THE UNIVERSITY OF CALGARY

Ethical Interpretation in Ethical Conflict

by

Lorraine B. Hardingham

A THESIS

SUBMITTED TO THE FACULTY OF GRADUATE STUDIES

IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE

DEGREE OF MASTER OF ARTS

DEPARTMENT OF PHILOSOPHY

CALGARY, ALBERTA

APRIL, 1994

ISBN 0-315-93908-7

Canada

Name Lorraine B. Hardingham

Dissertation Abstracts International is arranged by broad, general subject categories. Please select the one subject which most nearly describes the content of your dissertation. Enter the corresponding four-digit code in the spaces provided.

Philosophy — SUBJECT TERM

0422 — SUBJECT CODE

U·M·I

Subject Categories

THE HUMANITIES AND SOCIAL SCIENCES

COMMUNICATIONS AND THE ARTS
- Architecture 0729
- Art History 0377
- Cinema 0900
- Dance 0378
- Fine Arts 0357
- Information Science 0723
- Journalism 0391
- Library Science 0399
- Mass Communications 0708
- Music 0413
- Speech Communication 0459
- Theater 0465

EDUCATION
- General 0515
- Administration 0514
- Adult and Continuing 0516
- Agricultural 0517
- Art 0273
- Bilingual and Multicultural 0282
- Business 0688
- Community College 0275
- Curriculum and Instruction 0727
- Early Childhood 0518
- Elementary 0524
- Finance 0277
- Guidance and Counseling 0519
- Health 0680
- Higher 0745
- History of 0520
- Home Economics 0278
- Industrial 0521
- Language and Literature 0279
- Mathematics 0280
- Music 0522
- Philosophy of 0998
- Physical 0523
- Psychology 0525
- Reading 0535
- Religious 0527
- Sciences 0714
- Secondary 0533
- Social Sciences 0534
- Sociology of 0340
- Special 0529
- Teacher Training 0530
- Technology 0710
- Tests and Measurements 0288
- Vocational 0747

LANGUAGE, LITERATURE AND LINGUISTICS
- Language
  - General 0679
  - Ancient 0289
  - Linguistics 0290
  - Modern 0291
- Literature
  - General 0401
  - Classical 0294
  - Comparative 0295
  - Medieval 0297
  - Modern 0298
  - African 0316
  - American 0591
  - Asian 0305
  - Canadian (English) 0352
  - Canadian (French) 0355
  - English 0593
  - Germanic 0311
  - Latin American 0312
  - Middle Eastern 0315
  - Romance 0313
  - Slavic and East European 0314

PHILOSOPHY, RELIGION AND THEOLOGY
- Philosophy 0422
- Religion
  - General 0318
  - Biblical Studies 0321
  - Clergy 0319
  - History of 0320
  - Philosophy of 0322
- Theology 0469

SOCIAL SCIENCES
- American Studies 0323
- Anthropology
  - Archaeology 0324
  - Cultural 0326
  - Physical 0327
- Business Administration
  - General 0310
  - Accounting 0272
  - Banking 0770
  - Management 0454
  - Marketing 0338
- Canadian Studies 0385
- Economics
  - General 0501
  - Agricultural 0503
  - Commerce-Business 0505
  - Finance 0508
  - History 0509
  - Labor 0510
  - Theory 0511
- Folklore 0358
- Geography 0366
- Gerontology 0351
- History
  - General 0578
  - Ancient 0579
  - Medieval 0581
  - Modern 0582
  - Black 0328
  - African 0331
  - Asia, Australia and Oceania 0332
  - Canadian 0334
  - European 0335
  - Latin American 0336
  - Middle Eastern 0333
  - United States 0337
- History of Science 0585
- Law 0398
- Political Science
  - General 0615
  - International Law and Relations 0616
  - Public Administration 0617
- Recreation 0814
- Social Work 0452
- Sociology
  - General 0626
  - Criminology and Penology 0627
  - Demography 0938
  - Ethnic and Racial Studies 0631
  - Individual and Family Studies 0628
  - Industrial and Labor Relations 0629
  - Public and Social Welfare 0630
  - Social Structure and Development 0700
  - Theory and Methods 0344
- Transportation 0709
- Urban and Regional Planning 0999
- Women's Studies 0453

THE SCIENCES AND ENGINEERING

BIOLOGICAL SCIENCES
- Agriculture
  - General 0473
  - Agronomy 0285
  - Animal Culture and Nutrition 0475
  - Animal Pathology 0476
  - Food Science and Technology 0359
  - Forestry and Wildlife 0478
  - Plant Culture 0479
  - Plant Pathology 0480
  - Plant Physiology 0817
  - Range Management 0777
  - Wood Technology 0746
- Biology
  - General 0306
  - Anatomy 0287
  - Biostatistics 0308
  - Botany 0309
  - Cell 0379
  - Ecology 0329
  - Entomology 0353
  - Genetics 0369
  - Limnology 0793
  - Microbiology 0410
  - Molecular 0307
  - Neuroscience 0317
  - Oceanography 0416
  - Physiology 0433
  - Radiation 0821
  - Veterinary Science 0778
  - Zoology 0472
- Biophysics
  - General 0786
  - Medical 0760

EARTH SCIENCES
- Biogeochemistry 0425
- Geochemistry 0996
- Geodesy 0370
- Geology 0372
- Geophysics 0373
- Hydrology 0388
- Mineralogy 0411
- Paleobotany 0345
- Paleoecology 0426
- Paleontology 0418
- Paleozoology 0985
- Palynology 0427
- Physical Geography 0368
- Physical Oceanography 0415

HEALTH AND ENVIRONMENTAL SCIENCES
- Environmental Sciences 0768
- Health Sciences
  - General 0566
  - Audiology 0300
  - Chemotherapy 0992
  - Dentistry 0567
  - Education 0350
  - Hospital Management 0769
  - Human Development 0758
  - Immunology 0982
  - Medicine and Surgery 0564
  - Mental Health 0347
  - Nursing 0569
  - Nutrition 0570
  - Obstetrics and Gynecology 0380
  - Occupational Health and Therapy 0354
  - Ophthalmology 0381
  - Pathology 0571
  - Pharmacology 0419
  - Pharmacy 0572
  - Physical Therapy 0382
  - Public Health 0573
  - Radiology 0574
  - Recreation 0575
  - Speech Pathology 0460
  - Toxicology 0383
- Home Economics 0386

PHYSICAL SCIENCES

Pure Sciences
- Chemistry
  - General 0485
  - Agricultural 0749
  - Analytical 0486
  - Biochemistry 0487
  - Inorganic 0488
  - Nuclear 0738
  - Organic 0490
  - Pharmaceutical 0491
  - Physical 0494
  - Polymer 0495
  - Radiation 0754
- Mathematics 0405
- Physics
  - General 0605
  - Acoustics 0986
  - Astronomy and Astrophysics 0606
  - Atmospheric Science 0608
  - Atomic 0748
  - Electronics and Electricity 0607
  - Elementary Particles and High Energy 0798
  - Fluid and Plasma 0759
  - Molecular 0609
  - Nuclear 0610
  - Optics 0752
  - Radiation 0756
  - Solid State 0611
- Statistics 0463

Applied Sciences
- Applied Mechanics 0346
- Computer Science 0984
- Engineering
  - General 0537
  - Aerospace 0538
  - Agricultural 0539
  - Automotive 0540
  - Biomedical 0541
  - Chemical 0542
  - Civil 0543
  - Electronics and Electrical 0544
  - Heat and Thermodynamics 0348
  - Hydraulic 0545
  - Industrial 0546
  - Marine 0547
  - Materials Science 0794
  - Mechanical 0548
  - Metallurgy 0743
  - Mining 0551
  - Nuclear 0552
  - Packaging 0549
  - Petroleum 0765
  - Sanitary and Municipal 0554
  - System Science 0790
- Geotechnology 0428
- Operations Research 0796
- Plastics Technology 0795
- Textile Technology 0994

PSYCHOLOGY
- General 0621
- Behavioral 0384
- Clinical 0622
- Developmental 0620
- Experimental 0623
- Industrial 0624
- Personality 0625
- Physiological 0989
- Psychobiology 0349
- Psychometrics 0632
- Social 0451

Nom _____

Dissertation Abstracts International est organisé en catégories de sujets. Veuillez s.v.p. choisir le sujet qui décrit le mieux votre thèse et inscrivez le code numérique approprié dans l'espace réservé ci-dessous.

SUJET

CODE DE SUJET

U·M·I

Catégories par sujets

HUMANITÉS ET SCIENCES SOCIALES

COMMUNICATIONS ET LES ARTS

Architecture 0729
Beaux-arts 0357
Bibliothéconomie 0399
Cinéma 0900
Communication verbale 0459
Communications 0708
Danse 0378
Histoire de l'art 0377
Journalisme 0391
Musique 0413
Sciences de l'information 0723
Théâtre 0465

ÉDUCATION

Généralités 515
Administration 0514
Art 0273
Collèges communautaires 0275
Commerce 0688
Économie domestique 0278
Éducation permanente 0516
Éducation préscolaire 0518
Éducation sanitaire 0680
Enseignement agricole 0517
Enseignement bilingue et multiculturel 0282
Enseignement industriel 0521
Enseignement primaire 0524
Enseignement professionnel 0747
Enseignement religieux 0527
Enseignement secondaire 0533
Enseignement spécial 0529
Enseignement supérieur 0745
Évaluation 0288
Finances 0277
Formation des enseignants 0530
Histoire de l'éducation 0520
Langues et littérature 0279
Lecture 0535
Mathématiques 0280
Musique 0522
Orientation et consultation 0519
Philosophie de l'éducation 0998
Physique 0523
Programmes d'études et enseignement 0727
Psychologie 0525
Sciences 0714
Sciences sociales 0534
Sociologie de l'éducation 0340
Technologie 0710

LANGUE, LITTÉRATURE ET LINGUISTIQUE

Langues
- Généralités 0679
- Anciennes 0289
- Linguistique 0290
- Modernes 0291

Littérature
- Généralités 0401
- Anciennes 0294
- Comparée 0295
- Médiévale 0297
- Moderne 0298
- Africaine 0316
- Américaine 0591
- Anglaise 0593
- Asiatique 0305
- Canadienne (Anglaise) 0352
- Canadienne (Française) 0355
- Germanique 0311
- Latino-américaine 0312
- Moyen-orientale 0315
- Romane 0313
- Slave et est-européenne 0314

PHILOSOPHIE, RELIGION ET THÉOLOGIE

Philosophie 0422
Religion
- Généralités 0318
- Clergé 0319
- Études bibliques 0321
- Histoire des religions 0320
- Philosophie de la religion 0322

Théologie 0469

SCIENCES SOCIALES

Anthropologie
- Archéologie 0324
- Culturelle 0326
- Physique 0327

Droit 0398
Économie
- Généralités 0501
- Commerce-Affaires 0505
- Économie agricole 0503
- Économie du travail 0510
- Finances 0508
- Histoire 0509
- Théorie 0511

Études américaines 0323
Études canadiennes 0385
Études féministes 0453
Folklore 0358
Géographie 0366
Gérontologie 0351
Gestion des affaires
- Généralités 0310
- Administration 0454
- Banques 0770
- Comptabilité 0272
- Marketing 0338

Histoire
- Histoire générale 0578
- Ancienne 0579
- Médiévale 0581
- Moderne 0582
- Histoire des noirs 0328
- Africaine 0331
- Canadienne 0334
- États-Unis 0337
- Européenne 0335
- Moyen-orientale 0333
- Latino-américaine 0336
- Asie, Australie et Océanie 0332

Histoire des sciences 0585
Loisirs 0814
Planification urbaine et régionale 0999
Science politique
- Généralités 0615
- Administration publique 0617
- Droit et relations internationales 0616

Sociologie
- Généralités 0626
- Aide et bien-être social 0630
- Criminologie et établissements pénitentiaires 0627
- Démographie 0938
- Études de l'individu et de la famille 0628
- Études des relations interethniques et des relations raciales 0631
- Structure et développement social 0700
- Théorie et méthodes 0344
- Travail et relations industrielles 0629

Transports 0709
Travail social 0452

SCIENCES ET INGÉNIERIE

SCIENCES BIOLOGIQUES

Agriculture
- Généralités 0473
- Agronomie 0285
- Alimentation et technologie alimentaire 0359
- Culture 0479
- Élevage et alimentation 0475
- Exploitation des pâturages 0777
- Pathologie animale 0476
- Pathologie végétale 0480
- Physiologie végétale 0817
- Sylviculture et faune 0478
- Technologie du bois 0746

Biologie
- Généralités 0306
- Anatomie 0287
- Biologie (Statistiques) 0308
- Biologie moléculaire 0307
- Botanique 0309
- Cellule 0379
- Écologie 0329
- Entomologie 0353
- Génétique 0369
- Limnologie 0793
- Microbiologie 0410
- Neurologie 0317
- Océanographie 0416
- Physiologie 0433
- Radiation 0821
- Science vétérinaire 0778
- Zoologie 0472

Biophysique
- Généralités 0786
- Medicale 0760

SCIENCES DE LA TERRE

Biogéochimie 0425
Géochimie 0996
Géodésie 0370
Géographie physique 0368
Géologie 0372
Géophysique 0373
Hydrologie 0388
Minéralogie 0411
Océanographie physique 0415
Paléobotanique 0345
Paléoécologie 0426
Paléontologie 0418
Paléozoologie 0985
Palynologie 0427

SCIENCES DE LA SANTÉ ET DE L'ENVIRONNEMENT

Économie domestique 0386
Sciences de l'environnement 0768
Sciences de la santé
- Généralités 0566
- Administration des hôpitaux 0769
- Alimentation et nutrition 0570
- Audiologie 0300
- Chimiothérapie 0992
- Dentisterie 0567
- Développement humain 0758
- Enseignement 0350
- Immunologie 0982
- Loisirs 0575
- Médecine du travail et thérapie 0354
- Médecine et chirurgie 0564
- Obstétrique et gynécologie 0380
- Ophtalmologie 0381
- Orthophonie 0460
- Pathologie 0571
- Pharmacie 0572
- Pharmacologie 0419
- Physiothérapie 0382
- Radiologie 0574
- Santé mentale 0347
- Santé publique 0573
- Soins infirmiers 0569
- Toxicologie 0383

SCIENCES PHYSIQUES

Sciences Pures

Chimie
- Généralités 0485
- Biochimie 487
- Chimie agricole 0749
- Chimie analytique 0486
- Chimie minérale 0488
- Chimie nucléaire 0738
- Chimie organique 0490
- Chimie pharmaceutique 0491
- Physique 0494
- PolymÇres 0495
- Radiation 0754

Mathématiques 0405
Physique
- Généralités 0605
- Acoustique 0986
- Astronomie et astrophysique 0606
- Electronique et électricité 0607
- Fluides et plasma 0759
- Météorologie 0608
- Optique 0752
- Particules (Physique nucléaire) 0798
- Physique atomique 0748
- Physique de l'état solide 0611
- Physique moléculaire 0609
- Physique nucléaire 0610
- Radiation 0756

Statistiques 0463

Sciences Appliqués Et Technologie

Informatique 0984
Ingénierie
- Généralités 0537
- Agricole 0539
- Automobile 0540
- Biomédicale 0541
- Chaleur et thermodynamique 0348
- Conditionnement (Emballage) 0549
- Génie aérospatial 0538
- Génie chimique 0542
- Génie civil 0543
- Génie électronique et électrique 0544
- Génie industriel 0546
- Génie mécanique 0548
- Génie nucléaire 0552
- Ingénierie des systèmes 0790
- Mécanique navale 0547
- Métallurgie 0743
- Science des matériaux 0794
- Technique du pétrole 0765
- Technique minière 0551
- Techniques sanitaires et municipales 0554
- Technologie hydraulique 0545

Mécanique appliquée 0346
Géotechnologie 0428
Matières plastiques (Technologie) 0795
Recherche opérationnelle 0796
Textiles et tissus (Technologie) 0794

PSYCHOLOGIE

Généralités 0621
Personnalité 0625
Psychobiologie 0349
Psychologie clinique 0622
Psychologie du comportement 0384
Psychologie du développement 0620
Psychologie expérimentale 0623
Psychologie industrielle 0624
Psychologie physiologique 0989
Psychologie sociale 0451
Psychométrie 0632

THE UNIVERSITY OF CALGARY

FACULTY OF GRADUATE STUDIES

The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies for acceptance, a thesis entitled "Ethical Interpretation in Ethical Conflict" submitted by Lorraine B. Hardingham in partial fulfillment of the requirements for the degree of Master of Arts.

John A Baker

Supervisor, John A. Baker, Department of Philosophy

Brenda M Baker

Brenda M. Baker, Head,Department of Philosophy

Janet G Storch

Janet Storch, Dean, Faculty of Nursing

Michael M. Burgess, Faculty of Medicine

April 22, 1994

Date

ABSTRACT

In this thesis, I examine how the concept of interpretation complicates ethical decision making in the health care setting, and contributes to conflict among professionals and between professionals and their clients, looking especially at the roles of physicians and nurses.

I argue that the various parties at the conference tables or at the bedside are engaging in a kind of reasoning that cannot be merely described as arguing about what ought or ought not to be done: what is happening is that the various parties have different views on *this* question because they *interpret* their goals, principles and values, their laws, codes and practices, differently. I explore the nature of the conflicts that arise out of or because of differences in the ways in which the participants interpret the goals, responsibilities, duties of, and the constraints on, their profession. I also address the more radical problem that interpretations can be not only of goals, laws, codes, etc. but also interpretations of situations. I look at those questions which cluster around the resolution of conflicts of these kinds and particularly in the question of how such conflicts can be resolved in ethically acceptable ways, and, if not, then in morally acceptable ways.

ACKNOWLEDGEMENTS

I would like to thank the following people:

John A. Baker for his talent at "discomforting the comfortable", and for his ability to make the discomfort worthwhile.

Maggie Kohl for being there.

Wendy Chrystal for a second home, cups of tea, and glasses of wine when I needed them.

The graduate students in the Department of Philosophy for their friendship and encouragement.

And all my nursing colleagues, whose dedication, enthusiasm, and shared stories have inspired me to continue my work in ethics.

DEDICATION

To James and Andrew, for their love, their self-reliance, and their willingness to take one day at a time.

TABLE OF CONTENTS

CHAPTER I: INTRODUCTION

1.1 THE INTERPRETATION PROBLEM: EXAMPLES

Example I

In an Intensive Care Unit (ICU) the health care team is holding a patient care conference. Around the table sit the patient's wife, son, family physician, the medical director of the ICU, the ICU resident, the nursing supervisor, the respiratory therapist, the ICU social worker, the pastoral care director, and the patient's primary nurse. The patient, Mr. White, is a 65-year old man who suffered a stroke one day following coronary artery bypass surgery one month previously. He has been on a ventilator since the surgery, and several unsuccessful attempts have been made to wean him from the ventilator. Mr. White has periods of consciousness, during which he indicates to the nurse that he wants to die. Mr. White has frequently attempted to pull out his tubes and lines; his hands are tied to the bed rails continuously to prevent him from doing so. Participants in the conference are discussing "code status" - whether or not Mr. White should be resuscitated should his heart stop beating.

Mr. White has suffered two cardiac arrests, and has been resuscitated each time. His prospects of discharge to his home are minimal, and the physicians are unsure when, if ever, he will be able to breath on his own without a ventilator. Mr. White's wife and son want "everything done"; the family physician supports the family, although admitting that he has had discussions with Mr. White about his patient's wishes that his life not be prolonged should he become incapacitated, but Mr. White did not find the time to document his wishes in a living will. The ICU director

(a physician) feels that this patient can possibly be weaned off the ventilator, and transferred to a regular nursing unit, although chances of him requiring long-term care are high. The ICU resident, who was in charge during the previous resuscitations, is in favour of writing a Do Not Resuscitate Order (DNR). She has talked to the patient and is aware that he wants to die. The patient's primary nurse and most other staff nurses in the ICU who have cared for Mr. White feel that the patient's wishes should be respected, and are requesting a DNR order to be written. The social worker, pastoral care director and the nursing unit supervisor disagree with the primary nurse, and support the family's wishes to continue with aggressive treatment for Mr. White.

Example II

Mrs. Edwards, an 87-year-old widow, is terminally ill with cancer and has metastases to her liver. She has a liver abscess which is collecting fluid. Mrs. Edwards is under palliative care, meaning that efforts to cure her are discontinued, and the focus is now on keeping her comfortable and as pain-free as possible and treating any complications that impede that goal. She appears to be comfortable and has told the nurses that she is not in any pain. She is very ill and it is obvious to all that she will die soon, probably within days. Mrs. Edwards drifts in and out of consciousness, but is lucid enough at times to recognize and speak with her family.

The surgeon is concerned about the fluid collecting in her liver, and recommends placing a tube under fluoroscopy into the abscess to drain it. This procedure is done by a radiologist in the X-ray department with a local anaesthetic injected into the skin, and no sedation. The nurses on the unit are concerned about

sending this patient for the procedure, as past patients have come back with reports of experiencing severe pain during the procedure.

The surgeon tells the family that Mrs. Edwards is probably uncomfortable because of the abscess, and that she would like to put in a drain to take some of the fluid off. She bases this recommendation on the fact that most patients with liver abscesses are uncomfortable. She tells the family that Mrs. Edwards will come back with a drain in place attached to a small container to collect the fluid, and that the procedure "will not bother her". The patient's family consents to the procedure; they tell the patient, "This is what you need, Mom" and Mrs. Edwards nods her head.

Mrs. Edwards returns from having the procedure done, and the nurse reports her as being "wild-eyed". Taking her hand and bending over Mrs. Edward's ear, the nurse asks, "Are you all right?" Mrs. Edwards replies, "I screamed and I screamed, it was the worst pain I've ever had". Mrs. Edwards lives another 30 hours, then dies.

The nurses on the unit feel that the procedure was unnecessary and they were aware that it was painful from reports by other patients. The nurses believed that Mrs. Edwards had been comfortable before the procedure, and viewed the decision to do the procedure as not a question of pain, cure, or therapeutics. The surgeon was aware that the patient had been comfortable before the procedure. However, the surgeon was someone that nurses "could not question. We have a couple of surgeons who don't even answer you sometimes if you ask a question". Several nurses directed questions to the family: "You have agreed to have this done?" "Why do you think this might be useful?", hoping to encourage the family to question the need for the procedure. The

family, however, never did.

