emphasizing a point regarding autonomy which was made in chapter three. Autonomy has several different senses and sometimes is used by authors without clarification. Partly to avoid such confusion, I used the term personal agency even though the nurses in this study on occasion spoke of autonomy. These nurses' understanding of autonomy was not the technical one of Kant (1959) nor the one of radical individualism versus communitarian theory which is the center of much scholarly attention (Bellah, Madsen, Sullivan, Swidler, and Tipton; 1985; Phillips, 1993; Reynolds and Norman, 1988). Instead, it is more akin to Miller's (1981) free and uncoerced action and Meyers' (1989) autonomy competency which is a set of skills enabling one to act responsibly in terms of self and others. Wiens (1993) developed an account of

Meyers position as a theoretical framework for understanding autonomy in nursing practice. I think Wiens' work is illuminating and the results of the present study are consistent with her framework. I do not believe, however, that her description as a care concept of autonomy adds anything to her position.

Cultural Ethos

The vantage point from which these nurses spoke reflect the cultural ethos of health care today. It is this position rather than their specific, identified concerns which I address in this section. The space nurses occupy in this cultural ethos affords them a view and what they see from this perspective is what they know and what they speak to. I am concerned with, to borrow from Foucault (1975), 'the gaze of nursing' and their 'speaking eye'. My point is that nursing ethics must work to liberate the voices of nurses in speaking out and thereby resisting 'the gaze of medicine' described so well in Sally Tisdale's words (1986) earlier in this work. I repeat them here:

> We have extended ourselves and our measurements. We see and hear beyond our given range, probe endlessly in the dark interiors, congratulate ourselves on progress (p. 430).

The nurses in this study participated actively in the 'gaze of medicine' but fundamentally, it was not their gaze. For these nurses, the patient was not a topography of some subterranean world of cells and viruses viewed with infinitely more interest than the patient as subject in the world of illness. The gaze of these nurses was focused on the patient as having a life, as occupying social and political space, as moving in routines of lived experience, as vulnerable to death. It is obvious that these are different universes and nurses operate on the boundaries of both. It is also clear that these nurses were far closer to the world of having a life because they viewed themselves as having lives, as sharing in a human existence that has fundamental commonalities like Nussbaum's 'grounding experiences'.

Yet is precisely this world which generally is seen as irrelevant to the ends of *institutionalized* medicine; the narrative knowledge of patients as subjects with lives is not knowledge and not important. Nurses are marginalized and their voices, when they speak, fall on deaf ears. Black feminist writer, Bell Hooks speaks of this marginalized space as conferring, outsider-within status (Collins, 1991) and status is an important consideration in *The Narrative Act* (Lanser, 1981) of speaking. The status of the speaker affects how "the message is received, interpreted, and valued" (Lanser, p. 86). Status is a matter of authority and nurses have little in the world of *institutionalized* medicine because they are mostly women doing 'natural' work, knowing what is not knowledge, and speaking the unimportant. The powerful interests of biomedical research, profit, and physician education over those of patient care (Ehrenreich and Ehrenreich, 1990; Roe, 1984) have squeezed the voice of nursing to a whisper. We must raise our voices at the bedside, in the classroom, and in the academy. In so doing, we resist the hegemony of *institutionalized* and challenge the very conception of authority (Addelson, 1991; Jones, 1988).

Limitations and Contributions

Generally speaking, the benefits of this investigation derive from its broad focus which offered these nurses the flexibility to tell their own stories in their own way. Such an approach yielded valuable knowledge about the ways these select home care and psychiatric nurses both experienced and communicated the ethical concerns of their practice. Thus, it provides a view of one actual morality as called for by Baier (1985a). In so doing, the findings lend empirical support to much philosophical work in ethics and moral psychology. While many of the concepts in this study are not new to nursing, such as acting for, relationship, and advocacy, the study also found empirical evidence for theoretical work in these areas. The concepts of having a life and artificial persons are new to nursing but were borrowed from philosophy and did provide some new insights. Harm to nurses, the understanding of respect and 'not liking' patients, the relevance of spatial considerations to practice, routines of lived experience, and testimony likewise provided new insights. These are rich concepts which, I believe, have the potential for a long life of relevance to understanding not only ethical experience in practice but other aspects of practice as well.

The strengths of this investigation were, paradoxically, its limitations in that the wide focus prevented an in-depth view of any one issue. This restricted the literature that reasonably could be covered, thereby limiting the amount and quality of discussion of the concepts. Although the story of nursing ethics told from this research is compatible with other theoretical and empirical work, the fidelity to accounts from other nurses remains an open question. These nurses were very experienced and very well-educated, living and working in a geographical area known for its diversity in several areas of human life. Even if the conceptual framework were corroborated in studies conducted in other places, the texture of that practice might look quite different. Another limitation was that the broad design did not facilitate a comparison between the two groups of nurses.

Implications for Education, Practice, and Research

Since the purpose of this inquiry was to study the ethics of practice from a philosophical perspective which grants practice a respected place as a source of values and knowledge, I find it difficult to organize this discussion in the traditional way. Therefore, I forego that method and present this discussion in terms of two ideas which have relevance for all three domains of the discipline: practical wisdom and reflection.

Earlier, I stated how grateful these nurses were for the opportunity to reflect on, name, feel, and talk about their ethical concerns. The question this section address is: What role does reflection play in the ethical experience of its practitioners and generally within the discipline of nursing? To begin, it is necessary to look at reflection as it relates to morality and here I turn to the work of Kekes (1984). Kekes rejects the Kantian emphasis on right action and argues that morality is about the kind of person we are. For Kekes, the kind of person we are is a matter of "how a person sees the situation in which he is to act" (p. 7), that is, as cruel, brutal, compassionate, just, and so forth. In the language I have used thus far, his morality is a virtue ethics. According to Kekes, reflection is a conscious, cognitive component to moral sensitivity requiring deliberate effort. It is necessary to the development of who we are because it "connect[s] a person's ideals with his actions" (p. 18). Reflection is made possible and nurtured by narrative discourse. Narratives humanize us by sensitizing us to the other (Booth, 1988; Charon, 1986; Langness and Frank, 1988; Ozick, 1986), serve as "models for lives" and call to us "to explore questions of human agency and explain lives" (Sandelowski, 1991, p. 163; Booth, 1988), justify moral stances (Eller, 1990; Fisher, 1987), and suggest other courses of action (Banks, 1982; Booth, 1988). Reflection and moral sensitivity in Kekes's terms or judgement and perception in Aristotle's constitute practical wisdom, the capacity to judge wisely in a given situation.

It would seem that we would want to nurture the capacity for reflection in each other so that we might strive towards a collective practical wisdom in the discipline. Reflection, however, takes a certain kind of ambience and it takes time. Reflection cannot be nurtured in an environment where moral vision and moral ideals are seen as irrelevant. Whether the place be the classroom or the bedside, the environment should seek to create a moral space in which ideals, actions, and reasons can be examined. We have seen that relativism is a criticism of virtue ethics but we have seen that it need not be. Wise judgements are recognized as such and they can be talked about, understood, and emulated. The development for this capacity requires a non-punitive but nonetheless, accountable environment where openness, integrity, and the willingness to face and experiment with the contingencies of human life and

nursing practice *are* the practice not the exception. And the nurturance of reflection takes time; it is not likely to flourish within the present cults of efficiency and bottom lines. This is not to ignore the hard realities of the latter but it is to say that our moral critique of them can not rest. To this end, we must continue: to resist the seductive belief that knowledge gained through technology is the only knowledge that counts; to nurture communication which preserves narrative; and to be attentive to what sociology, history, and literature have to teach us.

Furthermore, if we are to cultivate moral sensitivity and reflection, we must rethink the role of research in nursing ethics. Ethical inquiry must itself be a from of practical wisdom for the discipline. Maxwell (1984) argues that the profound problems in the world call for a new conception of academic inquiry; we need move from a philosophy of knowledge to a philosophy of wisdom. In his view, the mere amassing of knowledge does not necessarily lead to improved human life which, for him, is the aim of rational inquiry. The philosophy of wisdom, in contrast, conceptualizes inquiry as "articulating our problems of living, and proposing and criticizing possible solutions, namely possible human actions" (p. 3). Nursing is concerned directly with the improvement of human life and I believe, with Maxwell, that nursing inquiry and especially ethical inquiry must articulate the problems of nursing and propose and critique solutions of nursing actions. Similarly, other scholars have made a claim for the necessity of wisdom in academic inquiry (Fisher, 1993; Toulmin, 1988). Toulmin, for example, has argued for a return from our current abstract philosophy to practical philosophy which concerns itself with the oral, the particular, the local, and the timely. According to Toulmin, these are the qualities characterizing real life problems; we saw how they figured in this study. Theorizing about and seeking solutions to the realities of nursing practice is practical philosophy.

