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Who Acts? Self-Identity and Moral Courage in Nursing

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Who Acts? Self-Identity and Moral Courage in Nursing

by

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Abstract

Nurses who work in critical care face a unique array of ethical decisions in the course of their practice. This study aimed to examine the source of the ethical decision making of individual nurses using a virtue ethics framework as a starting point. The design used a philosophical hermeneutic approach based on the writing of Paul Ricoeur to provide an interpretation of the ethical decision making process of nurses. Six nurses currently practicing in intensive care were interviewed, with the transcripts of the interviews used as texts which were analyzed using the concepts of distanciation and appropriation taken from Ricoeur. The results revealed the main themes of time, experience, and communication, which were related to self-identity as the basis of ethical decision making.

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And finally to my daughter Lucia. Your courage is a model we would all be wise to follow.

Dedication

To all my family, for all your support through everything I have done.

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Epigraph

We will always have a choice
When you stand up to be counted,
Tell the world...this is my voice

There are many like it

But this one is mine.

Shane Koyczan
This is my voice

CHAPTER 1: Who acted? Rationale for the study

This thesis came about as a result of a fairly simple event. A nurse I work with had a situation where he refused a request from a physician to carry out a relatively minor action because he perceived it to not be in the best interest of his patient. When the physician became insistent in front of the patient, the nurse restated that he would not perform the task and left the room. On discussion with him and other nurses later in the shift, he seemed surprised when several other nurses told him they would not have been able to do what he did, while others said they hoped they would have acted in the same manner. When I commented on the courage required to refuse the action he again seemed surprised and stated that he could not have acted any other way. So the question is: why would nurses make different ethical decisions given the same situation? If our code of ethics, which is common to all, is intended to guide our actions, why would all nurses not make the same decision?

1.1 Introduction to the Problem

In *After Virtue*, Alasdair MacIntyre declares that we are living in an age where the ability to justify our actions on an ethical level has disappeared due to our loss on a societal level of the ability to understand and use the language of ethics. This loss is claimed to be largely due to the neglect of classical philosophical thought related to the way we live our lives. He states:

> What we possess, if this view is true, are the fragments of a conceptual scheme, parts which now lack those contexts from which their significance derived. But we have - very largely, if not entirely - lost our comprehension, both theoretical and practical, of morality. (1984, p. 3)

A confounding factor to this proposition is that in general we do not recognize this loss. In order for nursing as a profession to not fall into this same situation, namely an unacknowledged loss of an intelligible ethical foundation for practice, a strong examination of theoretical and practical aspects of ethics in everyday practice is important.

MacIntyre (1984) proposes that the main failing of the current state of ethics is that, as pointed out by Nietzsche, since the supposed demise of Aristotelean virtue ethics there has been an utter failure of any replacement modes of moral discourse. However, he argues that rumours of the death of virtue ethics have been greatly exaggerated, and that virtue ethics is still the most relevant form of ethical theory. MacIntyre advocates for a reexamination of Aristotelean or at least neo-Aristotelean virtue ethics.

Gadow echoes this lack of connection to ethics in her claim that nursing, by embracing dualism to the detriment of embodied knowledge, has resulted in a "self-imposed exile from the lived world of nursing" (1995, p. 211). Allen (1995) agrees with this position, in that "nursing discourse tries to position nurses as standing outside our practice world, [and] outside of the effects on the clients we serve or fail to serve" (p. 174). In order to regain our place in the world of nursing knowledge Gadow supports a return to an engagement with the people involved in the nursing process. She suggests using narrative to express this engagement since "narrative is a way of knowing because through it we offer one another our experience" (p. 213). Gadow also describes her goal of returning philosophy to the discourse of nursing, proposing "...that a postmodern philosophy of nursing is most fully expressed not only through language that is rational and clear but through text that is sensuous, emotional, and ambiguous - in other words, embodied" (2000, p. 90). This requires a move away from a framework

which focusses on the rational and literal interpretation of texts to one which allows for imagination, mediated by poetry and literature and aesthetics, in order to understand the narratives on a higher level, a level of embodiment.

1.2 Research Goal

The title of this study has a double meaning. The question 'who acts' refers to both the idea that some will act and some will not as well as to the question of the self-identity of the individual who chooses to act. The goal is to promote ethical awareness related to ethical decision making, determine what influences individual nurses in their decision to act or not to act in ethically difficult situations, and by discovering the sources of moral courage find ways to support and enhance this courage through reflective practice.

With this in mind, this thesis will examine ethical reflections of nurses from a standpoint of virtue ethics, specifically by using hermeneutic philosophical analysis of texts of narratives created from interviews of nurses describing the ethical aspects of their practice and their way in which they make their decisions regarding ethical dilemmas.

These ethical situations need not be critical events, it has been noted that "a focus on ethics draws attention to the nature of nurses' everyday commitments to others including concerns such as vulnerability, respect and dignity" (Hatrick Doane, Storch and Pauly 2009, p. 232). These elements of practice are not necessarily addressed by the majority of ethics literature, especially the clinical ethics literature which tends to focus on specific individual issues such as euthanasia and abortion. Because the focus of this study will be on both large and small ethical issues for nurses, hermeneutics "is a useful approach when one seeks to understand

meaning and practices that are often taken-for-granted and invisible" (McLeod, Tapp, Moules and Campbell 2010, p. 94).