Mrs. Edwards' nurse now says, "It's hard on us, after really working to keep someone comfortable, when the medical side reverses all our work. It is devastating that the relationship that we worked hard to establish with the patient has been profoundly changed. We certainly go on caring, but some level of trust in the relationship has been lost." The nurses felt that though the patient was in a little pain when she died, the emotional trauma was severe and unnecessary.[1]

Discussion of the Two Examples

Conflicts between patients, their families, physicians, surgeons, nurses and other professionals in the health care setting can arise from many sources. They can arise from personality clashes, from tiredness, from frustration, from fear. In this dissertation I want to concentrate on one cluster of sources for such conflict, sources which are radically different from the above. At a first approximation, I am interested in the fact that conflicts in such situations can also arise because the various people in a health care situation approach the situation from different "perspectives", with different views about the situation, with different principles, rules, and values guiding them, and so on. I am also interested in the idea that at least some of the conflict can be or should be resolved in some sense or other (and one of the aims of this dissertation is to try to spell out in some detail what is intelligible here by way of "resolution") by addressing the fact of *these* differences. Let me use the examples to introduce some of the ideas I want to examine.

---

[1]Both cases are based on real situations, but I have used pseudonyms.

In the first situation, we see what appear to be different values causing conflict between the various members of the health care team, the patient, and his family. Each individual brings a different perspective to the kind of care that should be given. I am using the term "perspective" here as it is habitually used, that is, I am assuming some "intuitive account"[2] of its meaning. As the discussion progresses I will dig deeper into the question of what constitutes and forms a "perspective" and when that happens the term will disappear from the discussion having been replaced by the various components which I will identify in my analysis. At this point, though, I will say that the family has one perspective, the patient another, and this is a result of being in different situations, the one ill, the others facing the illness of a loved one. The health care professionals, who have the responsibility of recommending the best course to follow, have others. The reasons for the different perspectives are clear enough, given the different roles and emotional investments in the case. Physicians, perhaps with the Canadian Medical Association (CMA) Code of Ethics in mind, want to do good and avoid harm. The nurses also want to do good and avoid harm, but have a different point of view that comes from being at the patient's bedside on a 24-hour basis and from being the ones who most frequently carry out the treatments and procedures. The nurses also want to support the patient's wishes and the patient's family. The social worker is attempting to help the patient and family members cope with the social,

---

[2] As Quine very usefully says in the footnote to page 36 of *Word and Object*, "By an intuitive account I mean one in which terms are used in habitual ways, without reflecting on how they might be defined or what presuppositions they might conceal." I will use the phrase in that sense.

psychological and financial costs of the illness. But what are we to make of the conflicts between members of the health care team, say between the nurse and the physician, or between the social worker and the primary nurse? Are the values and goals of each of the health care professions so distinctly different that conflict inevitably occurs when an ethical situation arises? How is a decision to be made when the various members of the health care team feel strongly about their opposing positions on how to treat the same patient?

In addition to the conflict between members of different professions, what are we to make of the different views of members of the *same* profession, for example, different views between two nurses or between two physicians? Does this mean that members of the *same* profession have different values, goals, and beliefs?

The second situation is more complex. What are we to make of the different views of what the situation is? The physicians in example II see a patient with an abscessed liver, which they feel is causing a *problem* requiring intervention. The question for them is whether the problem is discomfort or that there is an abscess. The nurses see no problem here; for them there is no problem[3] if there is no pain or discomfort, given the rest of the patient's situation. The family sees a loved one who is gravely ill, and a surgeon who is recommending a particular treatment. In other words, the conditions for the very existence of something to be counted as a problem

---

[3]They of course recognize that the liver is not functioning the way it should. This in a way is a problem, but it is not a problem that they (a) can do anything about (except inform the surgeon if she did not already know) because, first, it is outside their competence, and second, it is not within their role - they are concerned with comfort, pain, etc., and (b) it is not a problem which they think *anything* should be done about.

will vary with the profession or perspective. These different ways of interpreting the situation, of seeing it as a matter of finding the right medical treatment for the situation or as an ethical issue where a decision needs to be made as to whether any treatment at all is appropriate, can enmesh the participants in a web of miscommunication and conflict.

The different "perspectives"[4] brought by different parties to decision making in health care situations may provide a fuller picture of the situation, and possibly enable richer decisions to be made for each case. This has been recognized as a benefit in the team approach; we can see the merit of having many different professions working together on a team to benefit the patient. But do these various professionals have the same goal? We might say yes; that goal is to benefit the patient, to bring him or her to the highest possible state of health, or a peaceful death if that is inevitable, or to repair damage, ease pain or discomfort, or make the best of a bad situation through use of prosthetics, medication and/or loving comfort. One could also argue that the principles and values underlying decisions, such as respect for autonomy, the value of preserving life, and the importance of easing suffering, pain or discomfort, are similar. Perhaps the differences might be in the actual tasks needed to meet the obligations derived from these principles, for example, the physicians to order medications and procedures, and the nurses to administer nursing care to make the patient comfortable and to assess ongoing status.

However, although some conflict between professions may be explained in this

---

[4] See footnote 2 above.

way, it does not account for conflict between members of the same profession. For example, when ethical problems arise, nurses often disagree with each other or physicians disagree with each other on how to resolve issues. Does this mean that there are no common values, beliefs and goals among the members of a single profession? Is frequent conflict inevitable, not only interprofessionally, but among members of the same profession?

One of the theses in this dissertation will be that in health care situations conflicts frequently arise, and they arise not always out of differences in the goals, principles, and values of the various professions, but also

> (a) out of differences in interpretations of these goals, principles and values, these differences often reflecting
>
> (b) differences in the laws, codes and practices which are the articulations of and bases for them, and
>
> (c) differences in the interpretations of these laws, codes and practices.

Conflict, I will also argue, arises out of different interpretations of what the situation actually is. In the next section, I will give a preliminary analysis of the concept of interpretation.

1.2 INTERPRETATION

The ordinary uses of the word "interpret" are several. In one sense it means "to *explain* what is not immediately plain or explicit, to explain actions, events or statements by pointing out or suggesting inner relationships or motives or by relating particulars to general principles". It also means "to translate into familiar or intelligible language", and "to understand and appreciate in the light of individual belief,

judgment, interest, or circumstance".

I will use the term "interpretation" as follows:

To interpret the statement of a principle, rule or value is:

(a) to spell out, make explicit, how exactly that principle, rule or value is to be taken to apply in a particular situation, that is, it will spell out exactly which action is forbidden, permitted, or required in the situation in which the principle, rule or value is being applied

and/or

(b) to spell out, or make explicit exactly why that act is required, permitted or forbidden.

Putting the ideas here together with my comments earlier about what is happening in conflict situations, I can now say what I will be arguing in this dissertation. I will be arguing that the various parties at the conference tables or at the bedside (for example, in my two case situations), are engaging in a kind of reasoning that cannot be merely described as arguing about what ought or ought not to be done: what is happening is that the various parties have different views on *this* question in part at least because they *interpret* their goals, principles and values, their laws, codes and practices, differently, and these different interpretations can differ both extensionally and intensionally. I will argue that there is more to the situation than this, but there is at least this much. I will also, of course, address the question of what is involved in deciding on an interpretation of a principle, rule or value, of a law, a code or a practice (at least as far as these notions work in the medical context).

One story about how to identify the *correct* or an *acceptable* interpretation (both phrases are of course contentious) of a written principle or regulation is to check

the intentions of the legislating body or the members who wrote the original statement. I will argue that this is the place to start, but that the story cannot end here, because once a statement or principle is adopted it acquires a life of its own and its meaning becomes as the professionals using it interpret it. Another reason is that there may of course be moral questions about the intentions of the legislating body and hence about the interpretations which follow from these interpretations. So, the intentions of the legislator will turn out to be neither necessary nor sufficient for the fixing of what can serve as an acceptable interpretation.

I will argue more specifically that there are different ways of going about the project of fixing on an interpretation of a principle, rule, value, law, code or practice. I will argue that what is happening is a complex mixture of looking on the one hand at what has been said before, and on the other hand of creating something for use in the future. In other words, on the question of whether interpretations are there to be *discovered* (in the intentions of the person or body which formulated the principles, etc., or in the words which they picked to articulate the principle, etc.) or something to be *created* (no doubt as a way of solving a problem), the right view, I will argue, is a mix of the two views. Correspondingly, I will suggest that interpretations can be unimaginative, or too far from what was said, or an inventive and intelligible reading of what was said, clever or stupid, practically wise, or self-defeating, and so on.

Something like the above is the view I will suggest and illustrate.[5] To fix ideas

---

[5]These pictures of the activity of constructing and identifying a correct or acceptable interrpetation were suggested by J.A. Baker during our discussions on this topic.

let me expound on the kinds of picture which *might* be thought to fit the activity of constructing an interpretation. These pictures will serve to throw into relief the image I am suggesting.

The first is the "Platonic Picture": if the principle or value is not flawed (for example, by being vague or ambiguous), then the interpretation is there in the wording, and one must work to "see it".

The second is a kind of modified Platonic picture, what I will call the "Choice Picture": leaving aside vagueness and ambiguity, there is still more than one interpretation of many, if not all, principles and you just choose which one to use with (or perhaps without) good reasons for the choice. I will of course be interested in the reasons which might be given for, and the procedures which might be followed in making a choice of this kind.

The third picture is the "Creative Picture": the interpretation is not there to be discovered, but you actually develop a new a way of dealing with the situations that can arise.

The "Creative Picture" suggests that it would be a mistake to imply that the problem of interpretation is always a matter of figuring out what is already there before you start doing the interpreting. Instead, interpretation might be like a creative activity, where a solution is created, then checked against the principles or values to see if it is appropriate. Or, alternatively the aim of the health care team is a negotiated solution constructed with the aims of the component members of the team in mind, but neither a construct out of them, nor identical to any one of them. That is, in the

separate aims and goals of each individual member one does not expect to *discover* the aims of the team. Rather, a set of aims is *constructed* in the light of the stated aims of the people making up the team. An assumption here may be that each member has his or her own agenda, but recognizes that working with a team is the best way of meeting it. For example, the aim of the physician may be to have a healthy community, while the aim of the nurse is to have cared-for patients. What could be adopted as the aim of the health care team is respect for the autonomy of the patient, in which the patient's conception of her own well-being is sought. The aim of the health care team here might be to secure the well-being of the patient, of which "well-being" is made up partly of health and partly of being cared-for.

In the Platonic and Choice pictures, we take what might be viewed as a "top-down" approach - one starts from what is to be interpreted and by examining that comes up with a story of how it is to be applied and why. In the Creative approach one might take a partially "bottom-up" approach. On this partially bottom up approach one does not limit oneself to the principles, etc. themselves, one also addresses the task of interpreting them by looking at that to which they are to be applied, those for whom they are to be applied, and so on. For example, on the latter approach one can imagine *developing* an interpretation in a situation in varying ways[6], for example, by negotiation between the several people involved by various less explicit procedures similar in logic to the procedures by which two rowers come to row in unison without *saying* a word or even without *signalling* anything. I will later examine the kinds of

---

[6] I will later identify and examine several.

constraints there might be on such "negotiations" or "coordination" activities[7] and their ethical structure. I will also comment on their respective ethical, moral, and practical merits and otherwise.

In order to make sense of all of this I will need two notions which it would be useful to explicate here briefly, the notions of role and profession.

1.3 TWO NOTIONS: PROFESSIONS AND ROLES

The term "professional" is used in common parlance to cover many kinds of roles, many kinds of jobs, everything from lawyer, nurse and physician to plumber, carpenter and store clerk. I will be using the term in a narrower sense to cover roles of which the following conditions are true:

> 1. Extensive training and/or education is necessary before one can practice a profession.
>
> 2. This training involves a significant intellectual component.
>
> 3. This ability received through the training/education is an important service to society.[8]

In addition, in the narrower sense that I will be using the term, the following conditions are of importance:

> 4. The roles are ones that society, acting through its government, has so designated as professions by instituting an act of the legislative assembly or order in council, or which, although the government has not yet so designated, there are good arguments for saying that they should do so.
>
> 5. That society, still acting through its government, has so designated for the

---

[7] For example, constraints derived from the varying aims of the people involved.

[8] These first three are the necessary features of professions which have been given by most authors, and which mark them from other roles. See Bayles, 1988.

reason that such designation is needed to secure some great social good or to avoid some great social ill - which I will henceforth refer to as the *goals* or *purposes* of the profession.

6. These goals are only accessible if membership in the profession is limited to people with certain specialized knowledge, skills, and experience obtainable only (or best) by some accredited training program, whether it is in an institution of higher education or in a structured work setting.

By using the above ideas, I can "define" a role as a professional by a procedure which fits the following pattern: To define a role is to identify:

(a) a list of goals or purposes which people occupying this profession are to serve,

(b) a list of responsibilities and duties which are instrumental in relation to those goals,

(c) a list (at least in schematic form) of skills, abilities, bodies of knowledge which are needed if the people acting to secure these goals in accordance with these responsibilities and duties are to do so,

(d) a list of constraints on activities in pursuit of those goals and in accordance with these responsibilities and duties, these constraints articulating the parameters within which the profession will function.

For example, in the case of the health care professions, one of these constraints is that they will respect certain rights of their clients, most notably the right to refuse treatment. These goals, duties, and constraints are usually in the first instance codified in sets of simple rules, but over time the professional association, which typically serves as a disciplinary body for the members of the profession, amplifies these rules, and moreover also over time various less formalized rules come to be adopted in the profession as a whole, these rules further amplifying what is viewed as appropriate behaviour. I will refer to these as the "laws, codes and practices" of the profession.

The responsibilities, duties and rights of a professional role may be fixed in

one or more of the following ways:

a. by informal agreement by the parties involved

b. by formal agreement by the parties involved

c. by traditions and customs

d. by authoritative associations (with the authority to fix the responsibilities, etc.)

e. by the legal authorities.

Which of these factors fix the responsibilities duties and rights that go with a role depends on the jurisdiction in which the particular role is played. Several factors in the various jurisdictions play a part[9]:

1) the very nature of the role

2) tradition and custom

3) the legal structures of the jurisdiction concerned

and 4) sometimes some practical, efficiency considerations

or 5) some moral considerations.

Part of what is involved in understanding the moral and ethical position of people occupying such roles is the recognition that there is an implied promise or contract which the member of the profession becomes a party to when she enters the profession and/or when she enters a specific position, for example in a hospital as a member of this profession. This promise is in effect, *ceteris paribus*, until she resigns

[9] Probably a mix of all of these factors.

from the profession and/or the position in the hospital, etc.[10]

This notion of a profession is a narrower one than some but wide enough and precise enough for my purposes. I will pull the above ideas together a bit more and amplify them at a few points, but it is not my intention here to provide a theory of the professions: I simply want to do enough by way of setting up the notion to be able to use it.[11]

1.4 LAWS CODES AND PRACTICES OF A PROFESSION

If *all* the responsibilities, duties and rights of health care professionals were fixed by some legislative body, the profession would be either inflexible and rule-bound, or else too little regulated if the association kept them to a manageable level. Therefore, some sort of balance between the two must be found. The solution which has been taken by health care professionals in Canada is a mixture of at least 5 components:[12]

1. A set of principles explicitly adopted by the various professional associations specifying some of the goals, values and obligations of the profession.

2. Specific written rules, regulations and standards for the professionals to apply as guidelines for determining quality practice.

---

[10] There are complexities here which need not concern us, complexities, of course, (a) about the moral position of the presently unemployed professional, and (b) about the professional who has been dismissed from her employment for reasons other than misbehaviour.

[11] My use of the term is within the traditions of the literature, though developed and structured at several points with slightly different emphases from that literature. I am indebted to J.A. Baker's *Lectures on Biomedical Ethics*, Chapter II, for making these notions clear.

[12] Baker, 1993, Chapter II.

3. Some goals and values which are not codified which however become part of the traditions of the profession.

4. Norms and standards of appropriate practice, some of which are codified but some of which again become traditions of the profession.

5. Principles, and/or rules and/or regulations which have been imposed by the government on the various health care professions. These principles, rules and regulations are imposed as part of and a condition of the profession's recognition as a profession in the first place. (This last constraint provides a framework for the first four.)

6. Within the limits set by the above five constraints the professional is left some *discretionary authority* to decide what she views as being "for the best", but it is important that this discretionary authority is within these limits.

As I said, I will refer to the first four as the "laws, codes and practices" of the profession. These laws, codes and practices create a system of expectations of the practitioners, but it is important to notice here that it is not enough for the professionals just to follow the codes, but that there be an ongoing assessment of them as well.

1.5 MORAL BASIS FOR THE RESPONSIBILITIES, DUTIES AND RIGHTS OF HEALTH CARE PROFESSIONALS

Health care professionals, we may presume, enter their professional roles voluntarily. There are complexities here which I cannot go into, complexities from questions about the extent to which people needing a job can be said voluntarily to take on that job.[13] In accepting the role, the health care professional accepts, *ceteris paribus*, all of the responsibilities, duties, and rights that are set out in the laws, codes and practices of the profession. Thus, if the professional is required to do x by the

---

[13]Zimmerman, 1981.

laws, codes, and practices of her profession, ethically she ought to do x.[14] The duty to do x derives from the past voluntary act of taking on the role and the fact that the professional association has laid down the "rules" which specify what the duties, obligations and responsibilities of that role are to be, and in these rules, there is one rule which assigns these duties. In order to practice ethically, therefore, the health care professional must know what the relevant rules and standards of the profession are.

Notice that on the above account to say that what it is *ethical* to do is different from saying what it is *moral* to do. In this sense, "moral" is an evaluative term, referring to right conduct, to distinguishing between right and wrong. My usage here is perhaps a little artificial, and certainly this usage makes the term "ethical" semi-technical in my dissertation, but the gains in clarity are worth it. Many will continue to use the term "ethical" as an evaluative term. That is, when one says that something is ethically required one expresses approval or disapproval. But this approval or disapproval will now clearly come from the fact that since the person thinks that there is a *prima facie* duty to do what one has promised or contracted to do she will not unreasonably approve of ethical action - that is, from her approval of promise keeping. There is another source of the evaluative force of the term "ethical" even in this semi-technical sense. That is that in many laws, codes and practices there are clauses excusing health care professionals from a duty if it is contrary to conscience or religious beliefs. The result of this is that if a health care professional judges some act

---

[14] In this thesis, I use the word "ethical" in the context of professional ethics, following the suggestion of J.A. Baker. By "ethical" I mean that the behaviour is in accordance with the laws, codes, and practices of the profession.

obligatory for her then this implies that the act is not contrary to her religion or conscience.[15]

Notice, therefore, that a health care professional who acts ethically (that is, according to the laws, codes, and practices of her profession) could still be acting immorally (that is, if the laws, codes and practices of the profession were in some way immoral). This distinction points out that a professional needs to not only take into account the laws, codes and practices of her profession, but also needs to be aware that these may be morally flawed. The professional must therefore take responsibility for the laws, codes and practices; she must ask if, in the situation, what is required by the laws, codes and practices is morally what she ought to do.

This completes my digression. I now return to my examination of the notion of interpretation, free to use the semi-technical notions I have just developed. Correspondingly, it is important to be clear that when I henceforth use the terms I discussed, and especially the terms "role", "profession", "constraint" and "ethical", I will be using them in the senses I outlined above and that I will be addressing the questions I try to answer *within* this framework.[16]

1.6 RETURNING TO INTERPRETATION

One of my aims in this dissertation, then, is to investigate the nature of conflict among and between professionals and their clients. I am particularly interested in one

---

[15]See J.A. Baker, 1993, Chapter II.

[16] I do not, within this dissertation, plan to spend any time questioning the theoretical framework. That would be a task for another day.

kind of conflict - conflicts which consist in, arise out of, or arise because of differences in the ways in which the professionals concerned interpret the goals, responsibilities, duties of, and the constraints on, their profession. I will also be interested in those questions which cluster around the resolution of conflicts of these kinds and particularly in the question of how such conflicts can be resolved in ethically acceptable ways, and, if not in ethically acceptable ways, then in morally acceptable ways.

In view of these aims, I will clearly need to spend some time discussing the notion of an interpretation quite generally. I will ask four questions about interpretation:

> 1. What are we to take ourselves as talking about when we talk about interpretations in the ways which might be of interest in this dissertation?
>
> 2. How do we figure out what is a possible interpretation of a goal, a law or rule, a code, a practice, or of the sentences used to articulate such a goal, law, etc.?
>
> 3. How do we assess suggestions about interpretations of these kinds?
>
> 4. What ethically and morally and practically are we to do when we face two or more extensionally and/or intensionally non-equivalent interpretations, both (a) in the mind of one person, and (b) in two people's minds? That is, what mechanisms can we use to identify and justify an interpretation?

In the next chapter, Chapter II, I will explore some parameters that show how apparent differences in values, beliefs and goals can be demonstrated to be differences in interpretation of the laws, codes and practices in health care professions.

In Chapter III, I will look at the idea that interpretations can be not only of the kinds of thing I have discussed so far - goals, laws, codes, values - but also of

situations, as I will call them. My thesis will be that we can, though perhaps only in a metaphorical sense, talk of interpreting situations, and that different people do indeed interpret what we have reason to say is the same situation differently. I will suggest that such differing interpretations are at least to be expected, given the fact that different health care professionals belong to different professions and hence are acculturated to different laws, codes and practices. I will also suggest that different interpretations of situations can affect *how* and even *whether* ethical issues are noticed and understood.

In Chapter IV, I will give some possible solutions to the problem of interpretation.

In Chapter V, I will examine the motivation for the choice of a solution, making the moral point that, crucially, only certain types of solutions or resolutions are compatible with leaving nurses, physicians, patients and others as moral agents or autonomous agents. A related point, but much less important, is that only some solutions are going to lead to a work situation where there is less burnout, resistance, irritation, inappropriate work to rule, subversion, and other unwanted results. I will relate the concept of interpretation, as I have spelled it out, to the concepts of moral agency and autonomy for health care professionals. I will argue that without the capacity to interpret one's laws, codes, and practices, and to have that interpretation taken seriously and listened to, one cannot be autonomous in any substantial sense of the word.

In Chapter VI I will suggest some solutions to the problems of interpretation.