Patton (1990) has defined research as "the art of the possible" to which might be added the opening line of William Carlos Williams' (1984) *Danse Pseudomacabre*, "That which is possible is inevitable". Freedman and Goulet (1991) add that "research is a preliminary to a change in practice" (p. 34) but this is usually thought to work by the infusion of new knowledge from the outside into the practice arena. This is simply the amassing of more knowledge but if nursing is to approach ethical inquiry as practical wisdom, we must keep and nurture the moral ideals of practice through reflection. Olesen (1989) has written of the ways in which reflexivity is occasioned for and by researchers during the research process: 1) by the fact that researchers are "historically situated through the questions we ask and the manner in which we seek to understand and experience the world" (p. 9); 2) the process of exchange between researchers and participants is also the result of historical and cultural situatedness; and, 3) the act of writing which creates a text by transforming participants' accounts into a public account. Indeed, ethical inquiry as conversation is an invitation to nurses to be reflexive. In this sense, ethical inquiry is a form of practical reasoning.

Future Research

This research suggests further work in numerous areas. For example, we might inquire as to how nurses' understand the meaning of the thick ethical concepts of their practice, such as courage or perseverance. We might inquire as to how nurses manage their own moral ambivalence (Carse, 1991)--no trivial matter given the difficult patients for which we must sometimes care. We might examine, as Kass (1990) suggests for medicine, the moral sensibilities we inculcate in nursing students. Or we might investigate, as Mishler (1984) has proposed for medicine and Morse (1991) for nursing, the ways in which humane interaction between practitioners and patients influences treatment outcomes. What is the image we hold of ourselves as moral practitioners and how does this influence the care rendered? Ethnographic studies aimed at understanding clinical reasoning within a variety of practice cultures, such as the work being conducted by Fisher and Fonteyn (1993), will be extremely valuable in revealing how cultural context influences advocacy (Sellin, 1991), the preservation of patient agency, knowing the patient (Fisher, Fonteyn, and Liaschenko, 1993) and so forth. Furthermore, ethnographic studies of how power is understood, gained, used, shared, and negotiated between disciplines, patients, and families will illuminate how coercion actually takes place (Drought, 1993). What institutional structures and management styles preserve and extend ethical practice and what are those that deform it? How does the "psychology of the oppressed" reinforce destructive institutional policies? How do nurses as individuals and as a collective understand and use the political process to further social justice? These are some examples of the kind of ethical inquiry nursing could address.

Conclusion

This research demonstrated the ethical experience of select nurses revealing a morality of nursing practice. As a narrative act, this investigation bears witness to the reflexivity of research. Not only does the content show that nurses give testimony about their patients but the study itself is an act of testimony to these nurses in doing the best they could for vulnerable patients in an uncertain world.

> I tried to tell myself that I did the best I could with what I knew at the time. And I also tried to tell myself that I did what they would have wanted me to do or not do, that I was respecting their wishes whether I really agreed with it or not. I try not to think about it too much once I'm done for that day. I try not to dwell on it because ultimately, I don't always have the answer. God isn't sitting right there in the room saying, you did the right thing. So I just have to say, well, I think I did the best I could.
>
> I: What is it like to live and work knowing that there is no ultimate certainty?
>
> You ask tough questions. Well, it would be nice if it was all black and white, wouldn't it? (pause) I don't know how to answer that. I just take each case one step at a time. I mean, all of life is uncertain (HC6a, p. 39-40).

References

Abel, E. and Nelson, M. (1990). Circles of care: An introductory essay. In E. Abel and M. Nelson, (Eds.), Circles of care: Work and identity in women's lives (pp. 4-34). New York: SUNY.

Abelson, R. (1966). History of ethics (Medieval ethics). In P. Edwards (Ed.), The encyclopedia of philosophy, Volumes 3 and 4 (pp. 87-90). New York: Macmillan.

Acker, J., Barry, K., and Esseveld, J. (1991). Objectivity and truth: Problems in doing feminist research. In M. Fonow and J. Cook (Eds.), Beyond methodology: Feminist scholarship as lived research (pp. 133-153). Bloomington: Indiana University Press.

Addelson, K. P. (1987). Moral passages. In E. F. Kittay and D. T. Meyers (Eds.), Women and moral theory (pp. 87-110). Totowa, New Jersey: Rowman and Littlefield.

Addelson, K. P. (1991). The man of professional wisdom. In M. Fonow and J. Cook (Eds.), Beyond methodology: Feminist scholarship as lived research (pp. 16-34). Bloomington: Indiana University Press.

Akerlund, B. and Norberg, A. (1985). An ethical analysis of double bind conflicts as experienced by care workers feeding severely demented patients. International Journal of Nursing Studies, 22(3), 207-216.

Alcoff, L. and Potter, E. (Eds.). (1993). Feminist epistemologies. New York and London: Routledge.

Altheide, D. (1987). Ethnographic content analysis. Qualitative Sociology, 10(1), 65-77.

Angeles, P. A. (1981). Dictionary of philosophy. New York: Barnes and Noble.

Anscombe, G. E. M. (1958). Modern moral philosophy. Philosophy, 33(124), 1-19.

Anspach, R. (1993). Deciding who lives: Fateful choices in the intensive care nursery. Berkeley: University of California Press.

Aries, P. (1974). Western attitudes towards death from the middle ages to the present (P. Ranum, Trans.). Baltimore: The Johns Hopkins University Press.

Aristotle. (1989). The Nicomachean ethics (W. D. Ross, Trans.), (rev. by J. L. Ackrill and J.O. Urmson). Oxford: Oxford University Press (The World's Classics).

Aroskar, M. A. (1987). The interface of ethics and politics in nursing. Nursing Outlook, 35(6), 268-272.

Aroskar, M. A. (1989). Community health nurses: Their most significant ethical decision-making

Aroskar, M. A. (1993). Caring - another side. Journal of Professional Nursing, 7(1), 3.

Arras, J. (1991). Getting down to cases: The revival of casuistry in bioethics. Journal of Medicine and Philosophy, 16(1), 29-52.

Ashley, J. (1976). Hospitals, paternalism, and the role of the nurse. New York: Teachers College Press.

Baacke, D. (1986). Narration and narrative analysis in education and educational research [Special issue]. Poetics, 15(1-2), pp. 57-72.

Baier, A. C. (1985a). Theory and reflective practices. In Postures of the mind (pp. 207-227). Minneapolis: University of Minnesota Press.

Baier, A. C. (1985b). Caring about caring: A reply to Frankfurt. In Postures of the mind (pp. 93-108). Minneapolis: University of Minnesota Press.

Baier, A. C. (1985c). What do women want in a moral theory?. Nous, 19, 53-63.

Baier, A. C. (1986). Trust and anti-trust. Ethics, 96(2), 231-60.

Baier, A. (1987a). Hume, the women's moral theorist?. In E. F. Kittay and D. T. Meyers (Eds.), Women and moral theory (pp. 37-55). Totowa, New Jersey: Rowman and Littlefield.

Baier, A. (1987b). The need for more than justice. In M. Hanen and K. Nelson, (Eds.), Science, morality, and feminist theory (pp. 41-56). Canadian Journal of Philosophy, Supplemental Volume 13. Calgary, Alberta, Canada: University of Calgary Press.

Bange, P. (1986). Towards a pragmatic analysis of narratives in literature [Special issue]. Poetics, 15(1-2), pp. 73-88.

Banks, S. (1982). Once upon a time: Interpretation in literature and medicine. Literature and Medicine, 1, (pp. 23-27). New York: SUNY Press.

Barnard, D. (1986). A case of amyotrophic lateral sclerosis. Literature and Medicine, 5, (pp. 27-42). Baltimore: Johns Hopkins University Press.

Barnes, B. (1988). The nature of power. Urbana: University of Illinois Press.

Barrett, W. (1978). The illusion of technique. Garden City: Anchor Press/Doubleday.

Beauchamp, T. and Childress, J. (1983). Principles of biomedical ethics (2nd ed.). Oxford: Oxford University Press.

Bell, L. A. (1993). Rethinking ethics in the midst of violence. Lanham, Maryland: Rowman and Littlefield.

Bell, N. K. (1989). What setting limits may mean: A feminist critique of Callahan's Setting Limits. Hypatia, 4(2), 169-178.

Bell, S. (1988). Becoming a political woman: The reconstruction and interpretation of experience through stories. In A. Todd & S. Fisher (Eds.), Gender and discourse: The power of talk (pp. 97-124). Norwood, New Jersey: Ablex.

Bellah, R., Madsen, R., Sullivan, W., Swidler, A., and Tipton, S. (1985). Habits of the heart: Individualism and commitment in American life. Berkeley and London: University of California Press.

Belli, A. (1986). The impact of literature upon health: Some varieties of cathartic response. Literature and Medicine, 5, (pp. 90-108). Baltimore: Johns Hopkins University Press.

Benhabib, S. (1987). The generalized and the concrete other: The Kohlberg-Gilligan controversy and moral theory. In E. F. Kittay and D. T. Meyers, (Eds.), Women and moral theory (pp. 154-177). Totowa, New Jersey: Rowman and Littlefield.

Benjamin, W. (1968). The storyteller. In Illuminations: Essays and Reflections (pp. 83-109). New York: Schocken Books.

Benner, P. (1984). From novice to expert. Menlo Park, California: Addison-Wesley.