CHAPTER 2- Virtue Ethics

Virtue ethics as a framework for examining ethical decision making of nurses is an alternative to several other possible frameworks. Among the possible alternative frameworks are three which are commonly used: 1) a principle based approach, most commonly bioethical principle based on Beauchamp and Childress (autonomy, beneficence, non-maleficence, and justice), or a utilitarian approach such as that advocated by Singer 2) an emotivist approach, in which the emotional reaction to situations is seen as the basis for ethical intuition, and 3) relational ethics, in which relationships between individuals or groups are seen to be the justification for ethical decisions. Each of these frameworks standing alone lack certain elements which a virtue ethics framework can incorporate, making virtue ethics a very useful framework for studying ethics in nursing. The following sections are intended as a brief introduction only to the alternative frameworks.

2.1 Alternative Ethical Frameworks

2.1.1. Principle Based Approach

The principle based approach to bioethics, credited mainly to Beauchamp and Childress (2009), involves examining a given situation using the concepts of autonomy, beneficence, non-maleficence, and justice to guide the individual to consider all aspects of a given situation. For example, in a withdrawing of care situation, autonomy would refer to an individual's perceived right to self-determination, specifically the right to accept or refuse treatment, even life sustaining treatment. In cases of reduced capacity, autonomy can still be respected if the

individual's wishes were known through prior documentation such as a living will or personal directive. Beneficence and non-maleficence refer to the impact of the treatments on the patient, but also on the family and the caregivers. The positive effects (doing good, or beneficence) must be balanced against the negative effects (the requirement to do no harm, or non-maleficence) when considering which treatments to continue. For example, administration of morphine has the positive effect of reducing pain, but the negative effect of reducing respiratory drive. Finally, in this hypothetical case, justice refers to the fairness of providing treatments; what the patient deserves out of respect for the individual contrasted with what proportion of scarce resources should be allocated to a single patient in a large health care system. Here the cost to society (of providing treatment to the individual) is balanced against the cost to the individual of not providing treatment.

Utilitarian ethics are another variation on principle based ethics. Originating with Mill (1861), and advocated by Singer (1979), utilitarianism promotes the idea that what is ethically right is what provides the most benefit for the most people in any given situation. It is a consequentialist system, where the decisions must be made with the expected consequences having the most influence on the decision in question. The individual is minimized in this system with the collective good being more important. For most ethical decisions affecting nursing the potential outcomes can be very unclear, making assessments of utility difficult.

The main problem with reliance on a strictly principle based approach is that there are no principles which apply equally to all individuals in all situations, and the relative weight of each principle in decision making can vary. This is particularly evident in two cases: the balance of autonomy of the individual against the allocation of scarce resources (justice), and

the balance of beneficence versus non-maleficence in considering the benefit and harm of individual treatments.

Principle based ethics also fails to incorporate the individual into the decision making process. In order to be full participant in the ethical decision making process, the full self must be involved. Pask (2003) describes the balance between reason and the sense of self involved in our ethical decision making as "...our capacity, by the means of reason, to hold this view and so to recognize the moral principle that is the necessary forerunner to our developing capacity for practical judgement. However, as the nurses' accounts later in this study suggest, we are not to be thought of as impersonal and disengaged rational thinkers who exercise an impersonal will." (p. 171).

The other argument against a principle based approach to ethics specifically for nursing is again the argument that principles fail to incorporate one of the main elements of nursing care: the embodied nature of the nurse in the context of nursing. Gadow proposes "that a postmodern philosophy of nursing is most fully expressed not only through language that is rational and clear but through a text that is sensuous, emotional, and ambiguous - in other words, embodied" (2000, p. 90). Nurses need the full, rich context of care to be captured in any ethical framework. Narrative approaches to investigating this embodied context are helpful because they provide the richness needed to elucidate the philosophy as proposed by Gadow.

2.1.2. Emotivist Ethical Approach

Emotivism, first proposed formally in the 1950's, does tie ethics to action. This theory states that moral judgements are expressions of emotion concerning actions taken by an

individual and at the same time are exhortations to follow those actions which are considered favourable (Cohen, 2004). However, there exists a level of circularity of argument here, where the meta-ethical definition of what is 'good' is what feels good, and what feels good is what is ethically good becoming what MacIntyre bluntly describes as "vacuously circular" (p. 11). Emotivism suffers from an overemphasis on feeling to the expense of any consistence of approach. This can be related back to Hume (1739/1990) who believed that the basis of all moral thought is passion and not reason, and that rational thought has no connection to ethics. Specifically, he states:

> Since morals, therefore, have an influence on the actions and affections, it follows, that they cannot be deriv'd from reason; and that because reason alone, as we have already prov'd, can never have any such influence. Morals excite passions, and produce or prevent actions. Reason of itself is utterly impotent in this particular. The rules of morality, therefore, are not conclusions of reason. (1739/1990, p. 457)

If this is true, then the study of ethics becomes virtually impossible, and the source of moral agency becomes very indistinct.