The literature has not pointed out the problems of interpretation; it is therefore unable to provide the resources to deal with even the simple kinds of cases where interpretation presents problems (for example, the nurse-physician, or nurse-nurse relationship). I will attempt to deal with these simple cases, but hopefully the resources I provide will make it merely a series of corollaries on how to deal with others (for example between many different professions and interests).

In a word, in this dissertation, I hope to shed some new light on an old problem, that of conflict arising among the members of the health care team in relation to ethical problems. I propose to offer a schema for an alternative way of viewing and understanding ethical problems in health care settings, providing a basis from which to move towards a more satisfying way of resolving them.

CHAPTER II: THE INTERPRETATION PROBLEM

2.1 THE ORIGINAL PROBLEM

My task in this chapter will be to narrow down the interpretation problem, to set on one side all problems which are not really interpretation problems. I will do so by looking at the problem of interpretation of the laws, codes and practices in nursing.

In 1993 I read a paper on nurses and collective responsibility to an audience of mostly nurses and other health care professionals.[1] At the end of the paper, some nurses in the audience asked how nurses are to act collectively if different nurses have different values. Some of the nurses suggested that staff nurses have different values from each other, and that staff nurses frequently have different values (and goals) from nursing managers and nursing administrators. In the ensuing discussion, there seemed to be some confusion, and in particular confusion consequent on the conflation of what might be referred to as "personal", "institutional", and "professional" values. This led me to ask the question of what nurses should do ethically, morally and practically when confronted by the fact that other nurses have different values from their values. This in turn led me to ask more generally what they should do when they found that other health care professionals with whom they work have different values also. In thinking about these questions I concluded, in relation to nurses, that a more important and maybe more basic question was whether there *should* indeed *be* a single set of

---

[1] *Nursing Ethics in the 90's: Nursing in a Diverse Society*, Emmanuel College, University of Toronto, Oct.1-2, 1993.

principles or values which governs their activities. In what follows I will argue that indeed we should think of all nurses, at least all nurses in a single jurisdiction, as being governed by or subject to a single set of values. I will, in other words, argue against dividing nurses and their values by the types of work that they do and roles that they play in various kinds of settings. I will present the thesis that the nursing laws, codes, and practices represent a shared set of values, although these values may be *implemented* in different ways depending on various parameters and complexities related to the realities of nursing practice. Indeed, these common values may give nurses a common identity as members of a special group, despite the fact that individual nurses may appear to be implementing the values differently.

The attentive reader will have noticed that in the above I have talked of differences in *values* whereas in my introductory chapter it was clear that my interests in this dissertation cover, as I put it there, *goals*, *values*, *principles* and other things too. I have talked just in terms of values when describing the discussion at the conference because that was the vocabulary used in that discussion. It should be obvious, but it is perhaps worth emphasizing, that the differences in values discussed at the conference could and indeed do in the end cover everything I discussed in my opening chapter. Correspondingly, when I say above there are or are not differences in values I would wish my comments to be more widely construed than the vocabulary might suggest. In what follows I intend the discussion of diversity to cover diversity of this wider kind.

2.2 RESTRUCTURING THE PROBLEM

In this section I want to give the following argument. There is an appearance of diversity in values amongst nurses. But, there is good reason to think that the diversity is only apparent or is to be explained away in various ways. The reasons to think that the diversity is only apparent will be explicated in section 2.3. The reasons to think that the apparent diversity can almost be explained away are in sections 2.4 - 2.7. They are, briefly, that some of the differences arise from the fact that since nurses, like other professionals such as lawyers, occupy different roles, although still as nurses or lawyers, they are subject to the same value system, the differences here being explained away by the fact that these same values will be *implemented* in different ways consonant with the different employment situations of the nurses and lawyers. Some of the differences could arise from the status of the nurse, and some from mistaken perceptions about the laws, codes and practices. But at the end of this remains a residual problem which I will refer to as the interpretation problem.

In asking whether nurses as a group[2] have a common identity as nurses, and thus may have a common set of values (despite the various roles, tasks, and goals that they pursue), it would be helpful to compare them to lawyers as a professional group.

---

[2]In speaking about "nurses as a group" the phrase could mean either an empirical, sociological, or factual claim about the current practices of nurses, in other words, referring to how real life nurses in fact behave. I do not mean this. What I mean by "nurses as a group" for the purposes of this dissertation is a comment about how the laws, codes and practices of nurses structure the role, in other words, how, according to the laws, codes and practices, they are supposed to be behaving. We should worry, though, if there is too much discrepancy between the two interpretations. However, as far as my argument goes, I do not care if some nurses do not know the laws, codes and practices and/or are cynical about them.

Lawyers can clearly have different roles and goals. For example, there are criminal, corporate and civil lawyers, some of whom work in independent practice, and these different kinds of lawyers work in very different areas. Those same types of lawyers can be employed by corporations, and included in their role as lawyers would be their role as employees of those corporations. As well, there are crown attorneys, employed by governments to prosecute criminals, and legal aid lawyers, employed by organizations to defend citizens who cannot afford to hire a private lawyer. The differences in the kinds of duties and roles of a defending criminal lawyer are very different from the duties and roles of a corporate lawyer, but both nevertheless function as lawyers, and both consider themselves to be lawyers.

Another point to note is that if a lawyer is a corporation lawyer, (that is, the lawyer is a salaried employee of the corporation), she is an employee of this corporation.[3] Although she would have duties very similar to lawyers outside the corporation, there would also be some duties different from lawyers outside the corporation. These duties are duties to the corporation and, some might argue, would tend to impair her status as a professional by making her an employee as well as a professional. The employee may have less autonomy or independence or control over her work than a lawyer in private practice, thus, in some views, making her less of a

---

[3] This might be the interesting substantial point in the worry that many American physicians (and some Canadian physicians as well) have of becoming salaried, because if they are salaried as opposed to fee for service, they are then *employees*. If they are employees they have duties to the employer that may conflict with duties to the patient.

professional.[4] However, in general, lawyers are seen to be members of a well-defined group, that of the profession of lawyers.

In a parallel way, perhaps, we can say that nurses can still be seen to belong to the group labelled "nursing professionals" and be said to have the same values. We can also say that they *appear* to have different values, but say further that this is only an appearance. The idea would be that nurses, like lawyers, in a variety of ways occupy different employment situations. It is this that leads to the appearance of differing values, the explanation being that the single set of values are *implemented* in different ways as a function of these differing employment situations. Now, let us see if this idea will survive close examination.

I suggest that the problem be restructured in three stages. Firstly, I note that there are reasons to expect some unity in the values of nurses because there is one set of laws, codes and practices for all nurses: that is at least how they are written. Secondly, I note that in fact in a variety of ways the *situation* of nurses can differ radically in ways to be explained below, and thirdly, that the solution to the problems of defending the unity thesis lies just here, that the apparent differences in values can be shown to be not in fact differences in values, but instead differences in the way that the values for nursing are *implemented* in the differing situations under which nurses

---

[4] As Bayles notes, "no generally accepted definition of the term *profession* exists" (p.27), yet much of the literature on the criteria for a profession include the concept of autonomy or independence, or as I put it, "discretionary authority" - that is, a right to decide what is fitting in at least some settings within certain constraints. On autonomy and independence in the professional's work, see the Bayles, Hughes and Merrill papers in Callahan, 1988.

function.

I begin by briefly noting the point about the unity of values.

2.3 CODES OF ETHICS AND NURSING PRACTICE STANDARDS

There is much in the situation of any nurse which pushes towards an acknowledgment of unity in the nursing role. I will here discuss only the two factors I have already mentioned:

> (a) the unity that comes from the fact that all nurses in a given jurisdiction are subject to one set of codes of ethics.
>
> (b) the fact that there are for all nurses in a given jurisdiction a single set of nursing practice standards.[5]

Nurses are governed by Codes of Ethics that have been written by their professional organizations, and, in some cases, have been imbedded in the laws that govern their practice. The preamble of the Canadian Nurses Association (CNA) *Code of Ethics for Nursing*, for example

> represents a conscious undertaking on the part of the Canadian Nurses Association and its members to be responsible for upholding the following statements (values, obligations, and limitations).[6]

It seems that the Code seeks to identify the basic moral commitments of nursing to serve as a basis for self-evaluation and for peer review, and to establish the public's expectations for the ethical conduct of nurses. Similarly, the International Council of Nurses (ICN) adopted a *Code for Nurses* in 1973, and the *Regulations Pursuant to the*

---

[5]See, for example the following: Alberta Association of Registered Nurses, 1991 (*Nursing Practice Standards*), 1992 (*Scope of Nursing Practice*), and also the Canadian Nurses Association 1991 document, *Code of Ethics for Nursing*.

[6]Canadian Nurses Association, 1991, p.ii.

Nursing Profession Act of the Government of the Province of Alberta have appended a "Code of Ethics Regulation", making ethical practice a legal responsibility of all nurses in the province of Alberta.[7]

In a similar way, the *Nursing Practice Standards* and *Nursing Scope of Practice* documents, written by the Alberta Association of Registered Nurses, set out minimum standards of practice, competencies and the scope of practice for all nurses registered in that jurisdiction.

Now I will turn to the second stage of the restructuring - the question of the diversity of nursing situations.

2.4 KINDS OF NURSES

I will comment in this section on some of the parameters that must be considered when we look at the question of the relevance of the fact that nurses seem to occupy a wide diversity of roles to the suggestion that nurses have different values. While much of the literature seeks to distinguish nurses by type of education and/or education level reached or by years of experience in the profession, I believe that there are more parameters for types of nurses than simply these two (that is, levels of education and/or the types of tasks that the nurse is skilled at either through training or experience[8]). I will look at four parameters, or characteristics, of nursing practice to

---

[7] Government of the Province of Alberta, *Nursing Profession Act*, 1983.

[8]For example, a nurse may have a Master's degree in nursing, but may not have the *capacity* to translate theoretical knowledge into skilled nursing care at the bedside. A nurse with hospital training and several years of working experience may be more skilled at giving nursing care to patients in certain environments.

try to isolate a "logical space" in which to address the question of the relevance of diversity to the view that nurses have different values.

I begin with the familiar "education" parameter.

2.4.1 EDUCATION PARAMETER

The education parameter can be partitioned in various ways. Firstly, it can be partitioned as a function of whether the level of education is reached by formal education or by experience (whether or not in some structured setting). Benner, in her book *From Beginner to Expert*[9], for example, has outlined the stages through which a nurse proceeds as she gains experience. Benner points out that the nurse becomes an "expert nurse" through her experience of giving nursing care, gaining confidence in her capabilities to assess and plan for care needed by her patients. There is no doubt that a nurse with five years experience typically has much more skill and confidence than a new graduate. In another example, Dreyfus, Dreyfus and Benner outline how a nurse gains ethical expertise in nursing through experience.[10]

A second way of distinguishing between nurses is by type and level of education. There are in Canada at present three ways of becoming a Registered Nurse: hospital schools of nursing (2-1/2 to 3 years), community colleges (2 to 3 years) and university degree programs (4 to 5 years), although the hospital programs are fast disappearing or are combining with the universities to offer a more integrated

---

[9]Benner, 1984.

[10] Dreyfus, Dreyfus, and Benner, 1990.

program.[11] One of the essential attributes of professional behaviour is defined in terms of a high degree of generalized and systematic knowledge, and an emerging or marginal profession will seek to make its members more homogeneous with respect to the amount of knowledge they possess.[12] Nursing is attempting this, with the push for a baccalaureate degree as entry to practice for the profession. However, the present different entry points now available to the profession cause some confusion among the public, other health care professionals and nurses themselves. But it is important to note that all nurses, despite their having different levels of education and experience, are registered by the *same* body, and are thus able to practice nursing under provincial legislation. The crucial point is that whatever the method of education by which a nurse comes to be qualified as a nurse, she is still subject to the same legislation, practice standards, and code of ethics as other nurses.

A further point to be noticed is this. Whether we distinguish types of nurses by years of experience or by their level of education, each nurse is typically permitted to practice only up to her ability of skills and knowledge. For example, a nurse whose skills, knowledge and experience make her an excellent paediatric nurse on a general paediatric unit, will not have the requisite skills to be considered an efficient paediatric intensive care unit nurse, or a palliative care nurse. While she would be able to give basic nursing care to any patient (such ability coming from her basic nursing

---

[11] An example is the Calgary Conjoint Nursing Program offered by Foothills Hospital, Mount Royal College and the University of Calgary beginning Sept. 1993.

[12]Barber,1987. p.36.

education), she would acknowledge her limitations and lack of skills if asked to float to an intensive care unit or to a palliative care unit. The important point, again, is that whatever the method of education by which a nurse comes to be qualified as a nurse (through diploma, B.N., M.N. or Ph.D levels in nursing education), she is still required to practice only to the limits of her skills, knowledge and experience. She would still, however, count herself, and be counted, as a nurse.

2.4.2 CAPACITY PARAMETER

The capacity parameter looks at the ability to do something, the actual skills that a nurse brings to her practice. Examples are the capacity to relate to patients, to recognize problems, to have the right instruments ready for the surgeon in the operating room, etc. This capacity can be achieved through education, through experience, or through both. The crucial point to be clear about is that, of course, one can go through educational preparation, and/or have experience, but still not have the capacity to do the work. As well, nurses with similar education and experience can have different capacities; for example, one might be capable of skilled interaction with patients, while another may be very good at the technical skills required in the trauma room.

The point is that whatever the method of education by which a nurse comes to be qualified as a nurse, she is still subject to the same laws, codes and practices.

2.4.3 EMPLOYMENT SITUATIONS PARAMETER

By referring to an "employment situations parameter" I mean to be referring to the fact that nurses can find themselves performing vastly different jobs in vastly

different situations. Some nurses, for example, in the far north, may function as nurse practitioners, and do many of the things that physicians would do in a more populated area. Some nurses may do only research, some may work with computers, some may do lifestyle counselling. The kinds of work these nurses do and the roles they fill can be very diverse, and from this may come an assumption that the values that govern their varied behaviours are different as well. Again, the crucial point is that whatever the method of education by which a nurse comes to be qualified as a nurse, she is still subject to the same laws, codes and practices.

Related to this, though rather different, is the important point that nurses in hospitals are essentially part of health care teams, and the appropriate kinds of behaviour for them in such an institutional setting is not simply a function of nursing values or the welfare of the patient. It is also a function of how other health care professionals relate to each other. For example, if a nurse is working in a hospital where the hospital administrators or the physicians view nurses in the "handmaiden model", then the role of the nurse, and *a fortiori*, possibly the values of the nurse, just of necessity, would be different from the role and the values of the nurse working in a setting where the administration and the physicians are working with a "patient advocate" model of nursing. While the values may *appear* different, nurses working under these different models may believe that it is important to be cooperating members of a team, and may value the institution as a means of operationalizing care for patients. Placing a value on functioning within the existing system may affect how a nurse would implement a value, for example, truthtelling. If many physicians

believed that the decision as to whether or not to tell terminally ill patients the full details of their illness should be left entirely up to physicians, and the administration of the hospital believed that the physicians were right, then a nurse would likely not disclose details to a patient who asked. She would probably also not confront a physician about the decision to withhold information. In a hospital that viewed nurses in the "patient advocate" model, a nurse's behaviour in the same kind of situation might be entirely different.

2.4.4 RANK PARAMETER

Under the rank parameter I consider the different rank the nurse holds in her employment situation. For example, the nurse may be a staff nurse working at the bedside, or a nurse manager of a unit, or a nurse administrator in charge of the nursing department in a hospital, and so on. This parameter seems to be one which causes nurses a great deal of trouble when they consider values. For example, to a staff nurse concerned about caring for patients in an environment where staff and supplies are being decreased as a cost-saving measure, the goals and values of a nurse administrator may seem too closely tied to finances and budgets. Conversely, the nurse administrator may feel that the values she needs to pay attention to are different, and just as important, if not more important, than those of the staff nurse. The crucial point is that whatever the rank held by a nurse, she is still subject to the same laws, codes, and practices.

2.4.5 CONCLUDING COMMENT ON THE KINDS OF NURSES

So, there are a variety of types of nurses as a function of the different

parameters identified above and their interrelations. Of course, any given pair of nurses can be similar on some parameters though different on others. The crucial point is that whatever is the method of education by which a nurse comes to be qualified as a nurse or whatever is her rank, she is still subject to the same laws, codes, and practices.

2.5 THE FIRST ATTEMPTED SOLUTION TO THE PROBLEM

2.5.1 PRELIMINARY COMMENT

I have argued that nurses are of many different kinds, the kinds being a function of the four parameters identified above. There may be more parameters. If there are more this will not affect the basic structure of my argument, but will just be a refinement of it. So I will leave the question there.

I have also argued that there is apparently a strong thrust towards saying that there is much that is common in the situation of a nurse. I now put these two ideas together and suggest that the common core in the situation of a nurse is implemented in different ways as a function of the different parameters identified above. This in turn suggests the possibility that it only *appears* that there are different values for different nurses: the reality is that there are common values and these are *implemented* in different ways as a function of the differing situations nurses are in. This can be made persuasive by examining in some detail a couple of cases - cases, that is, where we can see the way in which the common values get implemented in different ways.

2.5.2 EMPLOYMENT SITUATIONS PARAMETER

As a first example, the values governing an operating room nurse may seem

importantly different from the values governing the behaviour of a geriatric nurse. The operating room (OR) nurse, while respecting the autonomy of the unconscious patient undergoing surgery, recognizes that the surgeon is in charge of what goes on in the OR, and her values rest on the importance of teamwork, accuracy and technical skills. Once the informed consent of the patient has been obtained (prior to the patient's arrival in the OR), the emphasis is on maintaining the life and health of that patient, in ways, of course, consistent with that consent. The success or failure of the surgical procedure will in an important way determine the future autonomy of the patient, and thus the OR nurse values skill and precision. The geriatric nurse also values the autonomy of her patient, but goes about implementing the value in a different way. Here the emphasis is on caring, human relationships, and maintaining the optimum independence and choice of her patient.

In the same way, I suggest, we can say that the values informing the behaviours of the nurse practitioner, the community nurse, the intensive care nurse, and so on, are the same, but that they would be *implemented in their different situations* in different ways, the differences deriving to at least some degree from these differences in their employment situations. They all, for example, will accept the value of respect for patient autonomy, but *how* this respect will be manifested will not be quite the same in each case. We might put the ideas here in either of two probably equivalent ways. We might say that there are some fundamental values which *may be implemented in different ways* in different employment situations. Or we might say that there are some fundamental values binding on all nurses but that, in the light of

different employment situations, from these fundamental values, we need to extract different *derived* values which nurses in the different employment situations will follow. These two formulations are probably extensionally equivalent and if only for that reason alone may be treated together. Because of this parameter of divergent employment situations, it may appear that nurses working in different settings have different values. It does not follow that nurses do not have a common set of values that inform all the different implementations of nursing roles.

2.5.3 THE RANK OF THE NURSE PARAMETER

As a second kind of example, let us look at the way in which the rank of a nurse can affect the way values are to be implemented. Depending on whether a nurse is a staff nurse, the manager of a nursing unit, or the vice-president of nursing in a large hospital, the value of patient autonomy would again be implemented in different ways. A staff nurse on a surgical unit would be responsible for a certain number of individual patients on her shift; a way of valuing patient autonomy, for her, might consist in ensuring that the informed consent of her patient is obtained before undergoing surgery. The nurse administrator, in valuing autonomy, would ensure that there are policies in place in the hospital to so that informed consent is consistently obtained for all procedures, and that these policies are followed. She would not be involved with individual patients unless a problem arose that could not be resolved at the unit level.

2.5.4 NURSING STATUS PARAMETER

There may be reason to go one further and allow implementation of codes in

different ways on a new and different parameter[13] which has been considered in the United States, what I will call the "nursing status parameter".

In several jurisdictions nurses have started to lobby for the introduction of a distinction between "technical nurses" and "professional nurses". The American Nurses Association, for example, is a case in point.[14] In a related way, I suggest, another nurse author, Koerner, advocates for differentiated practice based on competency, which she defines "as a performance standard that includes skills, knowledge, talents, and understanding that transcend specific tasks and is guided by a commitment to ethical and scientific principles of nursing practice".[15] Koerner's differentiation by competency, though, is made by levels of educational preparation.[16] However, it is important to note that if we distinguish between "technical" nurses and "professional" nurses, the codes at present list the same values for all nurses, although implemented in different ways on these different parameters.

It might seem that this is a possible difficulty for the solution thus far suggested. I think not. If we are familiar with the basic idea of alternative implementations, (see sections 2.4.1 through 2.4.4 above), this is not too big a jump, and independently might be defendable. For example, if advocacy is required for an

---

[13]This parameter, though different from both the education and rank parameters, is nevertheless related to them.

[14]Callahan, 1988, p. 27.

[15]Koerner, 1992, p. 336.

[16]Koerner divides the work responsibilities of client care across three distinct nursing roles, based on level of education: 1) the ADN (Associate degree nurse); 2) the BSN (Bachelor's of Science in Nursing; and 3) MSN (Master's of Science in Nursing).

individual patient, a technical nurse may need to consult a professional nurse in order to fulfil this role. Though both value advocacy, as a result of their status within the structure of the institution (or even possibly of legal status) the implementation of this value and the responsibility of each nurse would be different.

2.5.5 THE MISTAKE PARAMETER

This next parameter is really rather different from the parameters I have discussed so far. The other parameters are explained as merely apparent differences in values, etc., as a function of the ways in which, because of various factors or parameters, the values might be differentially *implemented.* This next "parameter" explains the differences away as apparent not by the fact that they are differently *implemented,* but by the fact that in some cases people make *mistakes* in implementing, so that what we have is not different implementations but in some cases mere misapplications or misimplementations.

Since nurses in different parts of the country, working in different hospitals, and educated in different ways, will have different perceptions of what the values governing the nursing profession are, some of these may be mistaken perceptions. For example, nurses may have read or may not have read the CNA Code, but may nevertheless agree with Value I, which states that a nurse treats clients with respect for their individual needs and values. Some nurses may not feel obligated to "aid clients in the expression of needs and values, including their right to live at risk", a moral norm which the code says has its basis in Value I. They may feel that certain risks are ones that an ethical nurse should not allow a client to take, and believe that a nurse

must always protect a client from making an unwise decision in relation to his or her health (a form of paternalism). So this parameter represents the problem of having a perception of what the Code says that is not what the Code actually says. From this perception will arise behaviour which is based on the nurse's *mistaken* perception of what the Code states.