Benner, P. (1988, October). Nursing as a caring profession. Paper presented at the American Academy of Nursing, Kansas City, Missouri.

Benner, P. (1991). The role of experience, narrative, and community in skilled ethical comportment. Advances in Nursing Science, 14(2), 1-21.

Benner, P., Tanner, C., Chesla, C., Dreyfus, S., and Rubin, J. (1991). The Helene Fuld Study of Clinical Expertise in ICU Nursing.

Benner, P. and Wrubel, J. (1989). The primacy of caring. Menlo Park, California: Addison-Wesley.

Berger, P. and Luckmann, T. (1967). The social construction of reality. New York: Anchor Books.

Bertaux, D. (Ed.), (1981). Biography and society. Newbury Park, California: Sage Publications.

Bertaux, D. & Kohli, M. (1984). The life story approach: A continental view. Annual Review of Sociology, 10, 215-37.

Bishop, A. and Scudder, J. (1987). Nursing ethics in an age of controversy. Advances in Nursing Science, 9(3), 34-43.

Bishop, A. and Scudder, J. (1990). The practical, moral, and personal sense of nursing. New York: SUNY.

Boddington, P. R. (1988). The issue of women's philosophy. In M. Griffiths and M. Whifford, (Eds.), Feminist perspectives in philosophy (pp. 205-23). Indianapolis: Indiana University Press.

Bogdan, R. and Biklen, S. (1982). Qualitative research for education: An introduction to theory and methods. Boston: Allyn and Bacon.

Booth, W. (1988). The company we keep: An ethics of fiction. Berkeley: University of California Press.

Bordo, S. (1987). The flight to objectivity: Essays on Cartesianism and culture. New York: SUNY.

Bosk, C.L. (1992). All God's mistakes: Genetic counseling in a pediatric hospital. Chicago: University of Chicago Press.

Broadie, S. (1991). Ethics with Aristotle. Oxford: Oxford University Press.

Brody, H. (1987). Stories of sickness. New Haven: Yale University Press.

Brody, J. K. (1988). Virtue ethics, caring, and nursing. Scholarly Inquiry for Nursing Practice: An International Journal, 2(2), 87-96.

Brown, P. (1988). The body and society: Men, women, and sexual renunciation in early Christianity. Columbia University Press.

Brüggemeier, F.-J. (1986). Sounds of silents: History, narrative, and life-recollection [Special issue]. Poetics, 15 (1-2), pp. 5-24.

Bruner, J. (1986). Actual minds, possible worlds. Cambridge, Massachusetts: Harvard University Press.

Bruner, J. (1987). Life as narrative. Social Research, 54(2), 11-32.

Burgess, R. (1984). In the field: An introduction to field research. Boston: Allen and Unwin.

Burke, P. (1985). Vico. Oxford: Oxford University Press.

Burrell, D. and Hauerwas, S. (1977). From system to story: An alternative pattern for rationality in ethics. In H. T. Engelhardt and D. Callahan (Eds.). Knowledge, value, and belief. New York: The Hastings Center.

Burton, K. (1989). A chronicle: Dax's case as it happened. In L. D. Kliever, (Ed.), Dax's case: Essays medical ethics and human meaning (pp. 1-12). Dallas, Texas: Southern Methodist University Press.

Card, C. (1990). Caring and evil. Hypatia, 5(1), 101-108.

Card, C. (1991). Feminist ethics. Lawrence: University of Kansas Press.

Carpenter, M. (1991). The process of ethical decision making in psychiatric nursing practice. Issues in Mental Health Nursing, 12(2), 179-191.

Carper, B. A. (1979). The ethics of caring. Advances in Nursing Science, 1(3), 11-19.

Carr, D. (1986). Time, narrative, and history. Bloomington, Indiana: University of Indiana Press.

Carse, A. (1991). The 'voice of care': Implications for bioethical education. Journal of Medicine and Philosophy, 16(1), 5-28.

Carson, R. (1990). Interpretive bioethics: The way of discernment. Theoretical medicine, 11, 51-59.

Carson, R. (1982). Literature and medicine. Literature and Medicine, 1, (pp. 44-46). New York: SUNY Press.

Casey, J. (1990). Pagan virtue: An essay on virtue. Oxford: Clarendon Press.

Chafe, W. (1986). Beyond Bartlett. Narratives and remembering [Special issue]. Poetics, 15(1-2), 139-152.

Chafe, W. (1990). Some things that narratives tell us about the mind. In B. Britton & A. Pellegrini (Eds.), Narrative thought and narrative language (pp. 79-98). Hillsdale, New Jersey: Lawrence Erlbaum.

Charon, R. (1986). To render the lives of patients. Literature and Medicine, 5, (pp. 58-74). Baltimore: Johns Hopkins University Press.

Chatman, S. (1980/81). What novels can do that films can't (and vice versa). In W. Mitchell (Ed.), On narrative (pp. 117-136). Chicago: University of Chicago Press.

Churchill, L. and Churchill, S. (1982). Storytelling in medical arenas: The art of self-determination. Literature and Medicine, 1, (pp. 73-79). New York: SUNY Press.

Churchill, L. (1982). Why literature and medicine? Literature and Medicine, 1, (pp. 34-35). New York: SUNY Press.

Clifford, J. and Marcus, G. (1986). Writing Culture: The poetics and politics of ethnography, (Introduction). Berkeley: University of California Press.

Coady, C. A. J. (1992). Testimony: A philosophical study. Oxford: Clarendon Press.

Code, L. (1988). Experience, knowledge, and responsibility. In M. Griffiths and M. Whitford, (Eds.), Feminist perspectives in philosophy (pp. 187-204). Indianapolis: Indiana University Press.

Code, L. (1991). What can she know? Feminist theory and the construction of knowledge. Ithaca, New york: Cornell University Press.

Cohler, B. (1982). Personal narrative and the life course. In P. Bates and O. Brim (Eds.), Life span development and behavior, 4, 205-241. New York: Academic Press.

Coles, R. (1982). Why novels and poems in our medical schools? Literature and Medicine, 1, 32-33). New York: SUNY Press.

Coles, R, (1989). The call of stories. Boston: Houghton Mifflin Company.

Collins, P. H. (1991). Learning from the outsider within: The sociological significance of black feminist thought. In M. Fonow and J. Cook (Eds.), Beyond methodology: Feminist scholarship as lived research (pp. 35-59). Bloomington: Indiana University Press.

Cooper, M. C. (1988). Covenantal relationships: Grounding for the nursing ethic. Advances in Nursing Science, 10(4), 48-59.

Cooper, M. C. (1989). Gilligan's different voice: A perspective for nursing. Journal of Professional Nursing, 5(1), 10-16.

Cooper, M. C. (1991). Principle-oriented ethics and an ethic of care: A creative tension. Advances in Nursing Science, 14(2), 22-31.

Cottingham, J. (1984). Rationalism. London: Paladin.

Crowder, E. (1974). Manners, morals, and nurses: An historical overview of nursing ethics. Texas Reports on Biology and Medicine, 32(1), 173-180.

Cunningham, N. and Hutchinson, S. (1990). Myths in health care ethics. Image, 22(4), 235-238.

Curtin, L. (1979). The nurse as advocate: A philosophical foundation for nursing. Advances in Nursing Science, 1(3), 1-10.

Dallmayr, F. and McCarthy, T. (1977). Understanding and social inquiry, (Introduction). Notre Dame: University of Notre Dame Press.

Daly, R. (1982). Language and the healing arts. Literature and Medicine, 1, (pp. 42-43). New York: SUNY Press.

Danford, J. (1990). Hume and the problem of reason: Recovering the human sciences. New Haven: Yale University Press.

Davis, A. and Aroskar, M. (1978). Ethical dilemmas and nursing practice. Norwalk, Connecticut: Appleton-Century-Crofts.

Davis, A. J. (1981). Ethical dilemmas in nursing: A survey. Western Journal of Nursing Research, 3(4), 397-407.

Davis, A. J. (1990). Are there limits to caring?: Conflict between autonomy and beneficence. In M. Leininger (Ed.), Ethical and moral dimensions of care (pp. 25-32). Detroit: Wayne State University Press.

Davis, A. J. (1991). The sources of a practice code of ethics for nurses. Journal of Advanced Nursing, 16, 1358-1362.

DeConcini, B. (1990). Narrative remembering. Lanham, Maryland: University Press of America.

Dent, N. J. H. (1984). The moral psychology of the virtues. Cambridge: Cambridge University Press.

Denzin, N. K. (1989). Interpretive interactionism. Applied Social Research Methods Series, vol. 16, Newbury Park, California: Sage.

Descartes, R. (1985). Meditations. In S. Cahn (Ed.), Classics of Western Philosophy (2nd ed.). Indianapolis: Hackett Publishing.

DeVault, M. L. (1990). Talking and listening from women's standpoint: Feminist strategies for interviewing and analysis. Social Problems, 37(1), 96-116.

Donovan, M. P. (1985). Nursing: The finest art. St. Louis: C. V. Mosby.

Douglass, B. & Moustakas, C. (1985). Heuristic inquiry: The internal search to know. Journal of Humanistic Psychology, 25(3), 39-55.

Doyle, L. and Gough, I. (1991). A theory of human need. New York: The Guilford Press.

Dreyfus, H. (1987, May). Practice in a theoretical discipline: The uniqueness of nursing. Paper presented at the conference on Stress, Coping, and Caring, The Quest for Clinical Excellence. University of California, Berkeley.

Drought, T. (1993). At the intersection of life, death, knowledge, and power: The patient and her caregivers in the Intensive Care Unit. Unpublished dissertation pilot study.

Ehrenreich, B. and Ehrenreich, J. (1990). The system behind the chaos. In N. McKenzie (Ed.), The crisis in health care: Ethical issues (pp. 50-69). New York: Meridian.

Eller, C. (1990). Oral history as moral discourse: Conscientious objectors and the second world war. Oral History Review, 18(1), 45-75.

Emblen, J. (1992). Religion and spirituality defined according to current use in nursing literature. Journal of Professional Nursing, 8(1), 41-47.

Engelhardt, H. T. (1985). Physicians, patients, health care institutions - and the people in between: Nurses. In A. Bishop and J. Scudder (Eds.), Caring, curing, coping: Nurse, physician, patient relationships (pp. 62-79). University, Alabama: University of Alabama Press.

Erlen, J. A. (1991). Nurses' perceptions of powerlessness in influencing ethical decisions. Western Journal of Nursing Research, 13(3), 397-407.

Evans, G. R. (1993). Philosophy and theology in the Middle Ages. London: Routledge.

Felman, S. and Laub, D. (1992). Testimony: Crisis of witnessing in literature, psychoanalysis, and history. New York: Routledge.

Fingarette, H. (1979). Feeling guilty. American Philosophical Quarterly, 16(2), 159-64.

Fisher, W. R. (1987). Human communication as narration: Toward a philosophy of reason, value, and action. Columbia: University of South Carolina Press.

Fisher, W.R. (1993). Narration, knowledge, and the possibility of wisdom. Manuscript submitted for publication.

Fisher, A. and Fonteyn, M. (1993). An ethnographic study of psychiatric nurses' reasoning and decision making about patient danger in a psychiatric emergency setting. (Work in progress).

Fisher, A., Fonteyn, M. and Liaschenko, J. (1994). Knowing: The case, the patient, the person. Symposium to be presented at the International Nursing Research Conference, Vancouver, B.C., Canada, May 4-6, 1994.

Fleming, M. H. (1991a). Clinical reasoning in medicine compared with clinical reasoning in occupational therapy. The American Journal of Occupational Therapy, 45(11), 988-996.

Fleming, M. H. (1991b). The therapist with the three-track mind. The American Journal of Occupational Therapy, 45(11), 1007-1014.

Flynn, P. A. (1991). Just decisions: Moral ordering and the social construction of bioethics. Doctoral dissertation, University of California, San Francisco.

Fonow, M. and Cook, J. A. (Eds.) (1991). Beyond methodology: Feminist scholarship as lived research. Bloomington: Indiana University Press.

Foot, P. (1978). Virtues and vices. Berkeley: University of California Press.

Forchuk, C. (1991). Ethical problems encountered by mental health nurses. Issues in Mental Health Nursing, 12(4), 375-383.

Forrest, J. and Jackson, E. (1990). Get real: Empowering the student through oral history. The Oral History Review, 18(1), pp. 29-44.

Foucault, M. (1975). The birth of the clinic: An archaeology of medical perception (A. M. Sheridan Smith, Trans.). New York: Vintage.

Fox, R. (1990). The evolution of American bioethics: A sociological perspective. In G. Weisz, (Ed.). Social science perspectives on medical ethics. Dordrecht: Kluwer Academic Publishers.

Fox, R. and Swazey, J. (1984). Medical morality is not bioethics - medical ethics in China and the United States. Perspectives in Biology and Medicine, 27(3), 336-360.

Frader, J. (March, 1991). Conversation. Bulletin of Society for Health and Human Values, 21(2), p. 4.

Frankfurt, H. G. (1988). The importance of what we care about. Cambridge: Cambridge University Press.

Freedman, B. & Goulet, M-C. (1991). Commentary on Case Studies. Hastings Center Report, 21(1), 34-35.

Freitas, L. (1990). Historical roots and future perspectives related to nursing ethics. Journal of Professional Nursing, 6(4), 197-205.

French, P. A., Uehling, T. E., and Wettstein, H. K. (Eds.). (1988). Midwest studies in philosophy: Volume XIII. Notre Dame: University of Notre Dame Press.

Fricker, E. (1987). The epistemology of testimony. Proceedings of the Aristotelian Society, S61, 57-83.

Friedman, M. (1987). Care and context in moral reasoning. In E. F. Kittay and D. T. Meyers, (Eds.), Women and moral theory (pp. 190-204). Totowa, New Jersey: Rowman and Littlefield.

Frohock, F. M. (1986). Special care: Medical decisions at the beginning of life. Chicago: University of Chicago Press.

Fry, S. (1989). The role of caring in a theory of ethics. Hypatia, 4(2), 88-103.

Fry, S. (1990). The philosophical foundations of caring. In M. Leininger, (Ed.), Ethical and moral dimensions of care (pp. 13-24). Detroit: Wayne State University Press.

Fulton, R. (Ed.). (1976). Death and Identity (rev. ed.). Bowie, Maryland: The Charles Press Publishers.

Gadow, S. (1980). Existential advocacy: Philosophical foundation of nursing. In S. Spicker & S. Gadow (Eds.), Nursing: Images and Ideals, Opening Dialogue with the Humanities (pp. 79-101). New York: Springer.

Gadow, S. (1985). Nurse and patient: The caring relationship. In A. Bishop and J. Scudder (Eds.), Caring, curing, coping: Nurse, physician, patient, relationships (pp. 31-43). University, Alabama: University of Alabama Press.

Garritson, S. (1988). Ethical decision making patterns. Journal of Psychosocial Nursing, 26(4), 23-29.

Gauthier, D. (1986). Morals by agreement. Oxford, England: Clarendon Press.

Geertz, C. (1973). Thick description: Toward an interpretive theory of culture. In The interpretation of culture (pp. 1-30).

Gergen, K. (1984). An introduction to historical social psychology. In M. Gergen and K. Gergen (Eds.), Historical social psychology (pp. 3-36). Hillsdale, New Jersey: Lawrence Erlbaum.

Gergen, M. and Gergen, K. (1984). The social construction of narrative accounts. In M. Gergen and K. Gergen (Eds.), Historical social psychology (pp. 173-189). Hillsdale, New Jersey: Lawrence Erlbaum.

Gilligan. C. (1982). In a different voice. Cambridge, Massachusetts: Harvard University Press.

Gilligan, C. (1987). Moral orientation and moral development. In E. F. Kittay and D. T. Meyers, (Eds.), Women and moral theory (pp. 19-33). Totowa, New Jersey: Rowman and Littlefield.

Gortner, S. (1985). Ethical inquiry. In H. Werley and J. Fitzpatrick, (Eds.). Annual Review of Nursing Research, 3, 193 - 214.

Gouinlock, J. (1976). The moral writings of John Dewey. New York and London: Hafner Press.

Greene, G. (1991). Feminist fiction and the uses of memory. Signs: Journal of Women in Culture and Society. 16(2), 290-321.

Griffiths, M. (1988). Feminism, feelings and philosophy. In M. Griffiths and M. Whitford, (Eds.), Feminist perspectives in philosophy (pp. 131-51). Indianapolis: Indiana University Press.

Gruber, H. E. and Voneche, J. J. (1977). The essential Piaget. New York: Basic Books.

Gülich, E. and Quasthoff, U. (1986). Story-telling in conversation: Cognitive and interactive aspects [Special issue]. Poetics, 15(1-2), 217-241.

Gusfield, J. (1976). The literary rhetoric of science: Comedy and pathos in drinking driver research. American Sociological Review, 41, 16-34.

Guthrie, S. D. (1992, December 7). Finding good, convenient child care remains issue for RN's. Nurseweek, pp. 1, 22.

Haddad, A. M. (1992). Ethical problems in home healthcare. Journal of Nursing Administration, 22(3), 46-51.

Hall, J. M., and Stevens, P. E. (1991). Rigor in feminist research. Advances in Nursing Science, 13(3), 16-29.

Hall, J. M. (1992). Lesbians experience with alcohol problems: A critical ethnographic study of problematization, helpseeking, and recovery patterns. Doctoral dissertation, University of California, San Francisco.

Hammersley, M. (1992). What's wrong with ethnography? New York: Routledge.

Hanen, M. (1987). Introduction: Toward Integration. In M. Hanen and K. Nelson, (Eds.), Science, morality, and feminist theory (pp. 1-24). Canadian Journal of Philosophy. Supplemental Volume 13. Calgary, Alberta, Canada: University of Calgary Press.

Harding, S. (Ed.), (1987). Feminism and methodology. Bloomington, Indiana: Indiana University Press.