Clearly this is a real complexity, but it is not a problem for the suggested approach at all. For the fact that two nurses have differing pictures of the values of nursing does not show that there are no common values which *ought* to be acted on, *if* the differing pictures are simply a function of misconceptions by one of the nurses.

2.6 THE INTERPRETATION PARAMETER

I have outlined a suggestion to the effect that most if not all of the kinds of cases which might lead one to question whether nurses can in fact be viewed as being subject to a single set of values can be explained away by saying that when these values are *implemented* in real life working situations, the nurses subject to them must implement these values in different ways, the different ways being determined in the light of various considerations (I call them parameters). I acknowledged that *some* of the differences cannot be explained away in quite that fashion: they can, however, be explained by saying that nurses do make mistakes about these values or about how to implement them. I have not, of course, *proved* any of this: to prove claims like this would be an exercise in the sociology of nursing. But it was not my intention in this dissertation to prove these claims: that is not their status in the discussion. What I want to do in this discussion is different. I want to argue that even if all differences in

values of the kinds the nurses were talking about at the conference were indeed explained away in the ways I indicated there would still remain a residue, an interesting residue, of difference. This residue is what much of the rest of this dissertation will address - its nature, its varieties, its significance and how to deal with it. The residue is what I will refer to as the "interpretation parameter". In this section I will merely introduce the ideas. In subsequent chapters I will examine these ideas in some detail.

Even given that there is a shared set of values (for example, the CNA Code), it is possible for nurses to *interpret* these values in different ways, especially if these values are stated in fairly general terms. And this is possible without anyone making any mistake of the kind discussed above. Let me illustrate the idea here.

Value IV states "The nurse is guided by consideration for the dignity of clients". The obligations arising from this value admit that ways of dealing with death and dying change and when they do nurses are challenged to find new ways to preserve human values, autonomy and dignity. This requires new interpretations, and given the diversity of nursing education, roles, capacities and rank, different interpretations will surely arise. For example, in some immigrant communities, showing respect for elders is exhibited by doing everything for them, in effect allowing them to become dependent on caregivers. Nurses generally believe that optimum independence in the patient should be promoted, and will not normally do for the patient what the patient can do for herself. However, in some situations, nurses must allow family members to do everything that a patient asks of them, because that

is their way of showing love and respect. The nurse who interprets dignity as having as much autonomy as possible would be reluctant to allow this to happen. But the nurse who interprets dignity in part as having one's choices respected, would allow family members to show their respect as they choose.

This problem is, I suppose, at one level not a real problem for the central thesis that nurses share values in the sense I outlined. It is no problem simply because the shared values are nevertheless a guide which constrains the possible different interpretations - not anything can count as an interpretation. Despite this, I think that the kinds of cases which can arise here are to be taken more seriously than the cases I discussed when discussing the other parameters. The problem is that the differences seem "real" and "pressing". After all two nurses interpreting the same clause differently may be lead in very similar circumstances to behave rather differently without error. So, I will say that this is, I think, the one residual truth in the suggestion that different nurses have different values. To be sure, I can *say* that it is not different values they have but different interpretations. However, the substantial point remains and is not to be ignored.

2.7 CONCLUSION

So, what are we to make of the claim that there are no shared values? Not much, because all the meaty and interesting problems for the shared values claim can be explained away by the common values/alternative implementations thesis as a function of the parameters discussed above. If differences are simply a function of differences in role, status, rank or even of capacity or education, then the worries

about different values are not interesting, because they can be dealt with by the alternate implementation move. But some are *not* like that. Of these, some can be dealt with by the mistake parameter and they are not interesting to my claim. While the alternative interpretation move is not terribly worrying to the idea of having shared values in the profession, if the interpretations are sufficiently diverse the common values thesis gets emptied of substantial content.

From my discussion it should now be clear that I need to do some analytical work on the notion of interpretation and some substantial work on the way we identify or the way we choose interpretations. To that end I go on in the next chapter to explore the idea that interpretations can be not only of the kinds of things I have discussed so far, that is, interpretations of goals, values, laws, codes, but also interpretations of *situations*, a more radical problem.

CHAPTER III: THE MULTIPLE REALITIES PROBLEM

3.1 INTRODUCTORY COMMENTS

In this chapter I want to introduce one final complicating factor before I address the question of a solution to what I am calling the interpretation problem. This factor I will call the "multiple realities problem". In this thesis I cannot hope to establish that there *is* a problem of the kind I will identify (if only because of space and time limitations). Instead what I will be saying should be construed as more a suggestion about a possibility, a possibility which is worth exploring. It is worth exploring if only because if the possibility were an actuality then I think it is interesting that my suggestions about the other parts of the interpretation problem could without much change be used to resolve this problem also. The task of establishing that indeed there does exist a problem of the kind I want to mention would be an exercise in the sociology of the professions and as such beyond the scope of this dissertation. So in effect what I am suggesting in this chapter is the following:

> (a) There are certain possible facts which I will describe. I will also describe some of the implications of these possible facts.
>
> (b) These possible facts, if they were facts, could be in a certain sense "dealt with" using the resources I will develop for dealing with the interpretation problem more generally.
>
> (c) Establishing that these possible facts are indeed facts is a social science research project for others.[1]

I begin with some ideas of H.T. Engelhardt. He writes:

---

[1]The details for the argumentation in this chapter were suggested by J.A. Baker.

> ...(M)edical reality is the result of a complex interplay of descriptive, evaluative, explanatory, and social labelling interests. The ways in which we speak of, react to, and experience medical reality are shaped and directed by these interests.[2]

For my purposes it is important at this point just to notice the language which Engelhardt uses here - he talks of "reality" as being structured by certain "interests".

Engelhardt then summarizes these clusters of "interests" under what he refers to as four "languages of medicine", a less than ideal way of putting his otherwise useful point. He comments that these are in fact "more than" *languages* and remarks that this talk of languages provides a "useful metaphor by suggesting that each...has its own grammar or rules for constructing meaning" that act as "'syntactical' and 'semantical' constraints that shape the ways we speak of, understand, and experience medical reality."[3] I will for brevity not embark on the needed critique of his terminology here. Instead I will use it and leave criticism for another day. The crucial thing I want from Engelhardt is what is in fact a familiar idea in philosophical circles, the idea that a person's conception of reality, or even what a person's reality is itself, is structured by the conceptual scheme through which she apprehends that reality. Let us now briefly review Engelhardt's suggestion.

Engelhardt begins his chapter "The Languages of Medicalization" with a succinct statement of the basic idea which underlies the thesis which I will refer to as the "multiple realities" thesis. He says:

---

[2]Engelhardt, 1986, p.163.

[3]Engelhardt, 1986, p. 164.

> Medicine medicalizes reality. *It creates a world.* It translates sets of problems into its own terms. Medicine molds the ways in which the world of experience takes shape; *it conditions reality for us.* The difficulties people have are then appreciated as illnesses, diseases, deformities, and medical abnormalities, rather than as innocent vexations, normal pains, or possession by the devil.[4]

Now this talk of "creating worlds", "conditioning reality", and so on may be hyperbole,[5] but it is striking and useful hyperbole, I think, if indeed it *is* hyperbole. Let me expand just a little on his ideas before I turn to the twist which I intend to put on these ideas.

Engelhardt develops his basic thesis through the following steps, most of which are worded using quotations from his discussion:[6]

> 1. "We are taught early how to explain the occurrences of our world." (This is a plausible empirical claim, one which it would be hard to deny, though, of course, there is a large literature devoted to the question of whether the basic categories in terms of which our learning takes place are in the language of the nineteenth century "innate" - in twentieth century language "genetically encoded" or "hard wired". I am sure that all would agree, even the most enthusiastic exponents of the hard wiring thesis, that how we explain our world is in part at least something we learn.)
>
> 2. "In the West we take for granted that a set of complex, etiologic forces directs the production of illness and disease. Individuals in other cultures or our antecedents in our own culture untutored by our current scientific world view, do not or did not see illness as the result of infectious agents, genetic flaws, or

---

[4]Engelhardt, 1986, p. 157.

[5]It is tempting to say that he simply confuses the obviously plausible thesis that one's *life* is affected, indeed deeply affected, by how one views it with the thesis that one's *world* is so changed.

[6]It is not at all clear what Engelhardt takes the direction of his thinking to be. *I* have taken him as starting from the thought that we learn our conceptions of reality. He mentions this fact, but does not mention it as the first point. For my purposes it does not much matter which Engelhardt intended: what matters is whether we can cobble together an intelligible theory. I think we can along the lines I have indicated, using quotations from Chapter 5, "The Languages of Medicalization".

endocrinological abnormalities. We, however, do." (This is of course a very plausible empirical/anthropological/sociological claim.)

3. "Our world is structured by a special set of assumptions about the rule governed character of our experience. These scientific and metaphysical presuppositions fashion for us our everyday expectations. They give shape to our lifeworld." (This is open to a variety of readings, but the basic idea is surely plausible, for it does not go much beyond what has been said in claims 1 to 2.)

This so far seems truistic, at least in outline. He now goes a little further and says, "In addition, the particular character of our social institutions invest occurrences with social significance. The current arrangements among dentists, surgeons, physicians, and psychiatrists is the result of a set of past historical forces in great proportion peculiar to our particular culture, but which contributes to the appreciated significance of a toothache, appendicitis, heart disease, or schizophrenia". If we add nurses to the above list of professionals, then one can see where I will be going, but that is not the point I want to make here. The point I want to make here is that the passage I have just quoted is still almost truistic if construed in one way, and that is how I would, for the moment like to construe it.[7] On the truistic reading we get the following points:

4. The *importance* attached to occurrences is in part a function of which profession addresses those occurrences. (This again is a sociological claim, and a plausible one. There is much literature addressed to the way, for example, in which certain illnesses are downplayed because the illnesses in question are ills treated by specialists who occupy low places on the medical totem pole. So, for example, take the differences in the amount of money devoted to research on breast cancer as opposed to AIDS, as compared to the incidence of these two diseases.)

5. The *manner in which* occurrences are responded to (with drugs, surgery, behaviour modification techniques, psychotherapy, advice or caring) is in part

---

[7]Though whether Engelhardt intends the truistic construal is a different point.

> at least a function of which profession addresses these occurrences. (Again this is a sociological claim, again a plausible one.)

and

> 6. "The current arrangements among dentists, surgeons, physicians, and psychiatrists (and I will add nurses) is the result of a set of past historical forces in great proportion peculiar to our particular culture". (A plausible historical thesis.[8])

This too is very close to being truistic, though clearly in a full discussion we would need to cite the various sociological studies of medicine, psychiatry and nursing which address the claims directly. Here I am concerned, as I said, not so much with the empirical truth of these claims as with the practical and ethical importance of their possible truth.

I will henceforth refer to the claims listed above and in particular to claims 4 to 6 as the *moderate multiple realities thesis*. What is claimed here is indeed very moderate. It is compatible with the rejection of the next thesis which Engelhardt states and for which he argues, though whether Engelhardt sees the difference between this thesis and the thesis to come is hard to say. I will refer to this further thesis as the *radical multiple realities thesis*.

Again I will introduce the ideas by means of a series of quotations from Engelhardt's useful discussion. Engelhardt suggests:

---

[8] See, for example, the comments by MacIntyre on how nursing has largely been defined in terms of other roles. He writes, "To the nurse has been allocated whatever has been left over from the often self-defined functions and tasks of the physician and surgeon and the bureaucratically defined tasks of the hospital administrator". Nursing, he asserts, is a label covering a "rag-bag of activities with no underlying real unity". MacIntyre, 1983, p.80.

We see the world through our social, scientific, and value expectations.[9]

a statement which is at least compatible with the moderate thesis I have just identified. He then continues:

> The medical *facts* with which bioethics deals are not timeless truths, but data given through the distorting biases of our history and culture. Recognizing a state of affairs as heart disease, cancer, depression, homosexuality, or tuberculosis, is a rich and complex process. All knowledge is historically and culturally conditioned, and the influence of history and culture is often...particularly marked in medicine.[10]

The second through fourth sentences here can certainly be read as compatible with the moderate thesis: they are indeed almost a cliche. The first sentence however is more radical, though it could still be read as compatible with the commonsense views found in the moderate thesis. So read it would simply say that *what we count as* medical facts varies as a function of our knowledge and understanding. Who could deny such a claim? It could also be construed as saying that what we count as medical facts is affected by our educational, social and professional background. Again, who could deny this? Though one might feel *some* discomfort at the suggestion, especially of one took it as affirming that one simply *cannot* "get behind" our educational, social and professional background, or that we cannot *assess* our background, that we cannot assess the categorizations with which we are brought up, or, most radically of all, that there *is* no reality which underlies and warrants the acceptance or rejection of the categorizations we use. There is a world of difference between saying that *what we*

---

[9]Engelhardt, 1986, p.158.

[10]Engelhardt, 1986, p.158.

count as a disease is in part or even in large part a function of our culture, education and professional background, and saying that *what is a disease* is in part a function or even in large part a function of our culture, education and professional background. Even stronger is, of course, the thesis that it *is entirely* a function of our culture, education and professional background. I will refer to this as the *second radical thesis.* It is not completely clear whether Engelhardt espouses the first or the second radical thesis, though it is my guess that he does not distinguish them or that he accepts only the first radical thesis. Let me look more closely at what he *does* say. Immediately after the passage quoted above he says:

> This is not to say that investigators do not attempt to know, timelessly unconstrained by social and cultural forces. In endeavouring to know truly, one attempts to understand the world as it would be seen from God's eye, from the view point of dispassionate, scientific observers, so that the finding could be shared with other investigators, even those outside our culture - in principle, even with alien investigators on planets circling distant stars.[11]

Again, this passage *could* be read as compatible with the moderate thesis. However, in the very next paragraph Engelhardt begins a series of remarks which make fairly clear that he at least flirts with the radical thesis in one or other of its possible forms, probably in the end the first. He says:

> The goal of undistorted knowledge is a heuristic.[12]

This, if taken as saying that it is *merely* heuristic, could clearly be taken as the second radical thesis. However, immediately afterwards he says:

---

[11]Engelhardt, 1986, p.159.

[12]Engelhardt, 1986, p.159.

> It directs us as knowers, as scientists, toward the truth...Any concept we have of reality is that of a reality that is experienced, even if experienced by ideal observers. To speak of the nature of reality undistorted by historical and cultural context is to speak of a view that would be possessed by unbiased knowers in full possession of all information.[13]

This however sounds just like what I am calling the first radical thesis. This thesis is compatible with the claim that there *is* a reality untouched by culture, and so on, or at least that there might at some points *be* such: the thesis says, however, that knowers can never secure knowledge of such a reality, that the best they can do is use the idea of such a reality as a "heuristic device" - something to aim at, and aiming at it will free us as far *as is possible* from the culture through which we must view it. As he says:

> The interest in knowing reality truly sets knowers on a journey from their unrecognised biases toward an ever more complete overcoming of those biases through a recognition of them and through endeavours to compensate for them in order to achieve a greater capacity to describe reality unconditioned by the idiosyncrasies of one's cultural context.[14]

So thus far it is tempting to take Engelhardt as espousing at least the moderate and at most the first radical multiple realities thesis. However, on page 163 he seems to go beyond this and to espouse the second radical thesis. He says:

> In both strong and weak senses, medicine creates a socially accepted reality. Through denominating a problem a medical problem, expectations are created and personal destinies influenced. They are obviously strong senses of fashioning reality in the case of classifications leading to legally enforced medical viewpoints. Here one might think of the vote by the American Psychiatric Association whether to classify homosexuality as a disease. The medical regard of homosexuality as a disease reinforced the legal proscription

---

[13]Engelhardt, 1986, p.159.

[14]Engelhardt, 1986, p.159.

> of homosexual activities. Its removal from the list of mental disorders weakened arguments for state sanctions. Somewhat less socially enforced are the particular stagings of cancer, which lead to particular levels of treatment. Such systems for staging reflect decisions made by communities of physicians regarding the most appropriate and useful ways to characterize an area of reality. The acceptance of a particular staging system involves agreeing to see and react to reality in a disciplined and coordinated fashion. ...
>
> Medical reality is the result of a complex interplay of descriptive, evaluative, explanatory, and social labelling interests. The ways in which we speak of, react to, and experience medical reality are shaped and directed by these interests.[15]

He then examines four such ways of organizing the interests.

Now, I cite the passage at length partly because here he does seem to flirt with the second radical thesis for at least some diseases, though for others he seems merely to be espousing some form of moderate thesis or maybe the first radical thesis, but partly because of the way he flirts with the second radical thesis. He flirts with it in a form which explains how it can be that diseases, at least some of them, can be "socially constructed". They are socially constructed in a quite down to earth sense. Certain states come to be diseases because for some professions and for some diseases what *is* a disease is something which is decided upon by the authoritative decision making bodies of the profession. *Saying* that such and such is a disease for these professions *makes it so*. Correspondingly, later in the chapter he addresses the question of how such decisions should be made - democratically, authoritatively, or what have you.

Now it should be obvious from my summary that Engelhardt's discussion is a hodge podge of half thought out and ill digested ideas, but it should also be obvious

---

[15]Engelhardt, 1986, p. 163.

that there are some interesting ideas in his discussion. Let me summarize what is, I think, interesting and for my purposes useful. I will set these points using as far as possible the Engelhardt language.

I suggest that the following suggestions are important and not to be ignored:

1. The Moderate Thesis: This will be articulated in the following set of statements:

> (a) "Our world is structured by a special set of assumptions about the rule governed character of our experience. These scientific and metaphysical presuppositions fashion for us our everyday expectations. They give shape to our lifeworld."
>
> (b) "The *importance* attached to occurrences is in part a function of which profession addresses those occurrences."
>
> (c) "The *manner in which* occurrences are responded to (with drugs, surgery, behaviour modification techniques, psychotherapy, advice or caring) is in part at least a function of which profession addresses these occurrences."
>
> (d) "The current arrangements among dentists, surgeons, physicians and psychiatrists (and I will add nurses) is the result of a set of past historical forces in great proportion peculiar to our particular culture."
>
> (e) "*What we count as* a disease is in part or even in large part a function of our culture, education and professional background."

Statement (a) is partly a causal claim and partly a conceptual claim. Both claims are trivial - they say simply that we conceptualize our world using the concepts we have. Claims (b) - (e) are important sociological claims. They are important as warnings against the careless assumption that the importance attached to a medical state maps in any simple way on the real (whatever that means) importance of that state. The moderate thesis is perfectly compatible, of course, with the idea that we can evaluate the concepts we use to explain and describe medical states. To say that our world is so

structured is to leave untouched the possibility of developing techniques for assessing how accurate or how useful our concepts are - after all, we might say, here is where experimental science takes off.

We now turn to the more radical theses:

2. The First Radical Thesis: This will be articulated in the following set of statements:

> (a) "What *is* a disease is always in part a function of our culture, education and professional background."
>
> (b) (a) is true because it is impossible to apprehend nature except as something known in some way or other, that is, except under some concepts or other.
>
> (c) The goal of medical science is to get as close as is possible to a reality *not* so structured by our culture, education and professional background.
>
> (d) This goal is not accessible, BUT it can usefully serve as a heuristic device.

Engelhardt seems to view what I am calling the first radical thesis as a thesis which is true not merely of medicine and the health care professions, but more generally as something true of all attempts to understand reality, all attempts, scientific and otherwise, to gain knowledge and understanding. He cites Charles Sanders Pierce in his support, and Pierce, of course, was talking quite generally. It is worth noticing that if all Engelhardt is espousing is *this* thesis, then medicine is not at all special, for *all* science and knowledge, Pierce thought, was like this. This seems *not* to be what Engelhardt *elsewhere* seems to think, for elsewhere in this very chapter he seems to suggest that the problems here are especially pressing for medicine. It is plausible to

say that claims (c) and (d) of the first radical thesis are intelligible, though quite how we are to make them plausible is not at all clear. This is a problem which in philosophical circles has been the subject of much discussion. It should be obvious that my comments here are at best superficial and tentative. This will be obvious to anyone who has worked through the literature addressed to the theses usually referred to as "metaphysical" and "internal" realism.

Now for the Second Radical Thesis:

3. The Second Radical Thesis: This will be articulated in the following set of statements:

> (a) "What *is* a disease is always *entirely* a function of our culture, education and professional background." There *is* no "fact of the matter", as some philosophers have put it. This is sometimes referred to as the "social construction of reality".
>
> (b) The truth of (a) can be illustrated by the fact that some health care professions do indeed vote to make certain states into diseases:

But, in the end,

> (c) Statement (a) is true because it is impossible to apprehend nature except as something known in some way or other, that is, except under some concepts or other and (a) is true not only of those diseases described in (b) though they are the most obvious: it is true of all diseases.

Despite (a) and (c),

> (d) The goal of medical science is to get as close as is possible to a reality *not* so structured by our culture, education and professional background.
>
> (e) This goal is not accessible, but it can usefully serve as a heuristic device.

It is worth saying that if we can just make sense of clauses (c) and (d) of the first

radical thesis, it is not at all clear why anyone would think that the parallel clauses here (clauses [d] and [e]) can be motivated.

This completes my exposition of Engelhardt's ideas about what I am referring to as the "multiple realities thesis". I will continue to refer to the thesis as such even though I have distinguished several versions of it because most of my comments will apply whichever version is being discussed. Let me now try to explain why I think that this thesis complicates, or should be viewed as complicating, my discussion of interpretation.

3.2 THE MULTIPLE REALITIES PROBLEM

Whether we accept the multiple realities thesis in its moderate form, or either of its radical forms it should be obvious that since physicians, nurses and patients have been acculturated, educated and professionalized at least at some points in different settings and in different manners with different mores, there is going to arise the possibility that, if you asked a group of physicians and nurses and patients to describe the facts of a situation, if they each list the facts by virtue of which there is a disagreement or there is an ethical puzzle, the various listings of facts would be different. Actually, this claim is plausible even without the underpinnings of the multiple realities thesis in any of its forms, except perhaps the moderate form. If we underpin the claim with merely the moderate thesis then it would be a somewhat inflated way of putting the point (but I think still a useful way of putting it), to say that they live in three different realities. If we are working with merely the moderate thesis then this is only a metaphor, but it is a striking way of putting the point and it

is worth putting the point in a striking way, lest we fail to notice how terribly important it is. On the moderate thesis there would be (or at least there need be) no suggestion that they live in different realities in any ontologically serious way. For example, on the moderate thesis there would be no need to assert that they cannot talk to one another - the moderate thesis would only require acknowledgment that it can be very difficult for them to talk to one another. But that would not be all the moderate thesis would need for my present purposes. For that difficulty of talking could be explained by a variety of competing hypotheses - for example, that their preoccupations are very different, that their concerns are very different, that their value systems are very different, that some are sexists and find it very hard to listen to what they count as inferiors anyway, etc. etc. None of these explanations would count as a multiple realities problem, though of course any or all of these might *explain* why there are multiple realities if there are.

In what follows I would like to use the multiple realities thesis to make sense of some ideas which are I think interesting, but to do so without addressing the question of whether the moderate or the more radical versions are in fact correct. To do that would be beyond the scope of this thesis.

This said, what *is* the multiple realities *problem*? The problem can be stated simply, given all that I have said. The problem is that *if* in any of the senses we can allow that physicians, nurses, other health care professionals and patients live in slightly different worlds, as I am allowing myself to put it, then we not only have the problem that it seems possible to interpret the laws, codes and practices which govern

the behaviour of the professionals in different ways for a given situation, we also have the problem that for the reasons given it might be worth countenancing the idea that for each of those participants there is a different situation, as we might put it. Now what this means is that if we are to develop a theory about how we can resolve conflicts about interpretation, the theory must be rich enough to cover not only the question of how to resolve conflicts of interpretation of laws, codes and practices, it must also cover the question of how to resolve conflicts about interpretations of reality - the theory will need to tell us how to pick which reality is to count if just one is, or perhaps how to cobble together some sort of compound reality - a reality compounded out of the various different realities. This then is the problem.

Let me close this section by pointing out that the view that there is something like a multiple realities problem can be argued using Engelhardt's ideas, along the lines I have suggested, but it could also be argued as follows.

We might start from some studies showing that nurses and physicians, for example, see the same ethical issues differently and also see the process of resolving problems differently. For example, Gramelspacher et al.[16] found that almost all nurses reported disagreements with physicians about ethical issues, whereas almost no physicians perceived such disagreements. Storch and Griener's study[17] on the effectiveness of institutional ethics committees in Canadian hospitals found that

---

[16] Gramelspacher, Howell, and Young, 1986.

[17] Storch and Griener, 1989.

although many physicians interviewed held that good interdisciplinary consultation was occurring on their units (and many head nurses agreed with them), the staff nurses on those units did not agree. The nurses stated that physicians believed that they were "consulting" when in fact they were "telling", rather than listening or asking questions. This was supported by non-nurses in the study who commented that nurses' concerns were not well-addressed.

Now these studies *might* be read as saying merely that the physicians and nurses disagree about how the laws, codes and practices of their professions apply to the situations in question. I think that it is clear that they suggest that even if these differences are part of what is happening, they are not all that is happening. In particular, I suggest, it is at least possible that what is happening in these situations is that what the physicians and the nurses count as the situation itself is different, and different because of the differences in their acculturation and the differences in their professional approaches: their professions, maybe, "structure" their realities differently. Now short of redoing these studies, I do not see how to decide whether the studies suggest what I am taking them to suggest. But for my purposes what is important is the possibility that this or something like it is what is happening.

One last comment about the nature of the multiple realities problem. Because of the fact that I am simultaneously discussing both the moderate and the more radical versions of the multiple realities problem it should be obvious that in what follows I will indifferently view the issue as being an issue

> a) about the possibility that there is more than one possible interpretation of the one situation,

and

> (b) about the possibility that there is more than one possible interpretation of what is in fact more than one situation.

It is perhaps worth noticing that in the discussion to follow, it rapidly becomes rather hard to distinguish the two. In fact, in what follows it will be useful to proceed explicitly as if what I was discussing was the former. If we say this, then I can contrast what I am here calling the multiple realities problem and the problems about interpretation I have discussed in the earlier chapters as follows:

> (a) In this chapter I have been discussing the fact that sometimes at least we are faced by *one* situation (perhaps), but there is more than one characterization or picture or *interpretation* of what the situation actually is.
>
> (b) In earlier chapters I have been discussing the fact that sometimes at least we are faced by *one* situation, whose characterization is agreed on by all, but *two* different interpretations of the laws, codes and practices and hence two views about which laws, codes and practices apply in this one situation or how they apply in this one situation about whose characterization all agree.

The former is what I am calling the "multiple realities problem" and the latter I will term the "multiple interpretations problem". It is the former that I am mainly concerned with in this section, but the two are intricately connected. As well, they are complicated by the fact that (b) often or perhaps even necessarily produces (a). What I mean by this is that since the laws, codes and practices of one's profession can be considered as the point of view from which one sees a situation, then these laws, codes and practices will affect how one sees the problem. For example, if the foundation of one's code is beneficence, then one would want to do as much good as possible, and if one believed that doing good was to cure, then one would see cure as good. If what the patient wishes stands in the way of cure, then the patient's wishes

would not be seen as being appropriate. On the other hand, if one's code of ethics placed a high value on respecting patients' individual needs and values, then what the patient wishes would be of prime importance.[18]

So my suggestion is that what can happen in such a situation is from fact that an alternative picture of the situation does not always get noticed (because of power, authority, fear, etc.)[19], there is a failure to discuss the fact that there are two construals of what the facts are. Hence the relevance of alternative interpretations of the laws, codes and practices is also not noticed. Thus comments such as "What is she/he fussing about now?", or "That is not an ethical problem - it is a personnel or administration problem" are commonplace, or seem to some nurses to be commonplace.

So it is important that we examine the phenomenon of the multiple different realities, because if it is not recognized, we not only have the question of which laws, codes and practices apply and how they are to be interpreted but we also have the question of which reality/situation they are to be applied to. And, if the alternate construal of the reality is not even allowed to be articulated, then how can an

---

[18]As a matter of fact, it is worth pointing out that these comments could be viewed, and indeed I will so view them, as providing a third route into the multiple realities problem. The first route was provided by Engelhardt's ideas, the second by the studies by Gramelspacher, et al., and Storch and Griener, and this third by the simple commonsensical point about the way laws, codes and practices can affect one's perception of the situation. As a matter of fact, of course, this third is only a particular application of the ideas underlying the moderate multiple realities thesis.

[19] I return shortly to the reasons why these alternative realities or alternative characterizations of the one reality are not noticed. See Section 4.3 below.

interpretation of that view of the laws, codes, etc. emerge?

To fix ideas, let me close this section by commenting very briefly on one approach to the multiple realities problem which has been perhaps common in previous times: in some hospitals it is still to be found. On this approach we would argue that if we use just one set of laws, codes and practices, for example, to have one profession with ultimate authority to decide what the reality is to be, then we would not have a multiple realities problem. There would then be only one set of laws, codes and practices to apply to the situation and only one situation for the laws, codes and practices to apply to. It is my view that this simply would not do, for a variety of reasons, some practical, some conceptual, and some ethical. I return to the reasons later in this dissertation. Here let me briefly explain why the approach will not do. The discussion will serve to show that I am not setting up a pseudo-problem in this chapter.

Firstly, even though on the suggested solution we might say that we would have all members of the health care team *using* the same code applied to the same reality, in fact this would only be an appearance of using the same code for the same situation, because even though the other professionals might have been silenced, they would or at least might continue to think of the situation in their own way in the light of their own laws, codes and practices: an imposed solution is only an appearance of a solution, or perhaps only a postponement of a problem. If the nurses continue to view the situation in the light of their code, but they act as the physician instructs in the light of her view of the situation in the light of her code, then they are engaging in

feats of double think which can become amazingly complex and difficult: they are asked to see the situation as the physician sees it, rather than as they see it, and then interpret the physician's code and apply it to *that* situation. Most physicians find applying their own code to their own world hard enough. The nurses are clearly being asked to do feats of imaginative interpretation far beyond anything asked of the physician!

The fact is that it is indeed very difficult to take on the laws, codes and practices of a different profession, especially in a context where one is also functioning in one's own profession. For laws, codes and practices represent the deep values, goals and emphases of one's profession. The mere fact that these different professions work in the same institutions, and care for the same patients does not make it any easier to take on another profession's picture of the situation and to act on that other profession's values, goals, etc.

So, this is the problem. That it is a real problem is suggested by the failure of simple minded solutions like the one that I have just briefly discussed. I will address the task of solving this problem as part of my general solution to the interpretation problems. I want to end this chapter by what is in a way a digression from my main line of argument. However, I think that to view it that way would be a mistake. It would be better to view it as a discussion which will serve further to enrich the ideas and the significance of the ideas found in the discussion to this point. I want to suggest that the multiple realities thesis and the related multiple realities problem have as just one instantiation a whole group of complexities and problems which have been

articulated in the literature of feminist critiques of the health care professions. A review of some of this literature will serve to deepen and in fact render more plausible some of the points I have been making in this chapter.

3.3 AN ILLUSTRATION OF THE MULTIPLE REALITIES PROBLEM

Feminist scholars have shown how the female and male worlds are different, and feminist writers are beginning to articulate how this difference has special significance within the health care setting.[20] Cheshire Calhoun, for example, argues that traditional moral thinking "may render invisible, unspeakable, or trivial routine moral activities that we sense (even if we cannot say) are central to goodness".[21] This "emotional work", most often done by women, for Calhoun, is "the management of *others'* emotions - soothing tempers, boosting confidence, fuelling pride, preventing frictions, and mending ego wounds".[22] This work falls outside our paradigms for moral activity. Sherwin notes that the distinction between feminist work and traditional philosophy is that "feminists readily admit to bias in their perspective, while philosophers continue to assume bias should and *can* be avoided."[23] This admission recognizes that "what has been claimed to be objective and universal is really a male point of view".[24] The relevance of these kinds of comments to the multiple realities

---

[20]For example, see Sherwin, 1992 and the *Hypatia Edition on Feminist Concerns in Bioethics*, Vol.4(2), 1989.

[21]Calhoun, 1992, p. 116.

[22]Calhoun, 1992, p.118.

[23]Sherwin, 1988, p.20.

[24]Sherwin, 1988, p.19.

problem is obvious, perhaps. However, I want to spell out the ideas in a little more detail.

Calhoun notes that oppressive wrongdoing often occurs at the level of social practice, where general social acceptance of a practice prevents the individual from being aware of it being wrong.[25] In another paper, Calhoun argues that two ideologies of the moral life are likely to result from the repeated inclusion or exclusion of particular topics in moral theorizing.[26] These ideologies are (1) that it is self-evident that special obligations are less important than the general, impersonal duties that theorists chiefly emphasize, and (2) that general rather than special, obligations are experienced most frequently in the moral lives of persons. The moral lives of women are often taken up with the details of special obligations, yet these concerns are discounted. The cumulative effect of generations of male-defined theorizing amounts to gender bias. There is a denial of the ethical significance of women's perspective and concerns. This denial is evident in the silencing of the multiple interpretations I have been discussing, some of which represent a more connected and person-centred approach than others.

Virginia Held writes that most feminists see morality as a matter of practice and art as well as of knowledge:

> Practice is involved both in understanding what we ought to do and in carrying out the norms of morality... I take moral inquiry to involve activity and feeling

---

[25]Calhoun, 1989, p.389.

[26]Calhoun, 1988.

as well as thought and observation.[27]

All health care professions include practice, art and feeling, but, again, some professions are involved on a more continuous basis with patients, and are thus able to establish a relationship where feelings are more likely to be explored.

Engaging in the development of feminist morality, notes Held, involves seeking to improve practices, in which knowledge, though important, is only one component. Held argues for room to be made for what she calls "moral experience", which is experience substantially different from that found in most male philosophical writing:

> Moral experience is the experience of approving or disapproving of action or states of affairs of which we are aware and of evaluating the feelings we have and the relationships we are in.[28]

Thus, moral experience must include a process of evaluating the actions we participate in.

The feminist view of experience is:

> ...the lived experience of feeling as well as thought, of acting as well as receiving impressions, and of connectedness to other persons as well as to self...When women test male constructs against our own experience, we often experience conflict.[29]

The empirical difference between the work of nurses and the work of physicians (at least in the hospital setting) is clear. Nurses are with the patient around the clock, hence learn more about the patient and family, and are frequently the ones who

---

[27]Held, 1993, p. 22.

[28]Held, 1993, p. 24.

[29]Held, 1993, p. 24.

administer the therapeutic treatments and observe and record the reactions. Nurses frequently have a sense of living through the illness with the patient and family, producing a different viewpoint which can lead to conflicts between beliefs about what is best for a patient. Held notes that "because of male domination, we may have attributed the clash to what we imagined to be our limited capacities, in comparison to men, to think or to act".[30] It is well-documented that nurses (mostly female) have been historically dominated in the hospital setting by physicians (mostly male) and the resulting denial of the importance of alternative experiences in moral decision making also denies the importance of feeling or emotions and the importance of connectedness to other people in the moral realm.

The result can be an imposed choice which can be explicit, for example, a nurse being told to "Shut up" or being denied the opportunity to express her views. Alternatively the imposed choice can be implicit, which is more worrying. The nurse's interpretation is ignored because the nurse's reality is ignored, so the choice is imposed in a sense that just doesn't look at the second interpretation.

Thus, the feminist concerns come in to the problem of interpretation at least at two points:

> 1. In the structuring of the reality which gives rise to the question as to whether there is an ethical problem in the first place,

and

> 2. the concerns come in at the conflict resolution stage. It may be that because of the dominance of male-defined experience in the health care situation there is a tendency to move to certain kinds of ways of dealing with a situation which may be ethically wrong. For example, it may be a tendency for the

---

[30]Held, 1993, p.24.

> nurses to accommodate instead of negotiate. There may be a tendency for a power imposition, or for avoidance.

In other words, if there really are multiple realities (for example, the nurse sees an issue in a certain light, and the physician sees it altogether differently), then in order for the two to come to an agreement that is satisfactory to both an understanding of each other's perspective of the reality of the situation must become clear. Then, and only then, can an interpretation of the laws, codes and practices come into play, for the communication of the alternative realities will open up the possibilities for alternative interpretations of the laws, codes and practices.

CHAPTER IV: POSSIBLE SOLUTIONS/RESOLUTIONS TO THE PROBLEM

4.1 PRELIMINARY COMMENTS

If my discussion of the multiple interpretations problem and the related multiple realities problem is correct, then to ignore the problem is inconsistent with securing the best benefits for the patient and the best operation of the health care team.[1] Structures to allow for the articulation and resolution of conflicts arising from differing interpretations of laws, codes and practices, situations, and goals and values in health and illness must consequently as a matter of ethical necessity be made an integral part of the health care system, given the need to "Consider first the wellbeing of the patient".[2]

An example of the need for us to address the interpretation and multiple realities problems is the so-called "slow code" situation. A problem faced not rarely by nurses, this situation would typically have a terminally ill patient who is very sick and whose physician refuses to write a "do not resuscitate" order. "It will be the slowest code in history if he arrests", the nurses say as a possible solution to their ethical dilemma of having to initiate what they think is a futile procedure. This kind of situation does seem to suggest that the multiple realities problem can motivate the various team members to take different approaches. And the alternative approaches may be implicitly working at cross purposes to each other. Hence, instead of a collective action by the health care *team*, we could have individual actions by the

---

[1] For an illustration, see the two examples of cases in Chapter I.

[2]See the Canadian Medical Association Code, Principle I.

various *components* of the health care team if the multiple interpretations are not discussed and a solution not negotiated taking each interpretation into account.

In this chapter, I am going to look at some solutions to the multiple interpretations and the multiple realities problems. I want first to comment that what really interests me are what might be called full blown solutions to these problems, but before I look at that, I want to acknowledge that in some situations it may be that the best thing for the patient's good, and maybe the best thing ethically, is not to *solve* the problem: it may be better to *avoid* the problem in several ways, or perhaps to ignore it, or to conceal it. The comments in the next section are addressed to this possibility.

4.2 THE PERFECT SOLUTION OR THE BEST POSSIBLE RESOLUTION?

It is important to notice that we may not be able to find a "perfect solution" to an ethical problem. We may instead have to choose the one that is the best that can be hoped for in the situation.[3] I will call this the "best possible resolution", one that would be the best that could be made in the circumstances. For example, prolonging life support for a brain-dead patient until a family has time to accept and cope with the death, while probably doing no good and possibly doing harm to the patient (not to mention the harm caused by the depletion of scarce resources on a "hopeless" case), allows the family time to say goodbye, make a decision, and resolve the guilt or anxiety over not "doing everything". Here the best possible resolution may be to decide to prolong life support for a certain period of time, when the decision could be

---

[3]I have developed this section from a very useful suggestion made by J.A. Baker.

changed if the patient's condition has not improved.

So, keeping this crucial point in mind, that we must not always count on finding a "perfect solution" for each problem, let us proceed to looking at possible approaches to resolving conflict resulting from the interpretation problem.

The example of the "slow code" situation is an example of the avoidance technique, as described by Bethany Spielman in a paper on conflict resolution approaches[4]. It might be that in certain circumstances one could argue that the right thing to do is to engage in avoidance behaviour. Avoidance may be appropriate because there might be something in the laws, codes, and practices such that, in relation to the well-being of a particular patient the best course would be to overlook the laws, codes or practices[5]. This would also assume that at the same time it might not be clear that there should be a change to the laws, codes and practices generally. For example, the physician may want to transfer a patient who refuses recommended surgery to another physician (to avoid conflict when the first physician feels very strongly about the benefits of the proposed treatment), or a nurse who requests that she not be assigned to patients undergoing abortions. It is important to notice a problem here, though. Since I argued earlier that there is a need to uncover conflict and have it discussed, the avoidance approach appears inconsistent. But, if avoidance is recognized

---

[4] Spielman states that avoidance is characterized by evasion and unwillingness to engage in problem solving. I footnote my categorizations in this chapter with the approaches that Spielman uses, for I think that they are interesting and complement mine, but are not as detailed as the ones I outline here. See Spielman, 1993.

[5] In this sense, the action would be perceived as being best *morally* (fixed by morality), although not best *ethically* (fixed by the laws, codes and practices).

as a *possible* way of dealing with some kinds of conflict it might be considered morally appropriate in some situations. It may be appropriate given limited available time, or when one of the participants feels so strongly about his or her position that negotiation is not possible. The point is that recognizing that avoidance (or other non-negotiation processes) may sometimes be appropriate helps the participants to see that the expectation of achieving a negotiated solution in every situation is an impossible expectation.

I now turn to a consideration of some "full blown" solutions, as promised.

4.3 POSSIBLE SOLUTIONS FOR INTERPRETATION

If we have two or more different interpretations of the laws, codes and practices of a profession (the multiple interpretations problem) or two or more interpretations of a situation (the multiple realities problem),[6] then what should we do? This section is addressed to the task of outlining some possible answers to this question.

I begin by providing in step form an outline of an approach which might be taken to the task of solving the multiple interpretations and multiple realities problems. More accurately, what I provide is in effect a check list of the necessary conditions for a solution to the interpretation and multiple realities problems which would count as being indeed a solution, rather than an avoidance or postponement of the problem.

A. Preliminaries:

---

[6]This would apply whether the interpretations are by the same person, different persons of the same profession, or persons from different professions.

Imagine that there is a disagreement in interpreting a situation (a multiple realities problem) or in interpreting the laws, codes and practices of one of the professionals involved in a situation (a multiple interpretations problem), or both. For example, imagine that one person perceives an ethical problem, and another does not. The following steps seem, as a first approximation, the kinds of steps we should expect to be supplied by a solution.

> 1. For each professional's laws, codes and practices, there will be an explication of how this professional takes her laws, codes and practices to apply in the situation; that is, for each professional there will be an interpretation of how her laws, codes and practices apply. There is no assumption that the interpretation will be the same, even for each member of the same profession. Notice that this interpretation may well be a very complex activity. For example, in the case of a physician this activity of interpreting the laws, codes and practices may involve figuring out what this patient's wellbeing should be taken to consist in (the physician here might be interpreting Principle I of the Canadian Medical Association Code), and in the case of a nurse the activity might consist in figuring out what she is supposed to do in this situation as the patient's advocate. The complexities are inevitable given a variety of points. Firstly, as I pointed out the codes of ethics are designed to leave flexibility, without emptiness, which is difficult to secure. Secondly, and consequently, both physicians' and nurses' codes contain both some very general statements ("principles" for the physicians and "values" for the nurses) and some more specific constraints (the various clauses which specify for the physicians what an "ethical physician" would do in various situations, and for the nurses the statements of "obligations").
>
> 2. For each participant there will be a specification of how that participant interprets the laws, codes and practices of each of the other participants.[7] This too is not easy to specify.
>
> 3. For each participant there will be a specification of how that participant interprets the situation to which the laws, codes and practices are meant to apply. Again, this is not an easy task to complete.

---

[7]In the case of one person, checking to see if the two interpretations really are different, or if perhaps one may not conform to the laws, codes and practices.

4. For each of the interpretations mentioned above either the interpretation fits the situation or it does not. There will be an account of the reasons why the interpretation fits or fails to fit.

In some situations this will yield a unique situation and a unique interpretation of what the laws, codes and practices demand. If this is so, and if that interpretation satisfies the conditions mentioned in 4, then that interpretation of the situation and of the laws, codes and practices is the solution to the problems. In other cases, this will not be what emerges. To these cases I now turn.

B. If There is More Than One Interpretation Which Fits the Laws, Codes and Practices:

If there are several interpretations which fit the laws, codes and practices or more than one interpretation of what the situation consists in, there are various possible approaches that might be used. In discussing them, I want to distinguish between interpretative kinds of approaches to the problem and non-interpretive kinds of approaches. The aim of all approaches here is, of course, to find a single interpretation of the laws, codes and practices and of the situation, this single interpretation satisfying some canons of an "acceptable" interpretation of the laws, codes and practices and the situation.

To ensure that the problem is clear, let me review the kinds of situation which we might need to deal with. Imagine that in a health care situation there were two physicians, two nurses and a single patient. Clearly the following possibilities might arise:

(a) The two physicians might interpret the situation in manner M1 and their laws, codes and practices in a single way L1, OR they may differ in each.

(b) The nurses again might both interpret the situation in manner M1, the same way as the physicians did, or they might interpret it differently, say in manner N1. Alternatively, they might not even agree with one another on how to interpret the situation. Clearly there are four ways of interpreting the situation which two nurses and two physicians could in fact come up with. Similarly, the two nurses might interpret *their* laws, codes and practices in the same way or differently.