Hardmeier, C. (1986). Old testament exegesis and linguistic narrative research [Special issue]. Poetics, 15(1-2), 89-110.

Hardwig, J. (1985). Epistemic dependence. The Journal of Philosophy, 82(7), 335-349.

Hauerwas, S. (1986). Suffering presence: Theological reflections on medicine, the mentally handicapped, and the church. Notre Dame, Indiana: University of Notre Dame Press.

Hawkins, A. (1984). Two pathographies: A study in illness and literature. Journal of Medicine and Philosophy, 9(3), pp. 231-252.

Hawkins, A. (1986). A. R. Luria and the art of clinical biography. Literature and Medicine, 5, (pp. 1-15). Baltimore: Johns Hopkins University Press.

Heilbrun, C. G. (1989). Writing a woman's life. New York: Ballantine.

Held, V. (1984). Rights and goods: Justifying social action. Chicago: University of Chicago Press.

Held, V. (1987). Feminism and moral theory. In E. F. Kittay and D. T. Meyers, (Eds.), Women and moral theory (pp. 111-28). Totowa, New Jersey: Rowman and Littlefield.

Held, V. (1993). Feminist morality: Transforming culture, society, and politics. Chicago: University of Chicago Press.

Henderson, V. (1966). The nature of nursing: A definition and its implications for practice, research, and education. New York: Macmillan.

Hill, T. E. (1992). Dignity and practical reason in Kant's moral theory. Ithaca: Cornell University Press.

Hoffmaster, B. (1990). Morality and the social sciences. In G. Weisz (Ed.). Social science perspectives on medical ethics (pp. 241-60). Dordrecht: Kluwer Academic Publishers.

Holden, R. J. (1991). In defense of Cartesian dualism and the hermeneutic horizon. Journal of Advanced Nursing, 16, 1375-1381.

Holly, C. (1986). Staff nurses; participation in ethical decision making: A descriptive study of selected situational variables (Doctoral Dissertation, Teachers College, Columbia University). Dissertation Abstracts International, 47, 2372B.

Holmes, H. B. (1989). A call to heal medicine. Hypatia, 4(2), 1-8.

Houston, B. (1987). Rescuing womanly virtues: Some dangers of moral reclamation. In M. Hanen and K. Nelson, (Eds.), Science, morality, and feminist theory (pp. 237-264). Canadian Journal of Philosophy. Supplemental Volume 13. Calgary, Alberta, Canada: University of Calgary Press.

Howard, G. S. (1991). Culture tales: A narrative approach to thinking, cross-cultural psychology, and psychotherapy. American Psychologist, 46(3), 187-197.

Hume D. (1989). Enquiries concerning human understanding and concerning the principles of morals (3rd ed.). Oxford: Clarendon Press. (Original work published 1777)

Hunter, K. (1991). The doctor's stories: The narrative construction of medical knowledge. Princeton: Princeton University Press.

Jaggar, A. M. (1989). Love and knowledge: Emotion in feminist epistemology. In A. M. Jaggar and S. R. Bordo, (Eds.), Gender, body, knowledge: Feminist reconstructions of being and knowing (pp. 145-71). New Brunswick: Rutgers University Press.

Jaggar A. and Bordo, S. (Eds.). (1989). Gender, body, knowledge: Feminist reconstructions of being and knowing. New Brunswick: Rutgers University Press.

Jaggar, A. (1991). Feminist ethics: projects, problems, prospects. In C. Card (Ed.), Feminist ethics (pp. 78-104), Lawrence: University of Kansas Press.

Jameton, A. (1984). Nursing practice: The ethical issues. Englewood Cliffs, New Jersey: Prentice-Hall.

Jecker, N. and Self, D. (1991). Separating care and cure: An analysis of historical and contemporary images of nursing and medicine. Journal of Medicine and Philosophy, 16(3), 285-306.

Johnstone, M. J. (1989). Bioethics: A nursing perspective. Australia: W. B. Saunders/Bailliere Tindall.

Jones, K. B. (1988). On authority: Or why women are not entitled to speak. In I. Diamond and L. Quinby (Eds.), Feminism and Foucault: Reflections on resistance (pp. 119-134). Boston: Northeastern University Press.

Kahn, D. and Steeves, R.(1988). Caring and practice: Construction of the nurse's world. Scholarly Inquiry for Nursing Practice: An International Journal, 2(3), 201-216.

Kalisch, B. and Kalisch, P. (1986). The advance of American nursing. Boston: Little, Brown, and Company.

Kant, I. (1959). Foundations of the metaphysics of morals and What is enlightenment. trans. by Lewis White Beck. New York: Macmillan. (Original work published 1785)

Kass, L. R. (1990). Practicing ethics: Where's the action? Hastings Center Report, 20(1), 5-12.

Kautzmann, L. N. (1993). Linking patient and family stories to caregiver's use of clinical reasoning. The American Journal of Occupational Therapy, 47(2), 169-173.

Kekes, J. (1984). Moral sensitivity. Philosophy, 59, 3-19.

Keller, M. (1985). Nurses responses to moral dilemmas. (Doctoral Dissertation, University of South Carolina). Dissertation Abstracts International, 46, 1870B.

Kelly, B. (1990). Respect and caring: Ethics and essence of caring. In M. Leininger, (Ed.), Ethical and moral dimensions of caring (pp. 67-80). Detroit: Wayne State University Press.

Kemp, T. P. & Rasmussen, D. (Eds.). (1989). The narrative path: The later works of Paul Ricoeur. Cambridge, Massachusetts: MIT Press.

Kermode, F. (1980/81). Secrets and narrative sequence. In W. Mitchell (Ed.), On narrative (pp. 79-98). Chicago: University of Chicago Press.

Kestenbaum, V. (Ed.). (1982). The humanity of the ill: phenomenological perspectives. Knoxville: The University of Tennessee Press.

Ketefian, S. with Ormond, I. (1988). Moral reasoning and ethical practice in nursing: An integrative review. New York: National League for Nursing Publications.

Kirmayer, L. (1989). Mind and body as metaphors: Hidden values in biomedicine. In M. Lock and D. Gordon, (Eds.). Biomedicine Examined (pp. 57-93). Dordrecht: Kluwer Academic Publishers.

Kittay, E. F. and Meyers, D. T. (Eds.). (1987). Women and moral theory. Totowa, New Jersey: Rowman and Littlefield.

Kleinig, J. (1991). Valuing life. Princeton: Princeton University Press.

Kleinman, A. (1988). The illness narratives: Suffering, healing, and the human condition. New York: Basic Books.

Knowlden, V. (1990). The virtue of caring in nursing. In M. Leininger, (Ed.), Ethical and moral dimensions of care (pp. 89-94). Detroit: Wayne State University Press.

Koenig, B. (1988). The technological imperative in medical practice: The social creation of a "routine" treatment. In M. Lock and D. Gordon, (Eds.), Biomedicine examined (pp. 465-496). Dordrecht: The Netherlands. Kluwer Academic Publishers.

Kotre, J. (1984). Outliving the self: Generativity and the interpretation of lives. Baltimore: Johns Hopkins University Press.

Kuhns, R. (1991). Tragedy: Contradiction and repression. Chicago: University of Chicago Press.

Labov, W. & Fanshel, D. (1977). Therapeutic discourse: Psychotherapy as conversation. New York, New York: Academic Press.

Langer, J. (1969). Theories of development. New York: Holt, Rinehart, and Winston.

Langness, L. & Frank, G. (1988). Lives: An anthropological approach to biography (fourth printing). Novato, California: Chandler and Sharp.

Lanser, S. S. (1981). The narrative act: Point of view in fiction. Princeton: Princeton University Press.

Lauritzen, P. (1989). A feminist ethic and the new romanticism-Mothering as a model of moral relations. Hypatia, 4(2), 29-44.

Lear, J. (1988). Aristotle: The desire to understand. Cambridge: Cambridge University Press.

Leininger, M. (1977). Caring: The essence and central focus of nursing. American Nurses' Foundation Nursing Research Reports, 12(1), 2-14.

Leininger, M. (Ed.). (1985). Qualitative research methods in nursing. Orlando, Florida: Grune and Stratton.

Lengermann, P. M. and Niebrugge-Brantley, J. (1988). Contemporary feminist theory. In G. Ritzer, Sociological theory (2nd ed.). New York: Alfred A Knopf.

Liaschenko, J. (1989, June). Ethical problems of psychiatric nurses. Paper presented at the meeting of the International Council of Nurses, Seoul, South Korea.

Liaschenko, J. (1993). Feminist ethics and cultural ethos: Revisiting a nursing debate. Advances in Nursing Science, 15(4), 71-81.

Lincoln, Y. S. and Guba, E. G. (1985). Naturalistic inquiry. Beverly Hills: Sage Publications.

Linde, C. (1986). Private stories in public discourse. Narrative analysis in the social sciences [Special issue]. Poetics, 15(1-2), 183-202.

Linde, C. (1990, March). Narrative as a resource for the social constitution of the self (Report No. IRL 90-0020). Palo Alto, California: Institute for Research on Learning.