(c) The nurses and the physicians might interpret the other profession's laws, codes and practices either as they interpreted them or differently.

(d) The patient might interpret the situation and the various professional codes as the professionals do, or they may interpret them differently.

Clearly the possible combinations of situations are enormously varied.

My suggestion is that in reaction to these kinds of situations there are a very large number of responses possible. There are reasons for the responses that I will give, but here I want merely to give a review of the possible responses. I will organise these responses as follows:

1. I will first describe some responses which in effect involve merely *more* interpretation of the laws, codes and practices.

2. I will then describe some responses which involve not more interpretation, but rather some *decision* between the various possible interpretations. This decision can be:

   i. imposed by power
   ii. imposed by an authority, or
   iii. negotiated.

3. I will thirdly describe some responses which in effect involve an exercise in which the parties *avowedly and explicitly negotiate* what to do in the light of the conflicting interpretations of the situation or the laws, codes and practices.

4. I will then describe some responses which in effect again involve an exercise in which the parties *negotiate* what to do in the light of the conflicting interpretations of the situation or the laws, codes and practices, but where it is not made explicitly clear that what is indeed happening is that the parties *are*

negotiating a solution.[8]

5. I will finally describe a response in which the parties just "pick" what to do.

1. Interpretation Approaches: The idea here is something like this. Imagine that we have a physician who interprets her code in manner Mi and a nurse who interprets her code in manner Ni. In a situation in which it emerges that the two codes conflict on *these* two interpretations, it might be that what this shows is that the two codes or one of the two codes should be given a different interpretation in the interests of avoiding conflict. The kinds of further interpretation I am thinking of here could take various forms, including at least the following:

> i. Checking further the fundamental values, goals, etc. of the professions involved; the aim is to determine what is wanted in an acceptable interpretation by finding consistency with the stated goals and values, etc. So, if a certain interpretation is going to cause practical problems which interfere with the fulfilment of the goals, then that interpretation can be ruled out, even if in one sense it is a possible interpretation.
>
> ii. Checking whether the interpretations fit the situation; here one needs to look at conciliation and coherence between values, goals, etc. Much can be done to decrease the problems of interpretation by "juggling" the various components that go together to make up the laws, codes and practices to secure what you might call "conciliation of the parts". To conciliate is to make compatible, to cause to be in accord. In another sense, to conciliate is to win over from a state of hostility or distrust, gain good will, or favour. Coherence is a state of systemic or methodical connectedness or interrelatedness, especially when governed by logical principles, or the integration of social and cultural elements based on a consistent pattern of values and a congruous set of ideological principles. Here we need to ensure that all the laws, codes and practices are working together to secure the stated outcome, for example, the benefit of the patient. If you have several principles, say in a code of ethics or in a traditional practice, which are open to two different interpretations, some possibility may

---

[8]The sources for this categorization are (a) the 1990 paper by Hutchinson, in which she explicates the idea of "responsible subversion", and (b) the books by Shwayder, 1965, and Lewis, 1969.

exist of solving the problem of competing interpretations by turning from this principle or group of principles and looking at the goals, or looking at the fundamental values. The CNA Code of ethics provides a very good example of how this can be done. The Code gives a list of values, from I to XIII; since in the preamble there are goals[9], some problems in interpretation of the values may be resolved by looking at the values and the obligations that arise out of the values and comparing them to the fundamental goals, and by looking at other principles that may apply in each case. Amongst the tests for an acceptable interpretation is the question, can the whole thing be coherent, are the various values, obligations, principles and goals that are stated compatible? Thus, the notion of coherence and conciliation[10] is appealed to in the procedure of identifying an acceptable interpretation.

iii. Negotiating an identification of finding an interpretation of the laws, codes and practices; this would still be an approach which put interpretation at the core of the solution of the problem (and hence it should be listed under this rubric); the conflicting interpretations would be the basis for continuing the resolution of the problem. This approach will be filled out further in section 3 below.

2. Approaches Which Take Over Where Interpretation Ends: The idea is that the approaches here *replace* further interpretative activities, though, note that the outcome of the approaches here might well be that one interpretation is acted on, even an interrpetation not previously thought of. The kinds of things I am thinking of here include any of the following:

---

[9]Though not explicitly stated as goals of the Code or of nursing, the Code gives a definition of nursing practice: a "dynamic, caring helping relationship in which the nurse assists the client to achieve and maintain optimal health...Nurses direct their energies toward the promotion, maintenance and restoration of health, the prevention of illness, the alleviation of suffering and the ensuring of a peaceful death when life can no longer be sustained". (CNA, 1991, p.i.)

[10]I am using the word "conciliation" here in a rather metaphorical sense. The idea is from William Kneale's use of the word "consilience", see Kneale, 1952.

i. Modes of acting imposed by exercise of *power*.[11] The choice of a single interpretation might be imposed by some person or group of people who already have or who take to themselves for the occasion the power to impose a choice of interpretation. Thus, for example,

> (a) The "Battle Axe Nurse": one of the nurses, the stereotypical "battle axe nurse", might simply by force of personality, rudeness, or whatever, impose her reading of the laws, codes and practices on everyone else. Notice here I say "power", not "authority".
>
> (b) The "Bullying Physician": one of the physicians, the stereotypical "bullying physician", might again by force of personality, rudeness, or whatever, impose her reading of the laws, codes and practices on everyone. The surgeon who refused to be questioned on her recommended treatment for a patient by the nurses in example II in Chapter I shows how this may occur.
>
> (c) The "Demanding Patient": one of the patients who is very aggressive and demanding might, again, simply by force of personality, rudeness, etc. impose her wishes or reading of the laws, codes and practices on the health care professionals. An example is the patient who demands to remain in an acute care hospital after recommended discharge to a nursing home, threatening to sue the hospital if forced to leave.
>
> (d) The Hospital Administrator: an administrator may impose an interpretation on the health care professionals on staff through her power to discipline or terminate employees. The danger of loss of employment to health care professionals who blow the whistle on unsafe practices is an example of an imposed interpretation.[12]

---

[11]I use the distinction between power and authority to organize the possibilities here. *Power* is a capacity notion, the ability to compel obedience, to make others do what we want them to do, whether or not they want to do it. *Authority*, on the other hand, is a rights notion, and implies the *right* to command. It is sometimes defined as "legitimate power", calling for respect, rather than fear, from those subject to it. Thus it implies voluntary acceptance and the acknowledgement that the person with the authority has the right to command. Hence, others have the duty to obey.

[12]Spielman would describe this as coercion, which she defines as a one-sided approach characterized by behaviour that conforms to one's own values and which sacrifices the other party's values (an imposed solution on the other party).

ii. Modes of acting imposed by exercise of *authority*:

(a) By a physician who has the authority to determine medical care for a patient: some physicians may feel that their decisions should not be questioned.

(b) By a nurse: Given that nurses have a certain amount of authority in the day-to-day running of their nursing units in the hospital, some may indeed think that the nurse is the one who should have the authority here.

(c) By the patient: Since she already has the right to refuse treatment by virtue of various clauses in the codes of ethics of nurses and physicians, she might also be viewed as having the right to impose her reading of any relevant laws, codes and practices or even her reading of the situation.

(d) By the hospital ethics committee: The committee may, in a similar way to physicians and nurses, have the authority to impose a decision in difficult cases[13].

(e) By the hospital lawyer: The lawyer may provide a legal opinion on what should be done, with the hospital then imposing a solution based on the expertise of the lawyer. Such a decision would then be grounded in prudential considerations.

(f) By an employer: The hospital administrator may have the authority to impose interpretations on employees.

Whereas the above are *imposed* solutions, the next are *negotiated* solutions.[14]

iii. Modes of acting when interpretations have clashed may be imposed, what is imposed being some form of negotiation about what to do: I will

---

[13]However, note that hospital ethics committees usually serve only in an advisory capacity. The physician may or may not act on their advice.

[14] Negotiation is a joint approach to problem solving, in which a settlement is reached through communication. Spielman does not use the term "negotiation", but rather two terms: "compromise" is characterized by give-and-take and some sacrifice of each party's values, and "collaboration" is an approach that produces a solution requiring little or no sacrifice of either party's values.

refer to this as the "imposed negotiation approach". Here the negotiation does not occur from the basis of the various interpretations, but from another base such as power or authority. This imposed negotiation approach will be discussed in more detail in the section on non-interpretive negotiation below.

3. Explicit negotiated approaches: The idea here is that when interpretations have clashed, the response might indeed be for the various parties *avowedly and explicitly to negotiate* what to do in the light of the conflicting interpretations of the situation or the laws, codes and practices. The negotiation can be direct: the parties involved directly negotiate. But it may also be vicarious: that is, it could be given to another group, such as the institutional ethics committee, thus letting someone else do the negotiation for the parties involved. The benefit here may be the continuation of healthy relationships between the physician and the nurse and/or others. Also it is possible to give the decision making authority to the hospital lawyer to decide, for example, in the case of a difficult patient. The ethics committee may still be involved, but the lawyer would help to make the final decision based on possible litigation. The negotiated approach could also be of the interpretive or non-interpretive kind, as follows:

i. Interpretive Negotiated Approach: On this approach the participants would start with two or more interpretations, then negotiate to a third position, assuming that each of the parties will use, as their status quo point for the negotiation, their interpretation of the situation and/or of the laws, codes and practices of their profession.[15] The basis for the negotiation from the status

---

[15] "Status quo point" is a standard phrase used in the negotiation literature. Most theories see negotiation as a process taking two stages:

1. The need to negotiate to a status quo point

and then

2. The need to negotiate from a status quo point to a solution.

For example, imagine there is a situation within a hospital setting where a nurse and a

quo point to the resolution of the problem, then, would be the two (or more) different interpretations.

ii. Non-interpretive Negotiated Approach: It might be that the status quo point is not set up as an application of the laws, codes and practices of the professions involved - that is, it would *not* be an exercise of an interpretive kind used to set the status quo point; the status quo point is set up based on the greater power or authority, etc. of one member of the team, and a resolution is negotiated from that point.

4. The Implicit Negotiated Approach: The idea here would be that the negotiation to a choice of what to do would take place more through *actions* than through *discussion.* David Lewis calls this a "convention", occuring where there is a general sense of common interest.[16] Using David Hume's example of the rowers in *A Treatise of Human Nature* the approach is similar to two people rowing a boat together. If the rowers row in rhythm, the boat goes smoothly forward; if not, the boat moves erratically and inefficiently, and there is the danger of hitting something. The two rowers are constantly choosing to row faster or slower, constantly adjusting their rate

---

physician have two different interpretations. There might be some negotiation that takes place which is negotiation to a status quo point, and the outcome to that negotiation might be an agreement on their part that the status quo point from which the future negotiation will take place will be their relative power, or their relative authority, or they might negotiate that the status quo point will be the two interpretations of the situation, or of the laws, codes and practices. Then, having picked a status quo point, they go on to negotiate a solution. In an interpretation kind of negotiation, the status quo point would be the two interpretations (setting aside authority and power), and the parties would look at the task of finding a solution that takes the two interpretations into account. The solution may not be exactly the same as the two interpretations but may in some way be a combination of them. For example, the nurse might give up decision making in the area of care insofar as "care" involves the use of medication, in return for increased authority in relation to patient advocacy.

[16]Lewis, 1969.

to match the other's. If they do coordinate their rhythm, they "do it by an agreement or convention, tho' they have never given promises to each other."[17] We can picture the implicit negotiation approach as being extensionally equivalent to the rowers' coordination problem; health care professionals would negotiate without words, coordinating their actions to each other.

Notice that the implicit negotiated approach could be either an interpretation kind of activity or a non-interpretation kind of activity, as defined in the previous section.

5. Arbitrarily Picking a Solution: The idea here is that the participants, or one participant, would simply "pick"[18] a solution from those put forward, rather than choosing one *for a reason.* Here, the assumption would be that two or more solutions fit with the laws, codes and practices and situation, so that one solution could be picked arbitrarily.[19]

4.4 THE PREFERRED APPROACH

Of the possible approaches, which is to be preferred? Or, in the sense of "best possible resolution", which can be seen to be the best possible approach given the

---

[17]Hume, 1978, p. 490.

[18]There is a small body of literature which uses the word "pick" as a technical word, contrasting it with "choosing". In this literature choosing is taking for reasons and picking is taking for no reason, but arbitrarily.

[19]Spielman's category of accommodation (which she describes as a one-sided approach to problem solving characterized by behaviour that conforms to the other party's values, sacrificing one's own values) is a difficult one to fit into my categorizations. I think perhaps it comes closest to "picking", for people would tend to accommodate when the solutions proposed do not conflict with their laws, codes and practices.

circumstances? As a first step to answering that question let me spell out some of the kinds of considerations which might be applied in choosing between the alternatives. A full consideration of how to go about answering the questions here will be provided in the next two chapters.

I will mention here just those kinds of considerations which might be brought to bear in choosing between the various approaches:

a. What I will call "the medical parameter": choosing an approach in the light of this parameter would consist in choosing in the light of the possible or probable medical benefit to the patient. This parameter must be considered an important one, for it is the stated goal of health care professionals and institutions. It is, after all, the reason why the patient approaches the health care professional in the first place; it is the need for improvement of presenting symptoms that patients and potential patients see as the justification the health care system.

b. What I will call "the cost effectiveness parameter": This parameter, especially given the changes now being made to the health care system, will almost always need to be taken into consideration. Not only financial costs are important, but emotional and physical costs (such as pain and suffering), and other costs, such as to the quality of life of the patient.

c. We can also choose in the light of what is *ethically* acceptable. I will refer to this as the "ethics parameter". As the word "ethical" was defined in Chapter I (that is, in accordance with the code of ethics of a profession), this parameter would have been already considered if the proposed solution fits with the laws, codes and practices.

d. We can also choose in the light of what is *morally* acceptable (using the definition of "moral" from Chapter I). I will refer to this as the "moral acceptability parameter". Some possible criteria on this parameter may be:

i. Does the solution leave the parties as persons?

ii. Does the solution infringe rights (e.g., respect for autonomy, dignity, etc.)? Does the proposed solution infringe the rights of patients, health care professionals or others?

iii. Ideal rule consequentialist testing: What are the consequences of the

> proposed approach? Will it benefit the most people? If the rule that is to be followed by the approach were to be applied consistently, would the amount of wellbeing in the world be at least as much as it would be on any other rule or principle?
>
> iv. Ideal rule contractarian testing: If the rule or principle followed in the approach followed were adopted for other similar situations, is it a rule that would be *ideal* in the sense that fully rational, fully informed people would accept it. Is it one which they would be willing to live under, even taking into account how they would feel about the rule in every position a person might find herself in under the rule?

All of the above parameters need to be taken into consideration. (There may be other considerations which may come into play as well.) However, as I have argued in previous chapters, if the interpretations of the various parties involved are not first taken into consideration, then the chosen approach will not be ethically acceptable (meaning, of course, ethically acceptable to all the professionals involved). In order to make it so, either the codes of ethics must be changed, or the solution to the problem must allow for the free expression of the various interpretations.

4.5 CONCLUSION

To sum up, we can ask the question, which of these possible solutions, is (are) the right one(s)? Before answering this question, I want to step back in the next chapter to look at a very deep question which might motivate the choice of a solution, to step back from the puzzles we are addressing and examine some questions about autonomy and the moral agency of the participants in the situation. If it is fundamental that all health care professionals are to be treated as autonomous agents in the health care situation, then the story of interpretation that is adopted has to be compatible with the moral agency of all concerned.

CHAPTER V: MOTIVATING A SOLUTION: MORAL AGENCY AND INTERPRETATION

5.1 PRELIMINARY COMMENTS

In the previous chapter I listed some of the possible solutions to the problem. In this chapter I will outline the connection between autonomy, moral agency and the interpretation problems and show how the requirements of autonomy and moral agency will motivate a solution to the problems. I begin with a brief discussion of moral agency and autonomy, then will argue for two points. The first, a moral point, is that only certain types of solutions are compatible with leaving nurses, physicians and patients as moral agents or autonomous agents. This point gives us a way of dumping some of the possible solutions quite quickly, at least if we can assume that we should prefer a morally superior solution. In this dissertation I will assume that we can, though I admit that it is possible to imagine scenarios where this assumption might come into question: wartime medicine and nursing spring to mind. The second point, a practical point (related, but much less important than the moral point), is that only some solutions are going to lead to a work situation which reduces the chances of burnout, resistance, irritation, inappropriate work-to-rule, subversion, and so on. And I will be assuming again just for the purposes of this thesis that these effects should be avoided if possible on both moral and efficiency bases. Again, it is possible to imagine scenarios where these effects might be accepted at least for a period of time - medicine and nursing under war and catastrophe are cases in point here.

5.2 AUTONOMY

An agent, as a first approximation, is someone or something that produces an effect on someone or something. I want to talk of autonomous agents. There are two ways in which people talk of autonomous agents. On one version an autonomous agent is one who has the *capacity* to adopt and act on rules which she has herself chosen. On the other version an autonomous agent is one who has the *right* to adopt and act on rules which she has herself chosen. Some people talk of autonomy as if to say that when someone is an autonomous agent it is to say that the person is "independent", "free", or "self directing". The third phrase might be taken to mean what I have said "autonomous" means, but the other two are clearly much wider notions. They are better thought of as the core notions of free agency than as the core notions of autonomous agency. The notion of free agency is clearly a much wider notion than the notion of autonomous agency. In what follows when I talk of autonomy I am using the narrower notion.

A comment about whether autonomy is to be thought of in terms of rights or in terms of capacities is called for. While the latter is important in discussions of freewill, it is the former notion that is important in biomedical ethics and is the notion that I want to use in this dissertation.

Notice the following points about the relation between the right and the capacity:

> a) It is not the case that from the capacity we can infer the right, i.e., the capacity is not a sufficient condition for the right. For example, criminals have a capacity, but we take away the right. It is also intelligible to circumscribe the right in certain circumstances.

b) It is not the case that from the right we can infer the capacity. In other words, the capacity is not necessary for the right. For example, a patient in a coma does not lose the right, just the capacity, to make decisions for herself. A hospital or a physician does not acquire the right to make decisions for her when she loses the capacity. Instead what happens in law and in morals is that the *early* exercising of her right can morally require the hospital or the physician to do certain acts or to abstain from certain acts (e.g. in a living will) or if she has appointed a proxy to exercise her rights for her, this proxy, not the hospital or the physician, gets to make the choices. If she has not appointed a proxy, then various rules re proxy exercising of her right become operable to assign proxy choosers.

c) When a person has an obligation to respect other people's autonomy, this means that she must not infringe their right to make laws for themselves, because, after all, she might not know that they have this capacity. Except in certain very special situations,[1] it is not one of her rights to check up on whether someone has the capacity to impose laws on themselves. In other words, respect for autonomy directs us to work on the default assumption that people do have the capacity to make laws for themselves. If we also respect privacy, then we have an obligation not to check if the morally required default assumption is correct. Entailed by this is the point that when we are enjoined to respect people's autonomy, the injunction is not to infringe their rights; it is not an injunction to pay attention to certain of their capacities, though of course in some cases doing the former will be by doing the latter.

Hence,

d) When in moral theories, especially Kantian ones, we are enjoined to respect people's autonomy, this is an injunction not to infringe their rights, not an injunction to pay attention to certain of their capacities, though of course in some cases doing the former will be by doing the latter.

Having said all this, I want to point out that there are connections between the capacity to make law for oneself (and other similar capacities) and the right to do so. For example, the possession of the capacity may be a necessary condition or at least a help in *exercising* the right. Thus we will exercise the right to make laws for ourselves if we have the capacity for free and authentic choice after effective deliberation, fully

---

[1]For example, dealing with persons who have attempted suicide.

aware of the alternatives and the consequences, and if we have chosen our laws, rules, values, after such reflection, rather than being socialized into them, and if in fact we have developed the maturity to choose the sorts of persons we will be.[2] However, my argument does not rest on these connections, although they may be an important part of an argument for how to educate nurses and other members of the health care team so that they are psychologically prepared for the exercise of their rights in the health care setting.

Along these lines it is interesting to notice that Bruce Miller, in explicating his often cited "four senses of autonomy"[3], is clearly talking not about autonomy as a right, but about autonomy as a capacity. He mentions (1) autonomy as free action, (2) autonomy as authentic action, (3) autonomy as action after effective deliberation, and (4) autonomy as action on moral reflection. Using for the most part his words, I outline his four senses as follows:

> 1. Autonomy as free action means a person's actions are voluntary and intentional. A voluntary action is one that is not the result of coercion, duress,

---

[2]Lynne Tirrell's concept of "semantic authority", which she defines as the "kind of authority to name, describe, and create our world that many men have had for a long time", is related to autonomy in the sense of authenticity. Further, Tirrell points out that it is not enough to be able to define who one is, but one must also have her or his definition taken up by the community in which she or he lives and works. So if a nurse, for example, accepts the laws, codes and practices of her profession then to "act in character" would be to act in accordance with those laws, codes and practices. But first, the opportunity to name, describe and create her world must be established, and others must also accept that definition. In a similar way, if the patient's interpretation of the situation is not heard and taken up, the autonomy and agency of the patient may also be diminished. See Tirrell, 1993.

[3]Miller, 1981.

> or undue influence. An intentional action occurs if it is the conscious object of the actor.
>
> 2. Autonomy as authenticity means that an action is consistent with a person's attitudes, values, dispositions, and life plans. In other words, the person is acting in character.
>
> 3. Autonomy as effective deliberation means that a person takes action on the belief that she is in a situation calling for a decision, and is fully aware of the alternatives and the consequences of the alternatives. She evaluates both the alternatives and the consequences, and chooses an action based on that evaluation.
>
> 4. Autonomy as moral reflection means that the moral values a person acts on are accepted by the actor. The values can be those the actor has because of the socialization process, or can differ from them, but they are values that she has reflected on and adopted. Autonomy as moral reflection is different from autonomy as effective deliberation in that a person can do the latter without questioning the values on which she is basing her choice.

Throughout the above, Miller is clearly talking about the capacity not the right.