Littlejohn, R. L. (1993). Ethics: Studying the art of moral appraisal. Lanham, Maryland: University Press of America.

Lucariello, J. (1990). Canonicality and consciousness in child narrative. In B. Britton & A. Pellegrini (Eds.), Narrative thought and narrative language (pp. 131-50). Hillsdale, New Jersey: Lawrence Erlbaum.

Lützén, K. (1993). Moral sensitivity: A study of subjective aspects of the process of moral decision making in psychiatric nursing (Doctoral dissertation, Department of Psychiatry, Karolinska Institutet, Huddinge University Hospital, Huddinge, Sweden). ISBN 91-628-0943-1.

Maclean, N. (1992). Young men and fire. Chicago: University of Chicago Press.

MacIntyre, A. (1966). A short history of ethics: A history of moral philosophy from the Homeric age to the twentieth century. New York: Collier Books.

MacIntyre, A. (1983). To whom is the nurse responsible? In C. Murphy and H. Hunter, (Eds.), Ethical problems in the nurse-patient relationship (pp. 78-83). Boston: Allyn and Bacon.

MacIntyre, A. (1984). After Virtue (2nd ed.). Notre Dame: University of Notre Dame Press

MacPherson, K. I. (1983). Feminist methods: A new paradigm for nursing research. Advances in Nursing Science, 5(2), 17-25.

Marston, J. (1986). Metaphorical language and terminal illness: Reflections upon images of death. Literature and Medicine, 5, (pp. 109-121). Baltimore: Johns Hopkins University Press.

Martin, W. (1986). Recent theories of narrative. Ithaca, New York: Cornell University Press.

Mattingly, C. (1991a). What is clinical reasoning? The American Journal of Occupational Therapy, 45(11), 979-986.

Mattingly, C. (1991b). The narrative nature of clinical reasoning. The American Journal of Occupational Therapy, 45(11), 998-1005.

Maxwell, N. (1984). From knowledge to wisdom: A revolution in the aims and methods of science. Oxford: Basil Blackwell.

May, W. (1983). The physician's covenant: Images of the healer in medical ethics. Philadelphia: The Westminster Press.

McDowell, J. (1979). Virtue and reason. The Monist, 62(3), 331-350.

McGuire, M. (1990). The rhetoric of narrative: A hermeneutic critical theory. In B. Britton & A. Pellegrini (Eds.), Narrative thought and narrative language (pp. 219-236). Hillsdale, New Jersey: Lawrence Erlbaum.

McInerny, W. (1987). Understanding moral issues in health care: Seven essential ideas. Journal of Professional Nursing, 3(5), 268-277.

McNaughton, D. (1988). Moral vision: An introduction to ethics. Oxford: Basil Blackwell.

Meyers, D. T. (1989). Self, society, and personal choice. New York: Columbia University Press.

Midgley, M. M. (1989). Wisdom, information, and wonder: What is knowledge for? London: Routledge.

Miller, B. (1981). Autonomy and the refusal of lifesaving treatment. Hastings Center Report, 21(4), 22-28.

Miller, P. and Moore, B. B. (1989). Narrative conjunctions of caregiver and child: A comparative perspective on socialization through stories. In Ethos, 17, 428-449.

Mishler, E. (1984). The discourse of medicine: Dialectics of medical interviews. Norwood, New Jersey: Ablex.

Mishler, E. (1986a). Research interviewing: Context and narrative. Cambridge: Harvard University Press.

Mishler, E. (1986b). The analysis of interview-narratives. In T. R. Sarbin (Ed.), Narrative psychology: The storied nature of human conduct (pp. 233-255). New York: Praeger.

Mishler, E. (1990). Validation in inquiry-guided research: The role of exemplars in narrative studies. Harvard Educational Review, 60(4), 415-442.

Mitchell, C. (1990). Ethical dilemmas. Critical Care Nursing Clinics of North America, 2(3), 427-430.

Moravcsik, J. M. E. (1982). Understanding and the emotions, Dialectica, 36(2-3), 207-24.

Morgan, K. (1987). Women and moral madness. In M. Hanan and K. Nelson, (Eds.), Science, morality, and feminist theory (pp. 201-226). Canadian Journal of Philosophy. Supplemental Volume 13. Calgary, Alberta, Canada: University of Calgary Press.

Moritz, P. (Ed.). (1990, April). Bioethics and clinical practice: Examining research outcomes and methods (NIH Publication No. 90-1579. Washington, DC: National Institute for Nursing Research.

Morris, H. (1976). On guilt and innocence. Berkeley: University of California Press.

Morse, J., Solberg, S., Neander, W., Bottorff, J., and Johnson, J. (1990). Concepts of caring and caring as a concept. Advances in Nursing Science, 13(1), 1-14.

Morse, J. M. (1991). Negotiating commitment and involvement in the nurse-patient relationship. Journal of Advanced Nursing, 10, 455-468.

Moulton, J. (1983). A paradigm of philosophy: The adversary method. In S. Harding and M. Hintikka, (Eds.), Discovering Reality: Feminist perspectives on epistemology, metaphysics, methodology, and philosophy of science (pp. 149-64). Dordrecht, Holland: Reidel.

Munhall, P. & Oiler, C. (Eds.). (1986). Nursing research: A qualitative perspective. Norwalk, Connecticut: Appleton-Century-Crofts.

Münz, R. and Pelz, M. (1986). Narration in social research [Special issue]. Poetics, 15(1-2), 25-42.

Murdoch, I. (1977). The fire and the sun: Why Plato banished the artists. New York: Viking Press.

Nelson, J. (1982). Authenticity: Fabric of ethical nursing practice. Topics in Clinical Nursing, 8(3), 142-152.

Nietzsche, F. (1968). The Anti-Christ, (trans. by R. Hollingdale). London: Penguin Classics.

Nightingale, F. (1860/1969). Notes on nursing: What it is and what it is not. New York: Dover Publications.

Nixon, R. (1961). An approach to the dynamics of growth in adolescence. Psychiatry, 24, 18-31.

Noble, D. F. (1992). A world without women: The Christian clerical culture of Western science. New York: Knopf.

Noddings, N. (1984). Caring: A feminine approach to ethics and moral education. Berkeley: University of California Press.

Norman, R. (1983). The moral philosophers: An introduction to ethics. Oxford: Clarendon Press.

Norton, D. L. (1988). Moral minimalism and the development of moral character. In P. A. French, T. E. Uehling, and H. K. Wettstein (Eds.), Midwest Studies in Philosophy Volume XIII (pp. 180-195). Notre Dame: University of Notre Dame Press.

Nussbaum, M. C. (1988). Non-relative virtues: An Aristotelian approach. In P. A. French, T. E. Uehling, and H. K. Wettstein (Eds.), Midwest Studies in Philosophy Volume XIII (pp. 32-53). Notre Dame: University of Notre Dame Press.

Oakley, A. (1981). Interviewing women: A contradiction in terms. In H. Roberts (Ed.), Doing feminist research (pp. 30-61). London: Routledge and Kegan Paul.

O'Brien, B. and Pearson, A. (1993). Unwritten knowledge in nursing: Consider the spoken as well as the written word. Scholarly Inquiry for Nursing Practice: An International Journal, 7(2), 111-124.

Oesterle, J. A. (1984). Introduction. In Aquinas, Treatise on the virtues. Notre Dame: University of Notre Dame Press.

Olesen, V. (1989, April). Re-thinking ethnography: Re-writing ourselves. Paper presented at the meeting of the Pacific Sociological Association.

Olesen, V. (1990). The neglected emotions: A challenge to medical sociology. Plenary Address, 20th Annual British Sociological Association Conference, Edinburgh, Scotland.

Omer, H. (1993). Quasi-literary elements in psychotherapy. Psychotherapy, 30(1), 59-66.

Orgel, G. S. (1983). They have no right to know: The nurse and the terminally ill patient. In C. P. Murphy and H. Hunter (Eds.), Ethical problems in the nurse-patient relationship (pp. 123-136). Boston: Allyn and Bacon.

Overall, C. (1989). The politics of communities: A review of Engelhardt's The Foundations of Bioethics. Hypatia, 4(2), 179-85.

Oxford English Dictionary (1982) (22nd printing). Oxford: Oxford University Press.

Ozick, C. (1986, May). The moral necessity of metaphor. Harper's, 62-68.

Packard, J. S. & Ferrara, M. (1988). In search of the moral foundation of nursing. Advances in Nursing Science, 10(4), 60-71.

Packer, M. and Addison, R. (Eds.). (1989). Entering the circle: Hermeneutic investigation in psychology. New York: SUNY Press.

Pagels, E. (1988). Adam, Eve, and the serpent. New York: Random House.

Pajunen, E. (1987). Editorial, Journal of nursing history, 3(1), 3-4.

Parker, R. (1990a). Measuring nurses' moral judgements. Image, 22(4), 213-218.

Parker, R. (1990b). Nurses' stories: The search for a relational ethic of care. Advances in Nursing Science, 13(1), 31-40.

Patton, M. Q. (1990). Qualitative Evaluation and research methods. (2nd ed.). Newbury Park: Sage.