To illustrate the importance of the capacity/right distinction, it is interesting to look at a frequently cited article by Yarling and McElmurry on nurses and moral agency.[4] They argue that the moral agency of the nurse is the foundation of nursing ethics. It is not clear whether Yarling and McElmurry are talking about the right or the capacity, but let me review what they say. I think it emerges from my review that in the end what they are best construed as talking about is the capacity rather than the right. This point is interesting in that it reveals the way in which noting the distinction between talk of the capacity and talk of the right can serve to point up both the nature of their suggestions and the limitations of their suggestions. Nurses, they say, are not free to be moral in the sense that they do not have freedom of choice. Here, with the

---

[4]Yarling and MacElmurray, 1986.

phrase "free to be moral", Yarling and McElmurry suggest that they are talking about the capacity to exercise their right to free or autonomous choice. They argue that nurses are not able (and this is clearly capacity) to actualize their commitment to patients in the practice setting when the freedom and well-being of the patient is in conflict with the interest of the hospital or the interests of the physicians. Nurses are taught verbally and overtly to be patient advocates,

> but in a thousand nonverbal and covert ways, they are taught by clinical example the limits of that advocacy. They learn quickly, by observing others, how to interpret the verbal message in terms of 'what nurses do' and 'what nurses do not do'. They learn that their commitment to patients must be carefully contained.[5]

So, I will take it that what these authors are talking about when they say that nurses are "not free to be moral" are the *preconditions* for exercise of the right to autonomous choice.

The authors also go on to say that nurses are free in one sense, that is, free to be heroic: but they say also that this is in a sense not to be free, because being heroic may put their jobs in jeopardy in the subculture of hospitals which requires that nurses not openly challenge established authority structures. Putting these points together I suggest that it is plausible to take Yarling and McElmurry as arguing the following:

> a) nurses have a right to make laws for themselves including perhaps the right to make a law requiring that they serve as patient advocates.

But

> b) the hospital rules and perhaps the nursing education system is set up in such a way as to make it very hard for them to exercise this right - it undermines

---

[5]Yarling and McElmurry, 1986, p. 67.

any capacity they may have to make and act on such laws

and so

c) if nurses *do* make laws for themselves and act on them, then this becomes heroic, supererogatory, rather than just a matter of them doing their duty.

Hence,

d) the system seems to be self-defeating.

If we do not distinguish between the right to make laws and the capacity, we weaken the position of nurses. For then we would allow that one has the right (versus the capacity to exercise it) only if one has the capacity to make laws for oneself. If we do not make this distinction, then we may see the power structure in hospitals (as Yarling and McElmurry argue) as preventing nurses from having the capacity to make laws for themselves (or at least view themselves as lacking it), which may be true. But, this does not mean that they do not have the right: all it means is that some may refuse to agree that that they do have this right.

5.3 MORAL AGENCY

One's standing as moral agent is in part a function of the fact that one has a *right*:

a) to identify an interpretation

and

b) to act on it.

Thus, one's standing as a moral agent is therefore not respected and one's rights are infringed if solutions are imposed by power or authority, as in the case of the

"battleaxe nurse" or the "bullying physician", or the hospital administrator.[6]

If a moral agent must be free to act in a self-legislating and independent way, within limits[7], then to be a moral agent a person must be free to interpret the laws, codes and practices she is subject to. Assuming that she has voluntarily chosen to take on the professional responsibilities, obligations and values of the profession when assuming that professional role[8], then to continue as a moral agent she must be free to act in accordance with them.

As the explication of the multiple realities problem shows, though, if there are actually multiple interpretations of the situation, each participant's interpretation of the reality of the situation must become clear. Then, and only then, as I have said, can the possibility of alternative interpretations of the laws, codes and practices become a part of the decision making, and the moral agency of *all* health care professionals can be preserved.

5.4 THE PRACTICAL POINT

The practical point about the need for health care professionals to retain the right and to be allowed to exercise their right to autonomy as moral agents is that some solutions may lead to work situations causing burnout, moral distress, resistance and subversion. In the long run these may lead to less efficiency in the provision of

---

[6] For a description of these types of imposed interpretations see Chapter IV, Section 4.3.

[7]The limits will plausibly be viewed as coming from the need to recognize others also are moral agents.

[8] See Chapter 1, section 1.3, on professional roles.

health care and possible harm to the patient.

When imposed interpretations fail to inform the experience of health care professionals, the professionals may question their moral competence, reinforcing acquiescence in the role.[9] Empirical evidence can be found in studies such as Wilkinson's, which finds that nurses suffer moral distress, and describes the behaviour which results. These behaviours include avoiding patients, keeping silent, or leaving the employment situation or the profession.[10]

Sally Hutchinson has explored some of the consequences of bureaucratic restraints on nursing practice, and identifies what she calls "responsible subversion", a term meaning bending the rules for the benefit of the patient.[11] Hutchinson terms this behaviour "responsible" because best nursing judgement is used to decide how and what rule to bend, "subversive" because it violates rules made by hospital administrators or physicians. "Responsible subversion is a complex process that requires energy and effort; following rules is inevitably easier"[12]. This behaviour may result in positive consequences such as benefits to patients, and the possibility of changing the rules through formal channels as the new behaviour gradually becomes accepted. But there may also be negative effects, for example personal consequences for nurses, such as reprimand or firing, or a nurse choosing to become less of a patient

---

[9]Parker, 1990.

[10]Wilkinson, 1987.

[11]Hutchinson, 1990.

[12]Hutchinson, 1990, p.7.

advocate in future if she is caught. Responsible subversion can also affect the patient or family in a negative way, causing rules to be tightened. Responsible subversion is an interesting version of the autonomy right - making it the right to make for oneself and to impose on oneself laws and rules, *and* the right to keep the rules *but* to bend them. These thoughts in a way bring us back to my earlier comments about solutions to conflicts when the solutions are less than perfect.

5.5 UNSUITABLE SOLUTIONS

The argument for the *right* to be treated as an autonomous agent, as a moral agent, clearly indicates that some of the possible solutions offered in Chapter IV can be discarded. The argument uses a moral principle as a premiss, that is, it is a principled argument for the choice of a solution. If the interpretations of the situation and/or laws, codes and practices of all professionals involved are expressed and considered in decision making, a requirement which I have said is essential for moral agency, then an imposed interpretation of the situation will not be acceptable in most cases. The argument also eliminates the acceptability of a negotiated solution where the status quo point does not include the various interpretations but is based on power or authority. Thus, imposed interpretations or negotiations of the non-interpretive kind are not ethically acceptable in most cases. The trickier cases are the ones where a kind of imposed interpretation is required, such as in the operating room, or in emergency situations. These cases will be discussed in the next chapter.

Is the implicit negotiated approach unsuitable? Although this approach may seem to work in some situations, the fact that alternative interpretations sometimes fail

to be noticed or to be taken into account in decision making, especially the different interpretations of the situation (for example, whether it presents an ethical dilemma or not), suggests that in the end this solution won't do. The possibility that some interpretations will not get expressed, or will be ignored is too high. I will discuss all this in more detail in Chapter VI.

CHAPTER VI: SOLUTION(S) TO THE INTERPRETATION PROBLEMS

6.1 PRELIMINARY COMMENTS

To ensure that the problem is clear, let me review the argument so far. I have stated that there are two problems, the multiple realities problem and the multiple interpretations problem. The multiple realities problem is that at least sometimes we are faced by *one* situation, but there is more than one characterization or interpretation of what that situation is. In this thesis I will be assuming that only those versions of the multiple realities problem which do not claim that there *is* more than one reality will be discussed. That is, I am talking only about how to deal with the possibility that there is more than one interpretation of the single reality. The multiple interpretations problem is that at least sometimes we are faced with one situation whose characterization is agreed on by all, but two (or more) different interpretations of the laws, codes and practices, and hence two (or more) views about which laws, codes and practices to apply. Or we could have conflicting characterizations of the situation, combined with conflicting interpretations of the laws, codes and practices, that is, *both problems can occur simultaneously.* These problems, I have said, can also be complicated by the fact that the multiple realities problem and the multiple interpretations problem are intricately connected, because the laws, codes and practices represent the fundamental values or principles through which one assesses situations. Also complicating the picture is the fact that, due to the authority or power structures in health care institutions, some interpretations are less likely to be articulated and

used in the decision making process[1].

I have identified a problem that is not discussed in the literature, and it is indeed a complex and difficult one. I have suggested in Chapter III that solving the multiple realities problem, *if* it exists, can be done as part of a general solution to the interpretation problems. In Chapter IV I gave a list of possible solutions. Chapter V, which argues for the importance of maintaining the moral agency of health care professionals (that is, their right to interpret and set their laws, codes and practices, within limits), puts constraints on any solutions we may choose and also gives us a lesson on the application of solutions. With this in mind, I now go on to comment on the solutions I described in Chapter IV.

6.2 THE SOLUTION(S) TO THE PROBLEMS OF INTERPRETATION

Preconditions for solving the interpretation problems are:

(a) The problems are explicated and explored by having the alternative interpretations of the situation expressed.

(b) Each participant specifies how she interprets the laws, codes and practices of her profession and of the other profession(s) as they apply to the situation.

(c) The participants check to see if the interpretations fit with the laws, codes and practices. (No assumption needs to be made that there will be only one interpretation of either the situation, or the laws, codes and practices.)

(d) If there are several interpretations, they need to be recognized, articulated, respected, considered, and be part of the process of making a decision.

These are the preliminaries I described in Chapter IV.

But a question still remains. What do we do when we have well-articulated,

---

[1] I am here referring to both interpretations of the situations and interpretations of the laws, codes and practices.

well-respected interpretations which represent fundamental disagreements, preventing easy resolutions to ethical conflicts? In Chapter IV, I gave five possible solutions to answer this question. Let us now consider how the discussion of the moral agency and autonomy of health care professionals helps to choose between these solutions. But before looking at the alternatives, I want to consider an important question of how decision-makers set about moral reasoning in ethical situations.

Spielman, in a paper seeking patterns of resolution in moral conflict in health care settings, suggests there are two levels of moral reasoning.[2] She envisages ethics in a clinical setting as a social activity requiring more than a process which uses abstract theory to find philosophically defensible moral positions using principles, virtue ethics, and other theories, a process that she terms "first-level moral reasoning". A second level becomes operative, she says, after participants have used the various methods at the first level and arrived at conflicting solutions; this is the process of resolving disagreements *after* participants in a case have used first-level reasoning. For this second level, Spielman describes a strategy based on approaches to conflict resolution found in the business literature.[3]

Spielman's two levels of moral reasoning are not exactly the standard moral philosophers' two levels. The philosophers' two levels are as they are portrayed in R.M. Hare's writing, most systematically in his book *Moral Thinking*.[4] Hare proposes

---

[2]Spielman, 1993.

[3]See Chapter 4, Section 4.3, where I footnote Spielman's conflict resolution strategies to my own categorizations.

[4]Hare, 1981.

that one engages in first level moral thinking when one cites principles, values, rights, duties, etc. in deciding what to do and what rules one should adopt. This kind of thinking is perhaps best thought of as an exercise in generating consistency or coherence. It is the kind of thinking which is done when all that one is doing is *interpreting* the principles and values one accepts. It is, in other words, the kind of thinking engaged in when one does the interpretation activities I have discussed in earlier chapters. This kind of reasoning is also referred to as principled reasoning.[5] R.M. Hare in his *Moral Thinking* refers to basically the same thing as first level thinking.[6]

Hare and many others have pointed out that this kind of reasoning is invaluable in day-to-day living, when one does not have the time or the energy to do anything better, but it is, necessarily, seriously flawed. First of all, it is *not* (except in very limited ways) "self critical"; that is, with this kind of reasoning one never gets behind the principles and assesses them for racism, sexism, stupidity, superstition, arbitrariness, etc. (*unless* such things happen to be revealed directly or indirectly in the principles one *already* accepts). Secondly, and most importantly, reasoning at this level is necessarily incomplete because it leaves open the question of whether these principles are in the end acceptable. Now Hare (with his reversible universalizability method, following in one way in the footsteps of Kant), Brandt and Harsanyi (with

---

[5] As it is by J.A.Baker, personal communication, and in his applied ethics lecture texts.

[6]Hare also rudely calls it the thinking of the proles (after George Orwell's *1984*), versus second level thinking which is the thinking of the archangels!

their ideal rule utilitarianism, following in the footsteps of Bentham and Mill), and Gauthier and the Rawls of *A Theory of Justice* (with their rather different versions of ideal rule contractarianism, following in the footsteps of Rousseau and - in a way rather different than Hare does - in the footsteps of Kant) have all suggested procedures for getting *behind* these principles - in what Hare calls second level reasoning.

Now these two levels are rather different from Spielman's, but not too different. Let me explain. What Spielman's second level does can be contrasted with what these people see themselves as doing at exactly one point. Each of the people I have cited see themselves at the second level as engaging in moral reasoning, choosing from and assessing the materials at the lower level. Their second level reasoning will tell them what first level principles are *morally worthy of* attention and respect. Their second level reasoning, engaged in by these people as individuals, will tell them what moral principles they separately ought to respect and act on. But this second level reasoning (or the first level reasoning of people who have not engaged in second level reasoning) does not tell them what to do when, as members of a community, they either do not accept exactly the same moral rules as others in the community, or do not accept exactly the official rules of that community. In other words, these people's reasoning does not thus far tell them any story about what to do in a pluralistic society, "pluralistic" in the sense that the people in that society do not accept a single

uniform morality. It is exactly at *this* point that Rawls in his later writings[7] and others, including Spielman, have something interesting to say. For *perhaps* what they are doing, and I think that they can be construed in this way, is describing morally acceptable ways of figuring out what it would be morally acceptable to do in situations where people interact but where the parties to the interaction do not subscribe to exactly the same moralities. In Spielman's case (but using my terminology of "laws, codes and practices") she is describing morally acceptable actions in situations where people do not share or where they interpret differently their several laws, codes and practices.

So, tying all this in with *my* discussion, it is clear that my interpretation-like ways of resolving conflicts are first level. My non-interpretation-like procedures are higher level, but not necessarily higher level in the manner of Hare, Brandt, early Rawls and Gauthier.[8] They are higher level in the manner of the later Rawls and Spielman - that is, as means of dealing with unresolved pluralism.[9]

A further point is that absent from Spielman's model for conflict resolution is an account of how to deal with the fact that the participants on the health care team (and the patient) do not share the same power or authority, a fact which results in

---

[7]And perhaps in some of his earlier writings, though he is not as clear in them about this point as he is later. For a clear statement see Rawls' "The Idea of an Overlapping Consensus", 1987.

[8] Although they can be - at least in the sense that the procedures result in an interpretation which is morally (and ethically) acceptable to, and perhaps morally (and ethically) binding on, all.

[9]An idea that originated in personal communication with J.A.Baker.

some conflicts remaining unrecognized. In fact, by introducing the solution to the problems of interpretation at both levels of moral reasoning, that is, by acknowledging the problem and promoting discussion of the various interpretations, we can begin to reconcile the uneven levels of power and/or authority. I want to say here here, however, that solving the interpretation problem will not solve this different problem (the unequal power or unequal authority problem); it will merely deal with one aspect of it - that *some* voices are silenced in the decision making process. In other words, by recognizing that there may be alternative interpretations (of situations and of laws, codes and practices), by hearing and respecting each interpretation, and by putting conflicting interpretations through a conflict resolution process, some of the problems related to power and authority will become more visible and open to resolution. What I am describing here, though, is not a *procedure* for putting all of this is put into effect. What I am describing is *what* needs to be put into effect. Notice that this is an important distinction; the former is a question about practical hospital politics, the latter is a question about what the politics should be aiming for.

6.3 RESOLVING ETHICAL CONFLICT

In Chapter IV I described five possible approaches to the problem we have when there are several interpretations which fit the laws, codes and practices and/or more than one interpretation of what the situation consists in. Let us look at the five approaches and briefly assess their moral and ethical acceptability in the light of the previous chapters. In the examination I will use the same organization of approaches as I used in Section 4.3 of Chapter IV.

1. Interpretation Approaches:

If it is necessary for respect for the autonomy of all health care professionals that the interpretation problems be resolved, as I argued in Chapter V, then the interpretation approaches I described must be presumed to be the preferred approach unless there are good reasons to the contrary. The non-interpretative negotiation approaches, which use as a status quo point the authority or power of one or other of the participants, may not be cognizant enough of interpretations, but at times may be all that is possible in the circumstances[10]. When there are conflicting interpretations one can check them against the fundamental values and goals of the professions (usually implicitly or explictly stated in the Codes of ethics), and look for coherence or conciliation among the various professionals' laws, codes and practices. Second level reasoning can enter here when coherence and conciliation are unattainable, when the various professions that work together may decide to coordinate their various laws, codes and practices so that they *do* fit, or if it becomes apparent through the interpretation and negotiation process that they clearly need to be changed.

2. Approaches Which Take Over Where Interpretation Ends:

I will frame my discussion here around the authority/power distinction I described in Chapter 4. While various players on the health care team may have different amounts of power, the difference between the *capacity* to make rules for oneself and the *right* to make rules for oneself should be kept in mind. The question should always be asked, when making decisions, about who has the *authority* (that is,

---

[10]See Chapter IV, Section 4.2 regarding the "best possible resolution".

the right) to make the decision. If my analysis of the multiple interpretations problem and the multiple realities problem is correct, it should be obvious that everyone on the health care team, including the patient, has some authority and should[11] feel free to discuss her interpretation. And it may be that the person with the most personal power in the situation, perhaps through force of personality or rudeness, may not have the authority to be the decision-maker. For example, the patient clearly has the right to refuse any medical procedure or treatment that she does not want, but the patient may be intimidated into consenting to something against her wishes if a nurse, physician or hospital administrator uses the strength of personality or rudeness to persuade her.

But complicating this picture may be the fact that in some situations there is no time for alternative interpretations to be discussed, or the fact that negotiation is sometime inappropriate (such as in emergencies or in the operating room). Notice that this is not to say that there *are* no multiple realities or multiple interpretations present in the situation. Alternative interpretations may certainly exist, although they may remain hidden because of the lack of time for negotiation and discussion. However, if the interpretations that are present in an emergency situation can be discussed afterwards (for example, in a retrospective case conference) then it may be possible to prevent future problems, or satisfy people that the best procedure possible for a difficult situation had been followed. A retrospective discussion could also assist interpretations to play a part in the future cases of even these kinds of emergency

---

[11]Here I take "should" to mean "morally, ethically, prudentially, and practically should".

decisions. For example, after a cardiac arrest and attempted resuscitation on a terminally ill patient, the team could meet to discuss the actions taken, the feelings and values of the various team members, and to plan future approaches to similar problems. Or, a team working in an operating room could hold regular meetings to discuss cases where there has been conflict, and talk about future ways of proceeding in the light of these discussions.

Probably one of the most important ways to ensure that interpretation problems be considered in the negotiation process is to recognize the need to integrate the concept into the education of health care professionals: students should have the opportunity during training to study and discuss the codes of ethics, regulations, and practices of their own and other discplines, preferably in an interdisciplinary setting.[12] From such formal structures and discussions, the various professions may come to appreciate the amount of interpretation that actually does take place in health care. The possibility exists that this recognition will have the long-term effect of making health care institutions more open to other interpretations, for example, those of patients, patients' families, etc.

Although there may be times when the imposition of a solution by authority or when non-interpretive negotiation approaches may be best in the circumstances (that is, solutions which may be imposed), the interpretation of the *situation* (the multiple realties problem) should not be imposed. Imposition here might void the purpose and

---

[12]There are some programs where medical and nursing school students have opportunities to take classes together, especially ethics classes, and this is probably a first step to what I have in mind.

usefulness of the health care team, whose value lies in the bringing together of several different disciplines and their various problem-solving strategies. Not only by virtue of the principle of respect for autonomy, but also by virtue of the fact that the alternative is unethical (in the sense that it is against the laws, codes and practices of a profession) we should ensure that all members of the health care team have the opportunity to reflect on and act on their laws, codes and practices.

The idea of "imposed interpretation" by institutions[13] suggests that the structure of institutions is more addressed to the agenda of the institutions and the people who work in them than in advancing the agenda of the patient. Patients and their families must be considered as part of the team, and thus part of the negotiation process. By not including patients, health care professionals might concentrate on (a) only their own interpretations of their laws, codes and practices[14], and/or (b) creating a joint interpretation which includes only the professionals' goals, values, etc. Thus, the interpretation may not be shared with the patient and the patient's family, the result still being an imposed interpretation - imposed on the patient.[15]

---

[13]The phrase "imposed interpretation" is from MacIntyre, 1977. An example would be the "Policies and Procedures" established by hospitals, which attempt to standardize decision making, both clinically and bureaucratically, for nurses, physicians, and all other employees of the institution, and which do not allow much room for individual interpretations of the situation.

[14]One of the purposes of a professional code of ethics is to establish for their clients and for the society in which they practice the expectations for the ethical conduct of those professionals.

[15]It is interesting to notice here that if the CNA code is followed, the patient will be allowed into the decision-making process. See the Canadian Nurses Association *Code of Ethics for Nursing*, 1991, Values I and II. It is not clear that the Canadian Medical Association Code ensures this.

Imposed interpretation and negotiation approaches, I said in Chapter IV, can be explicit (for example, when a physician makes a decision about medical treatment) or implicit (for example, deferring to a demanding patient). Imposed negotiation may be the morally the right approach, for example, in the case of a Jehovah's Witness child who requires a lifesaving blood transfusion. Obtaining a court order to authorize the transfusion against the parent's wishes involves a kind of negotiation process[16] which uses both expertise and authority to impose a solution.[17] Imposed interpretation or non-interpretive negotiation may be morally inappropriate in other cases (for example, in the cases of a "bullying physician" or of an administrator "pulling rank", which is the inappropriate use of authority mixed with power).

3. Explicit negotiated approaches:

Explicit negotiation techniques, considered the preferred approach by some health care professionals,[18] may be appropriate in some situations only if there is time to work on resolving conflict. The compromise option of continuing aggressive treatment for a specified period of time in the case of a patient in persistent vegetative state, after which the participants will review the case, is an example. After a period of time the participants in favour of aggressive treatment may step back from their

---

[16]Despite initial appearances to the contrary, we may say that a court procedure *is negotiated* in the sense that all the parties have the opportunity to express their views and to state what their wishes are.

[17] Although note that force in the ethics literature is not used by some writers in connection with authority and the *right* to decide.