Pellegrino, E. D. (1982). To look feelingly - The affinities of medicine and literature. Literature and Medicine, 1, (pp. 18-22). New York: SUNY Press.

Pellegrino, E. D. and Thomasma, D. C. (1981). A philosophical basis of medical practice: Toward a philosophy and ethic of the healing professions. Oxford: Oxford University Press.

Penticuff, J. (1991). Conceptual issues in nursing ethics research. Journal of Medicine and Philosophy, 16(3), 235-258.

Personal Narratives Group (Eds.), (1989). Interpreting women's lives. Bloomington, Indiana: Indiana University Press.

Phillips, D. L. (1993). Looking backward: A critical appraisal of communitarian thought. Princeton: Princeton University Press.

Piaget, J. (1965). The moral judgement of the child (M. Gabain, Trans.). New York: The Free Press.

Pike, A. W. (1991). Moral outrage and moral discourse in nurse-physician collaboration. Journal of Professional Nursing, 7(6), 351-363.

Pincoffs, E. L. (1986). Quandaries and virtues: Against reductivism in ethics. Kansas: University of Kansas Press.

Polkinghorne, D. (1988). Narrative knowing and the human sciences. State University of New York Press.

Pred, A. (1990). Constructing geographies. In Making histories and constructing human geographies: The local transformation of practice, power relations, and consciousness (pp. 1-40). Boulder: Westview Press.

Prince, G. (1987). The dictionary of narratology. Lincoln: University of Nebraska Press.

Purdy, L. M. (1989). Feminists healing ethics. Hypatia, 4(2), 9-14.

Rabinow, P. and Sullivan, W. (Eds.). (1989). Interpretive social science: A second look. Berkeley: University of California Press.

Rabkin, E. (1986). A case of self defense. Literature and Medicine, 5, (pp. 43-53). Baltimore: Johns Hopkins University press.

Rachels, J. (1986). The end of life: Euthanasia and morality. Oxford: Oxford University Press.

Rawls, J. (1971). Self-respect, excellences, and shame. In J. Rawls, A theory of justice (pp. 400-46). Cambridge, Massachusetts: Harvard University Press.

Reckling, J. (1991, October). Ethical problems for ICU nurses. Poster session presented at the meeting for the Society for Health and Human Values, St. Louis, Mo.

Reed, J. (1989). On narrative and sociology. In Social Forces, 68(1), 1-14.

Rembar, C. (1980). The law of the land: The evolution of our legal system. New York: Touchstone Books.

Reverby, S. M. (1987). Ordered to care: The dilemma of American nursing, 1850-1945. Cambridge, England: Cambridge University Press.

Reynolds, C. and Norman, R. (Eds.), (1988). Community in America: The challenge of habits of the heart. Berkeley: University of California Press.

Richardson, L. (1990a). Narrative and sociology. Journal of Contemporary Ethnography, 19(1), 116-35.

Richardson, L. (1990b). Writing strategies: Reaching diverse audiences. Newbury Park: Sage Publications.

Ricoeur, P. (1980/81). Narrative time. In W. Mitchell (Ed.), On narrative. (pp. 165-186). Chicago: University of Chicago Press.

Riessman, C. K. (1988). Worlds of difference: Contrasting experience in marriage and narrative style. In A. Todd & S. Fisher (Eds.), Gender and discourse: The power of talk (pp. 151-173). Norwood, New Jersey: Ablex.

Riessman, C. K. (1993). Narrative analysis. Newbury Park: Sage Publications.

Roe, W. (1984). "Science" in the practice of medicine: Its limitations and dangers as exemplified by a study of the natural history of acute bronchial asthma in children. Perspectives in Biology and Medicine, 27(3), 386-400.

Rorty, A. O. (Ed.), (1980). Explaining emotions. Berkeley, California: University of California Press.

Rorty, A. O. (1988). Virtues and their vicissitudes. In P. A. French, T. E. Uehling, and H. K. Wettstein (Eds.), Midwest Studies in Philosophy Volume XIII (pp. 136-148). Notre Dame: University of Notre Dame Press.

Rothman, D. (1991). Strangers at the bedside: A history of how law and bioethics transformed medical decision making. New York: Basic Books.

Rubin, J. (1990, November). Qualitative distinctions in clinical expertise. Paper presented at the conference on nursing ethics. California Nurses Association and the American Society for Law and Medicine. University of California, San Francisco.

Ruddick, S. (1980). Maternal thinking. Feminist Studies, 6, 342-367.

Ruddick S. (1989). Maternal thinking: Towards a politics of peace. New York: Ballantine Books.

Ruddick, S. and Daniels, P. (Eds.). (1977). Working it out. New York: Pantheon Books.

Russell, R. L. and van den Broek, P. (1992). Changing narrative schemas in psychotherapy. Psychotherapy, 29(3), 344-354.

Sacks, O. (1985). The man who mistook his wife for a hat and other clinical tales. New York: Simon and Schuster.

Sacks, O. (1986). Clinical tales. Literature and Medicine, 5, (pp. 16-23). Baltimore: Johns Hopkins University Press.

Salsberry, P. J. (1992). Caring, virtue theory, and foundation for nursing ethics. Scholarly Inquiry for Nursing Practice; An International Journal, 6(2), 155-167.

Sandelowski, M. (1986). The problem of rigor in qualitative research. Advances in Nursing Science, 8(3), 27-37.

Sandelowski, M. (1991). Telling stories: Narrative approaches in qualitative research. Image, 23(3), 161-66.

Sandelowski, M. (1993). Rigor or rigor mortis: The problem of rigor in qualitative research revisited. Advances in Nursing Science, 16(2), 1-8.

Sarbin, T. (Ed.). (1986). Narrative psychology: The storied nature of human conduct. New York: Praeger.

Schafer, R. (1980/81). Narration in the psychoanalytic dialogue. In W. Mitchell (Ed.), On narrative (pp. 25-50). Chicago: University of Chicago Press.

Schatzman, L. and Strauss, A. L. (1973). Field research: Strategies for a natural sociology. Englewood Cliffs: Prentice-Hall.

Schneewind, J. B. (1983). Moral knowledge and moral principles. In S. Hauerwas and A. MacIntyre, (Eds.), Revisions: Changing perspectives in moral philosophy (pp. 113-26). Notre Dame, Indiana: University of Notre Dame Press.

Schott, R. M. (1988). Cognition and Eros: A critique of the Kantian paradigm. Boston, Massachusetts: Beacon Press.

Schultz, P. R. and Schultz, R. C. (1990). Nodding's caring and public policy: A linkage and its nursing implications. In M. Leininger (Ed.), Ethical and moral dimensions of care (pp. 81-88). Detroit: Wayne State University Press.

Sellin, S. C. (1991). Patient advocacy among institutionally employed registered nurses. Doctoral dissertation, University of California, San Francisco.

Sexson, M. (1982). The wounded healer: A meditation on the serpent as mythic symbol of health. Literature and Medicine, 1, (pp. 104-115). New York: SUNY Press.

Sherblom, S., Shipps, T. and Sherblom, J. (1993). Justice, care, and integrated concerns in the ethical decision making of nurses. Qualitative Health Research, 3(4), 442-464.

Sherman, N. (1989). The fabric of character: Aristotle's theory of virtue. Oxford: Clarendon Press.

Sherwin, S. (1989). Feminist and medical ethics: Two different approaches to contextualist ethics. Hypatia, 4(2), 57-72.

Sherwin, S. (1992). No longer patient: Feminist ethics and health care. Philadelphia: Temple University Press.

Sichel, B. A. (1989). Ethics of caring and the institutionalized ethics committee. Hypatia, 4(2), 45-56.

Silberstein, S. (1988). Ideology as process: Gender ideology in courtship narratives. In A. Todd & S. Fisher (Eds.), Gender and discourse: The power of talk (pp. 125-150). Norwood, New Jersey: Ablex.

Smith, D. (1986). The limits of narrative. Literature and Medicine, 5, (pp. 54-57). Baltimore: Johns Hopkins University Press.

Solomon, R. (1990). A passion for justice: Emotions and the origins of the social contract. Menlo Park, California: Addison-Wesley.

Sommers, C. H. (1987). Filial morality. In E. F. Kittay and D. T. Meyers, (Eds.), Women and moral theory (pp. 69-84). Totowa, New Jersey: Rowman and Littlefield.

Sontag, S. (1979). Illness as metaphor. New York: Vintage.

Spinoza, B. (1951). A theologico-political treatise (R. H. M. Elwes, Trans.). New York: Dover Publications. (Original work published 1670)

Stenberg, M. J. (1979). The search for a conceptual framework as a philosophic basis for nursing ethics: An examination of code, contract, context, and covenant. Military Medicine, 144(1), 9-22.

Stevens, P. E. (1992). Health care experiences of a racially and economically diverse group of lesbians: A feminist narrative study. Doctoral dissertation, University of California, San Francisco.

Stinson, R. and Stinson, P. (1981). Focus: Current issues in medical ethics. Journal of Medical Ethics, 7, 5-18.