[18] Collaboration, one form of negotiation, is considered the ideal goal in much of the bioethics literature, especially in the nursing literature. See, for example, Pike, 1991, and Baggs, 1993.

position to negotiate from a status quo point that includes consideration of the interpretation that continued treatment may be harmful to the patient. Collaboration, a way to achieve a solution that sacrifices little of the participants' values, may then be possible.

The negotiation process can be direct, with the parties involved directly negotiating, but the process may also be vicarious, for example, the problem may be sent off to the institutional ethics committee for a decision[19]. While this approach could be viewed as avoiding the problem, allowing others to do the negotiating on behalf of the participants may serve the purpose of maintaining healthy relationships between physicians and nurses, or physicians and patients.[20]

An alternative to solving some problems could be what I will call a "Fishkin forum", where a group of citizens are gathered together, immersed in an intensive deliberative processes about a problem, then polled on what decision they would make. A clear account of the interpretive nature of health care decision making would be helpful in such a forum. An example of the usefulness of this process may be for the gathering of public opinion about which kinds of treatment should be funded by a

---

[19]This direct/vicarious subdivision can be true of both explicit negotiation and implicit negotiation.

[20] In the same way, the decision could be given to the hospital lawyer to decide based on possible litigation, for example in the case of a difficult and demanding patient. But this could not be viewed as a solution to the interpretation problem; it is clearly a prudential solution in which the major consideration is the welfare of the institution.

government health care plan.[21]

4. The Implicit Negotiated Approach:

Implicit negotiation techniques may sometimes be appropriate for the well-being of the patient or the good of the hospital. For example, a physician may want to accommodate the demands of a parent by prescribing antibiotics for a child who has a cold, a treatment with no medical benefit. The use of the antibiotic may calm the parent's fears, which may in itself help both the child and the parent, and preserve the relationship between physician and patients. Sometimes, however, the right thing to do in such a case would be to insist on negotiation. Negotiation might be a better choice in this example because prescribing an antibiotic of doubtful efficacy may lead to harm.[22] In other cases, going along with a patient's wishes or a physician's orders without verbal discussion may be a benign way of promoting the efficiency of the team, and of preserving relationships.

5. Arbitrarily Picking a Solution:

When there are two or more interpretations that fit with all the goals, values,

---

[21] This process, called by Fishkin a "deliberative opinion poll", is outlined in Fishkin, 1991. As Fishkin notes, "The point of a deliberative opinion poll is prescriptive, not predictive. It has a recommending force, telling us that this is what the entire mass public would think about some policy issues or some candidates if it could be given an opportunity for extensive reflection and access to information." (p.81). Ordinary polls, notes Fishkin, model only what the electorate thinks given the limited information it has. The term "Fishkin forum" was coined by J.A. Baker.

[22] As scientists are discovering, the overuse of antibiotics is resulting in a proliferation of bacteria that are becoming resistant to almost every antibiotic. See, for example "Rising Infections Alarm Doctors:", Calgary Herald, Mon. Mar. 28, 1994.

laws, codes, etc. but the proposed solutions are not extensionally equivalent, just "picking" a solution may be *the only way* to resolve a problem. Also, in emergency situations, "picking" a solution to an *ethical* dilemma may also be appropriate. This is not to say that some choosing will not be done, hopefully as solutions to the *medical* problems, with medically beneficial reasons in mind.

6.4 CHOOSING IN PARTICULAR SITUATIONS

In her article, Spielman introduces four case-specific variables which provide a very useful account about whether and how conflict will be addressed and which may indicate which approach to conflict resolution is most likely to be used and why. Spielman is thus addressing causal factors. *I* will use these variables (and two more of my own) as *tools* for choosing an approach, tools which I think can provide guidelines as to which approaches *should* be used to solve interpretation problems. Notice that some of the variables, such as time available, have already been discussed briefly in the previous section. Spielman's four variables, using *my* terms for possible approaches[23], are the following:

> 1. The participants' degree of commitment to the relationship: A high level of commitment to a relationship is likely to result in an implicit or explicit negotiation approach. A low level of commitment is more likely to result in an imposed solution or avoiding the problem. So, this suggests that if we want the former rather than the latter we should train and support nurses and other health professionals to make and have the fortitude to stick with commitments.

[23] That is, I have used my terminology for possible approaches to a solution here rather than Spielman's terminology for approaches to conflict resolution.

2. The participants' level of moral certainty[24]: This variable affects the choice of approach in the following way. We are more tolerant and accommodating to the views of others when we are less certain of the correctness of our own moral view.[25] With a low level of moral certainty decision makers are more likely to avoid a problem, to simply "pick" a solution, or else to use an implicit negotiated approach. With a high level of moral certainty, an imposed solution or an explicit negotiated approach are more likely. So we should train nurses to feel more confidence in their own judgement, for example by getting them to see themselves as autonomous professionals who are members of an independent and worthwhile profession.

3. The time available to address and work through the conflict: When time is short, an imposed interpretation or avoidance are preferred because they can be completed quickly. Negotiation usually requires time to complete, so we need to structure the work environment to leave time for such decsion making. Sometime this is best accomplished by structural changes in the working procedures so that a point in the procedures is created at which such questions *are* discussed.[26]

4. The cost-benefit ratio of working through the conflict: This includes (a) assessing the benefit to the patient (and to the health care professional), (b) assessing whether the proposed action conforms to the professional's moral position, (c) assessing the risk of creating disruption in the professional's relationships with the patient and/or family or other health care professionals, and (d) assessing the perceived nonnegotiability of the other parties' positions. An unfavourable cost-benefit ratio encourages avoidance; as the ratio improves, negotiation, that is, compromise and collaboration (both of which require cooperation), become more attractive options. Again, this suggests the need to ensure that the decision making structure is set up in a way to make this

---

[24] Spielman uses the discussion of gradations of moral certainty found in Jonsen and Toulmin, 1988, as a basis for this variable.

[25] This moral uncertainty may be, in part, the result of uncertainty about medical facts, uncertainty about society's ethical consensus about an issue, or strictly subjective moral uncertainty.

[26] My idea is paralleled in the world of business decision making by the suggestion by Weber that we should "institutionalize ethics". What he means is that as part of the corporate structure ethical considerations will be addressed "getting ethics formally and explicitly into daily business life, making it a regular and normal part of business. It means putting ethics into company policy making at the board and top management levels and through a formal code, integrating ethics into all daily decision making and work practices for all employees..." (p. 533). See Weber, 1983.

possible.

Notice, though, that Spielman fails to list two very important, and, some might say *the* most important, variables, variables which I have previously said must be considered.[27] They are:

> 5. Medical benefit to the patient: The higher the likelihood that the patient's wishes are consulted, the higher the likelihood she will benefit from the procedure. Depending on the situation, an imposed solution may be better, consultation may be better, and in others letting nurses be the advocate of the patients may be a better approach. Again, this suggests the need to ensure that there is a place and a time where the patient's well being gets explicit attention in its own right. It is astonishing that we need to say this, but we do need to say it!
>
> 6. The moral acceptability of the various solutions: This is related to moral certainty, but we should consider this variable separately because deontological and consequential considerations are concerns usually brought into decision making, as in, for example, the common question "What if we did the same thing in every similar situation?" As with moral certainty, the direction would seem to be that the higher the moral acceptability, the more likelihood of a solution imposed by authority, or an explicitly negotiated solution. This suggests the need to ensure that there is a place and time to discuss moral accptability, and also that the participants have the capacity to understand and work through the principles, values, etc. in a fairly sophisticated way.

Notice, however, that the *kind* of approach decided upon would affect the moral acceptability of the solution; as I have argued in Chapter V, a solution which does not respect the right to autonomy and moral agency of all the participants involved would be unacceptable. Recall that I said that autonomy consisted in the right to make the laws one chooses to live under, within limits. If space for the consideration of the

---

[27] These variables are described in Chapter IV, Section 4.3. Some may conclude that these two very important variables are also at times not considered by health care providers and bureaucracies when important decisions are being made, for example, when cutting costs.

laws, codes and practices the professionals voluntarily[28] and publicly have chosen to practice under is not made, then the solution will not be morally, ethically and practically acceptable. If the patient has no say in how the laws, codes and practices are applied to her, then the approach would not be morally, ethically[29] and practically acceptable.

The significance of the variables is, according to Spielman, that a decision maker could encourage an approach different from the one that appears likely, by changing one or more of the variables. But let me make another point about the usefulness of the variables, a non-causal point. If the various interpretations of the situation are not considered, and if the various interpretations of the laws, codes and practices are not expressed, then the variables may not have sufficient detail or richness to be of as much use as they could be. Take, for example, the variable of "medical benefit to the patient" and apply it to the example of the patient with the liver abscess in Chapter I. If the different realities are not considered, with attention paid only to the surgeon's reality, then the medical procedure is much more likely to be done. The question of medical benefit to the patient is not as likely to be fully developed, because the whole team would not hear the nurses' interpretation of the situation, would not deliberate on the nurses'interpretation of which laws, codes and

---

[28]See Chapter I, Sections 1.3 and 1.4 on the notions of professions and roles, and of the laws, codes and practices of a profession.

[29]Not ethically acceptable given that some of the health care professionals' codes of ethics require, for example, that the patient has the "right to control their own care" and the "right to choose". (Quotes are from the Canadian Nurses Association Code, 1991, p.3)

practices apply to that situation, and perhaps even would not consider the patient's subjective contribution about her perception of the situation and her wishes. The surgeon diagnosed a liver abscess, and given that in her experience liver abscesses usually require drainage (a "simple procedure"), she recommended that it be done. Nurses saw a woman who was dying, who was comfortable, and who would not benefit from another invasive medical procedure. The patient was never asked, despite the fact that she was able to carry on conversations with her family and the nurses.

To sum up, the benefits of creating a place for the consideration of alternative interpretations are the following:

> i. The actual situation may become clearer, a benefit of recognizing the need for interpretation given the multiple realities problem.
>
> ii. It will be clear that there is more than one set of laws, codes and practices to be applied to a situation, whether there is a single interpretation of the situation or several.[30]

The first benefit deals with the multiple realities issue and the second deals with the multiple interpretations of laws, codes and practices issue.

An even more important point is that the patient surely has a say and, if she is competent surely has an *overriding* say, in what the reality is and in how the laws, codes and practices are to be implemented on *her*! In other words, the patient's right of refusal guaranteed in both the CMA and CNA Codes is a vital consideration here. It

---

[30] For example, if the nurse's interpretation of the situation as an ethical dilemma is not articulated, then the nurse's obligation to provide ethical care may be impossible to fulfil. The requirements of the nurse's code of ethics may not even be considered to be relevant to the situation by other health care professionals. The result may not only be ethical distress on the part of the nurse, but that important information about the patient may not be taken into account.

is important to remember, then, when assessing interpretations, that the interpretations of health care professionals may not be interpretations that are shared with the patient and the patient's family.[31] If the interpretation is not shared, there may be an imposed interpretation *on the patient*, either through power or authority or both.

Looking again at the first example in Chapter I, that of the health care team conference, our analysis of the interpretation problem can help us to understand why several nurses might disagree with each other, or the two physicians disagree with each other. The primary nurse, who is familiar with the patient's wishes through caregiving for 12-hour shifts, has encountered the patient's suffering and he has communicated his wishes to her. This contributes to her interpretation of the situation, and the picture of the patient's autonomy, for the nurse, includes the context of his day-to-day experience. The supervisor supports the family because they have been talking to her about their hope for recovery; the picture the supervisor has of the situation has not been balanced by the experience of continuous presence at the bedside. The ICU resident and the physician interpret the same value - beneficence - differently: the physician by doing as much as possible to maintain life, the resident by not prolonging death at the expense of suffering. We can imagine the benefits that would occur if all participants, including the family, could have their interpretations of

---

[31]It is interesting to notice that if the nursing code is followed the patient will be allowed into the decision-making process. See CNA *Code of Ethics for Nursing*, 1991, Values I and II. It is not clear that the Canadian Medical Association Code ensures this. The notion of the patient's right of consent is included in both Codes. It is not included, though, in the list of "Principles of Ethical Behaviour" in the physician's Code. "Respect for Client Choice" is a Value in the nurses' Code.

the situation attended to, and the various interpretations of the different laws, codes and practices articulated. Filtered through the variables of medical benefit, cost-benefit ratios, commitment to relationship, moral acceptability, moral certainty, and time available, we can see that the parties in this situation should be able to come up with a negotiated solution. For example, during the team conference the nurse would have the opportunity, and the time, to express her feelings about restraining Mr. White's arms and legs to prevent him from pulling out his tubes. The resident could explain why he felt so frustrated during the second resuscitation procedure. Perhaps then the family might begin to see continued aggressive treatment as prolonging Mr. White's suffering. Similarly, if the family explained their strong religious convictions around the sanctity of life, the professionals might have more understanding of the request to have "everything done".[32]

In Chapter I, I pointed out that it should *not* be assumed that the question of *how* an interpretation ought to be chosen should be answered by asking *who* should decide. My analysis shows that it is a mistake to lump the two questions together; this makes it difficult to sort out what a morally and ethically acceptable solution is.

I want to mention one other complication, one that I touched on in Chapter V. That is the inexperience and perhaps in some cases consequential lack of skill of some professionals at expressing their ideas, interpretations, and suggestions in decision

---

[32] These suggestions, while not spelling out all the possibilities, are enough to give an indication as to how the various interpretations would help. The point is that even if the nurses know of the family's feelings and share that information with others on the team, a direct conversation with the family would have more impact. The opportunity would also be available to correct any misinterpretations or misunderstandings.

making. Here I am thinking especially of nurses. This may hinder finding solutions to the interpretation problems, but it is a factor that is not impossible to overcome.[33]

Spelling out procedures to bring about the resolution is not what I have attempted in this thesis. What I have done is to point out the need to aim at the goals of bringing each participant's interpretations into the resolution of ethical conflict, to understand how deeply the problems of interpretation affect the moral agency of health care professionals and patients, and from this analysis to look at how some solutions would be more compatible than others with the principle of respect for autonomy of all the participants in the health care setting.

[33]Some authors suggest education, restructuring institutions, nursing ethics forums, or nursing ethics rounds to enable what I call nursing interpretations to be uncovered. See, for example, Rodney and Starzomski, 1993 and Levine-Ariff and Groh, 1990.

BIBLIOGRAPHY

Alberta Association of Registered Nurses. (1991). *Nursing Practice Standards.* Edmonton,AB: Author.

Alberta Association of Registered Nurses. (1992). *Scope of Nursing Practice.* Edmonton, AB: Author.

Baggs, J.G. "Collaborative Interdisciplinary Bioethical Decision Making in Intensive Care Units." *Nursing Outlook*, 41(3), 1993, p. 108-112.

Baker, J.A. "The Moral Position of the Health Care Professional." *Lectures in Biomedical Ethics.* 1993.

Barber, B. (1987) "Professions and Emerging Professions." In *Ethical Issues in Professional Life*, J. Callahan (Ed.). Oxford: Oxford University Press, 1988, p.35-39.

Bayles, M.D. "The Professions". In *Ethical Issues in Professional Life*, J. Callahan (Ed.). Oxford: Oxford University Press, 1988, p.27-30.

Benner, P.E. *From Novice to Expert: Excellence and Power in Clinical Nursing Practice.* Menlo Park, Calif.: Addison-Wesley, 1984.

Bishop,A. and Scudder,J. "Nursing Ethics in an Age of Controversy." *Advances in Nursing Science*, 9(3), 1987, p. 34-43.

Bok, S. "Round Table Discussion: The Physician as Moral Agent." In *Philosophical Medical Ethics: Its Nature and Significance*, Spicker, S.F. and Engelhardt, Jr., H.T.(Eds.). Dordrecht: D. Reidel Publishing Company, 1977, p.230-234.

Calhoun, C. "Emotional Work". In *Explorations in Feminist Ethics: Theory and Practice*, E.B. Cole and S. Coultrap-McQuin (Eds.). Indianapolis: Indiana University Press, 1992, p. 117-122.

Calhoun, C. "Responsibility and Reproach". *Ethics*, 99(2), 1989, p. 389-406.

Calhoun, C. "Justice, Care, Gender Bias." *The Journal of Philosophy*, 85(9), 1988, p.451-63.

Callahan, J. (Ed.) *Ethical Issues in Professional Life.* Oxford: Oxford University Press, 1988.

Canadian Medical Association. *Code of Ethics.* Ottawa: Author, 1987.

Canadian Nurses Association. *Code of Ethics for Nursing*. Ottawa: Author, 1991.

Dreyfus, H.L., Dreyfus, S.E. and Benner, P.E. . *Acquiring Ethical Expertise in Nursing*. A paper sponsored in part by the Helene Field Foundation, 1990.

Engelhardt, H.T. Jr. *The Foundations of Bioethics*. Oxford: Oxford University Press, 1986.

Fishkin,J.S. *Democracy and Deliberation*. New Haven: Yale University Press, 1991.

Gadow, S. "Existential Advocacy: Philosophical Foundation of Nursing". In *Nursing, Images and Ideals*, S.F.Spicker and S. Gadow (Eds.). New York: Springer Publishing Company, 1980, p. 79-101.

Gauthier, D.P. *Practical Reasoning*. Oxford: Clarendon Press, 1963.

Government of the Province of Alberta. *Nursing Profession Act*. Edmonton: Author, 1983.

Government of the Province of Alberta. *Regulations Pursuant to the Nursing Profession Act*. Edmonton: Author, 1983.

Gramelspacher, G.P., Howell, J.D., and Young, M.J. "Perceptions of Ethical Problems by Nurses and Doctors." *Archives of Internal Medicine*, 146, 1986, p. 577-8.

Hare, R.M. *Moral Thinking*. Oxford: Clarendon Press, 1981.

Held, V. *Feminist Morality: Transforming Culture, Society, and Politics*. Chicago: University of Chicago Press, 1993.

Hume, D. *A Treatise of Human Nature*. L.A. Selby-Bigge, Ed. Oxford: Clarendon Press, 1978.

Hutchinson, S.A. "Responsible Subversion: A Study of Rule-Bending Among Nurses." *Scholarly Inquiry for Nursing Practice: An International Journal*, 4(1), 1990, p. 3-17.

Hypatia. Special edition on feminist concerns in bioethics, 4(2), 1989.

Jonsen, A.R. and S. Toulmin. *The Abuse of Casuistry: A History of Moral Reasoning*. Berkeley: University of California Press, 1988.

Kant, I. *Foundation of the Metaphysics of Morals.* Transl. L.W. Beck. Indianapolis: The Bobbs-Merrill Company, Inc., 1959.

Kneale, W.C. *Probability and Induction.* Oxford: Clarendon Press, 1952.

Koerner, J. "Differentiated Practice: The Evolution of Professional Nursing." *Journal of Professional Nursing*, 8(6), 1992, p. 335-341.

Levine-Ariff, J. and Groh, D.H. "Creating an Ethical Environment." *Nurse Managers' Bookshelf*, 2(1), 1990.

Lewis, D.K. *Convention.* Cambridge: Harvard University Press, 1969.

Liaschenko, J. "Feminist Ethics and Cultural Ethos: Revisiting a Nursing Debate." *Advances in Nursing Science*, 15(4), 1993, p. 71-81.

MacIntyre, A. "To Whom is the Nurse Responsible?" In *Ethical Problems in the Nurse-Patient Relationship*, C.Murphy and H.Hunter, (Eds.). Boston: Allyn and Bacon, Inc., 1983, p. 79-83.

MacIntyre, A. "Patients as Agents". In *Philosophical Medical Ethics: Its Nature and Significance, S.F. Spicker and T.H. Engelhardt, Jr.,(Eds.).* Dordrecht: D. Reidel Publishing Company, 1977, p. 197-212.

Miller, B.L. "Autonomy and the Refusal of Lifesaving Treatment." *The Hastings Center Report*, 21(4), 1981. p 22-28.

Parker, R.S. (1990). "Nurses' Stories: The Search for a Relational Ethic of Care". *Advances in Nursing Science, 13*(1), p. 31-40.

Pike, A.W. "Moral Outrage and Moral Discourse in Nurse-Physician Collaboration." *Journal of Professional Nursing*, 7(6), 1991, p.351-363.

Quine, W.V. *Word and Object.* Cambridge, Mass.: Technology Press, 1960.

Rawls, J. "The Idea of an Overlapping Consensus". *Oxford Journal of Legal Studies*, 7, February, 1987.

Rawls, J. *A Theory of Justice.* Cambridge, Mass.: Harvard University Press, 1971.

Rodney, P. and Starzomski,R. "Constraints on the Moral Agency of Nurses." *The Canadian Nurse*, 89(9), 1993, p.23-26.

Sherwin, S. *No Longer Patient. Feminist Ethics and Health Care.* Philadelphia: Temple University Press, 1992.

Sherwin, S. (1988). Philosophical Methodology and Feminist Methodology: Are they Compatible?" In *Feminist Perspectives: Philosophical Essays on Method and Morals*, L. Code, S. Mullett, C. Overall (Eds.). Toronto: University of Toronto Press, 1988, p.13-28.

Shwayder, C.S. *The Stratification of Behaviour.* London: Routledge & Kegan Paul, 1965.

Spicker, S.F. and Engelhardt, Jr., H.T. (Eds.) *Philosophical Medical Ethics: Its Nature and Significance.* Dordrecht: D. Reidel Publishing Company, 1977.

Spielman, B.J. "Conflict in Medical Ethics Cases: Seeking Patterns of Resolution." *The Journal of Clinical Ethics*, 4(3), 1993, p. 212-218.

Storch, J.L. and Griener, G. *Final Report of a Pilot Study to Assess the Effectiveness of Institutional Ethics Committees.* NHRDP Project # 6609=1553-55. Ottawa, 1989.

Tirrell, L. "Definition and Power: Toward Authority Without Privilege." *Hypatia*, 8(4), 1993, p. 2-33.

Weber, J. "Institutionalizing Ethics into the Corporation." In *Ethical Theory and Business*, 2nd Ed., T.L. Beauchamp and N.E. Bowie (Eds.). Englewood Cliffs, N.J.: Prentice-Hall, Inc., 1983.

Wilkinson, J.M. "Moral Distress In Nursing Practice: Experience and Effect." *Nursing Forum*, 23(1), p.16-29.

Yarling, R. and McElmurry, B. "The Moral Foundation of Nursing." *Advances in Nursing Science*, 8(2), 1986, p. 63-73.

Zimmerman, D. "Coercive Wage Offers". *Philosophy and Public Affairs*, 10, 1981, p.121-145.