Stocker, M. (1987). Duty and friendship: Toward a synthesis of Gilligan's contrastive moral concepts. In E. F. Kittay and D. T. Meyers, (Eds.), Women and moral theory (pp. 56-68). Totowa, New Jersey: Rowman and Littlefield.

Stout, J. (1988). Liberal society and the languages of morals. In C. Reynolds and R. Norman, (Eds.), Community in America: The challenge of habits of the heart. Berkeley: University of California Press.

Stout, J. (1988). Ethics after Babel: The languages of morals and their discontents. Boston: Beacon Press.

Strauss, A. and Corbin, J. (1990). Basics of qualitative research: Grounded theory procedures and techniques. Newbury Park: Sage Publications.

Street, A. F. (1992). Inside nursing: A critical ethnography of clinical nursing practice. Albany: SUNY.

Stuhlmiller, C. (1991). An interpretive study of appraisal and coping of rescue workers in an earthquake disaster: The cypress collapse. Doctoral dissertation, University of California, San Francisco.

Suppe, F. & Jacox, A. K. (1985). Philosophy of science and the development of nursing theory. In H. Werley and J. Fitzpatrick, (Eds.). Annual Review of Nursing Research, 3, (pp. 241-267). New York: Springer.

Swift, G. (1983). Waterland. New York: Vintage Books.

Szasz, A. (1991, March). Paper presented to the faculty and students, School of Nursing, University of California, San Francisco.

Taylor, C. (1985). What is human agency? In C. Taylor, Human agency and language: Philosophical papers, Vol. 1 (pp. 15-44). Cambridge: Cambridge University Press.

Taylor, C. (1987). Interpretation and the sciences of man. In P. Rabinow and W. Sullivan (Eds.), Interpretive social science: A second look (pp. 33-81). Berkeley: University of California Press.

Taylor, C. (1989). Sources of the self: The making of the modern identity. Cambridge, Massachusetts: Harvard University Press.

Taylor, G. (1985). Pride, shame, and guilt: Emotions of self-assessment. Oxford: Clarendon Press.

Taylor, R. (1985). Ethics, faith, and reason. Englewood Cliffs, New Jersey: Prentice-Hall.

Tesch, R. (1990). Qualitative research: Analysis types and software tools. New York: The Falmer Press.

Tisdale, S. (1986). Swept away by technology. American Journal of Nursing. April, 429-430.

Todd, A. D. & Fisher, S. (Eds.). (1988). Gender and discourse: The power of talk. (Introduction) (pp. 1-16). Norwood, New Jersey: Ablex.

Toulmin, S. (1981). The tyranny of principles. The Hastings Center Report. December, 31-39.

Toulmin, S. (1988). The recovery of practical philosophy. The American Scholar, 57, 337-352.

Toulmin, S. (1990). Cosmopolis: The hidden agenda of modernity. New York: The Free Press.

Turner, V. (1980/81). Social dramas and stories about them. In W. Mitchell (Ed.), On narrative (pp. 137-164). Chicago: University of Chicago Press.

Tronto, J. C. (1989). Women and caring: What can feminists learn about morality from caring? In A. M. Jaggar and S. R. Bordo, (Eds.), Gender, body, knowledge: Feminist reconstructions of being and knowing (pp. 172-87). New Brunswick, New Jersey: Rutgers University Press.

Van Manen, M. (1990). Researching lived experience. London, Ontario, Canada: The Althouse Press.

Van Maanen, (1988). Tales of the field. Chicago: University of Chicago Press.

von Wright, G. H. (1963). The varieties of goodness. London: Routledge and Kegan Paul.

Verhave, T. and van Hoorn, W. (1984). The temporalization of the self. In M. Gergen and K. Gergen (Eds.), Historical social psychology. Hillsdale, New Jersey: Lawrence Erlbaum.

Walker, M. U. (1989). Moral understandings: Alternative "epistemology" for a feminist ethics. Hypatia, 4(2), 15-28.

Walker, M. U. (1992). Feminism, ethics, and the question of theory. Hypatia, 7(3), 23-38.

Walkup, J. (1990). Narrative in psychoanalysis: Truth? Consequences? In B. Britton & A. Pellegrini (Eds.), Narrative thought and narrative language (pp. 237-268). Hillsdale, New Jersey: Lawrence Erlbaum.

Wallace, J. (1988). Moral relevance and moral conflict. Ithaca, New York: Cornell University Press.

Walzer, M. (1987). Interpretation and social criticism. Cambridge, Massachusetts: Harvard University Press.

Warnock, M. (1987). Memory. London: Faber and Faber.

Warren, C. and Messinger, S. (1988). Sad tales in institutions. Journal of Contemporary Ethnography, 17(2), 164-182.

Warren, V. L. (1989). Feminist directions in medical ethics. Hypatia, 4(2), 73-87.

Watson, J. (1979). Nursing: The philosophy and science of caring. Boston: Little, Brown.

Watson, J. (1985). Nursing: Human science and human care. Norwalk, CT: Appleton-Century-Crofts.

Watson, M. J. (1988). Response to "Caring and practice: Construction of the nurse's world". Scholarly Inquiry for Nursing Practice: An International Journal. 2(2), 217- 221.

Wax, R. (1971). Doing fieldwork: Warnings and advice. Chicago: University of Chicago Press.

Weisz, G. (Ed.). (1990). Introduction, Social science perspectives on medical ethics (pp. 3-15). Dordrecht: Kluwer Academic Publishers.

Welbourne, M. (1979). The transmission of knowledge. The Philosophical Quarterly, 29, 1-9.

Wendell, S. (1989). Towards a feminist theory of disability. Hypatia, 4(2), 104-24.

White, H. (1980/81). The value of narrativity in the representation of reality. In W. Mitchell (Ed.), On narrative (pp. 1-24). Chicago: University of Chicago Press.

Wiens, A.G. (1993). Patient autonomy in care: A theoretical framework for nursing. Journal of Professional Nursing, 9(2), 95-103.

Wiedemann, P. (1986). Don't tell any stories. Theories and discoveries concerning story-telling in the therapeutic setting [Special issue]. Poetics, 15(1-2), 43-56.

Wiggins, D. (1978). Deliberation and practical reasoning. In J. Raz (Ed.), Practical Reasoning (pp. 144-151). Oxford: Oxford University Press.

Wilkinson, J. (1987/88). Moral distress in nursing practice: Experience and effect. Nursing Forum, 23(1), 16-29.

Williams, B. (1973). Morality and the emotions. In B. Williams, Problems of the self (pp. 207-29). Cambridge, England: Cambridge University Press.

Williams, B. (1981). Persons, character, and morality. In B. Williams, Moral luck (pp. 1-19). Cambridge, England: Cambridge University Press.

Williams, B. (1985). Ethics and the limits of philosophy. Cambridge: Harvard University Press.

Williams, Carlos W. (1984). Danse Pseudomacabre. In The doctor stories (pp. 88-91). New York, New York: New Directions Books.

Williams, G. (1984). The genesis of chronic illness: narrative and re-construction. Sociology of health and illness. 6(2), 175-200.

Wilson, J. (1987). A preface to morality. Totowa, New Jersey: Barnes and Noble.

Winslow, G. (1984). From loyalty to advocacy: A new metaphor for nursing. The Hastings Center Report, 14, 32-40.

Winslow, B. J. and Winslow, G. R. (1991). Integrity and compromise in nursing ethics. The Journal of Medicine and Philosophy, 16, 307-323.

Wodak, R. (1986). Tales from the Vienna woods. Sociolinguistic and psycholinguistic considerations of narrative analysis [Special issue]. Poetics, 15(1-2), pp. 152-182.

Wolf, E. S. (1988). Treating the self: Elements of clinical self-psychology. New York: The Guilford Press.

Wolf, Z. Robinson (1988). Nurses' work, the sacred and the profane. Philadelphia: University of Pennsylvania Press.

Wolgast, E. (1992). Ethics of an artificial person: Lost responsibility in professions and organizations. Stanford: Stanford University Press.

Wrye, H. and Churilla, J. (1979). Looking forward, looking backward: Reminiscence and the life review. Frontiers, 2(2), 79-84.

Yarling, R. and McElmurry, B. (1986). The moral foundation of nursing. Advances in Nursing Science, 8(2), 63-73.

Yearley, L. H. (1990). Mencius and Aquinas: Theories of virtue and conceptions of courage. Albany, New York: SUNY Press.

Zablow, R. (1984). Preparing students for the moral dimension of professional practice: A protocol for nurse educators. (Doctoral Dissertation, Teachers College, Columbia University). Dissertation Abstracts International, 45, 2501B.

Zaner, R. M. (1988). Ethics and the clinical encounter. Englewood Cliffs, New Jersey: Prentice Hall.

Zaner, R. M. (1989). Failed or ongoing dialogues? Dax's Case. In L. D. Kliever (Ed.), Dax's case: Essays in medical ethics and human meaning (pp. 43-62). Dallas: Southern Methodist University Press.

Zerwekh, J. V. (1991, October). True detectives: Tales from public health nursing. American Journal of Nursing, 30-36.