The failure of emotivist ethics to provide a complete picture of moral agency does not eliminate the role of emotion in ethical decision making. Scott (2000) summarizes the argument in favour of emotion as a crucial component of ethics. She argues that awareness of the emotional factors of a given situation is essential for accurate perception of moral issues and that good nursing, in the sense that Aristotle presents a good life, requires a well developed level of emotional sensitivity. The conflict identified for nursing is as follows:

"On the one hand our tradition, literature, and rhetoric as well as the arguments in this paper suggest that the morally good nurse, of necessity, must use a degree of emotion (educated emotion) in order to ensure accurate perception and sensitivity to the moral.....[o]n the other hand traditional moral theory claims that moral goodness is achieved through the exercise of reason. Therefore the rational must be paramount in the morally good nurse" (Scott 2000, p. 131).

The requirement identified is for an addition of emotional perception to rational ethical arguments in order to produce valid ethical judgements. In my opinion, this can be achieved within a virtue ethics framework where the practitioner strives to develop virtues which will provide a secure foundation, an Aristotelean character, for nursing practice.

2.1.3. Relational Ethics Approach

The relational ethics approach also falls short as an attempt at a complete explanation of ethical decision making. Although relationships contribute towards a comprehensive view of ethical understanding they do not stand alone as a source of ethical decision making, instead providing a context in which these decisions take place.

The relational ethics themes of engagement, dialogue, and presence are difficult to see when patients have little or no capability to participate in their own care. In an ICU the patients are often intubated and sedated. This means that they cannot (unless they have previously set out in writing) make their wishes known, and cannot provide direction with respect to their values, past experiences, and relationships with others. Consider a patient who arrives in the ICU after a cardiac arrest. Often the first contact the patient has with the health care system is when the ambulance arrives on scene and the paramedics begin resuscitation.

The patient is intubated, possibly defibrillated, and transported to hospital. Once there, no one has any information other than that provided by monitors and a search of the patients clothing. Family members or friends, if present at all, may or may not be able to provide accurate insight into the way the patient may have wished for this situation to be handled. However decisions still need to be made regarding the care of this person. Some of these decisions will have ethical components and the basis for these decisions will not be based on any relationship formed between the patient and the individuals, such as nurses, providing care.

Paley (2011) notes that those who advocate relational ethics assume a dichotomy which is actually non-existent. He states :

> It is an either/or assumption: either people are separate, autonomous, individualistic beings, or they are relational beings, already and necessarily immersed in a network of relationships. This is a polarization to which, in one respect or another, the ethics of care writers constantly refer. It represents a choice between a 'relational ontology' and, to use Martinsen's expression, an 'ontology of separatedness'. One is either a 'separate' being or a 'relational' being, not both. However, the either/or is never argued for; it is just assumed. for how can one be essentially 'separate' and essentially 'in relation' at the same time? However, surely one can. (p. 246)

Because one can conceive of being separate and in relation at the same time, relational ethics is an incomplete manner of viewing ethics. In particular, at the level of decision making, relational ethics is not comprehensive enough to explain the actions of the individual. Relationships exist, but are the context of the decision, not the source.

Another confounding factor for relational ethics in this case is the lack of ability of the nurses to fully understand the experience of the other. Relational ethics requires "us to connect with others in a particular way such that nurses become truly aware of what others might be experiencing" (Oberle and Raffin Bouchal, 2009, p. 41). It is not possible to have a good understanding of such a event without having experienced it, and even then the experience of one individual is so different from that of another that common factors shared by both are overwhelmed by the variation in experience and personal response. Here the idea that "my experience cannot directly become your experience" (Ricoeur, 1976, p. 16), a position which will be shown later to be the basis of an interpretive paradigm, tells us that attempts to understand the experience of others will always be subject to bias of interpretation resulting from one's own self-understanding and experience, or lack thereof, in any given situation. A simple example from my personal experience illustrates this point.

After years of working as a cardiac ICU nurse, taking care of critically ill cardiac patients, I thought I had a reasonable understanding of what the relatives of these patients were experiencing. When my father was in the position of being one of these patients I was unprepared for the intensity of the situation. I also saw that various members of my family reacted differently from myself and from each other and I could see, in part, how their own differing past experiences shaped their reactions. I could not fully understand their individual experiences, and I do not expect that they could fully understand mine. My increased self-understanding resulting from this experience consisted in part of a recognition that no matter how one person feels they can understand the experience of another, the reality is that this

understanding will always be limited to a relatively superficial grasp of commonalities at the expense of the highly personal details of experience.

This inability to perfectly understand the experience of another does not free us from the obligation to attempt to understand, to the best of our ability, the experiences of others. As Gadow (1995) pointed out above, the attempt to understand others is a cornerstone of ethical understanding. Knowledge of the condition of others is necessary for comprehensively evaluating a situation even when self-understanding is presented as the ultimate basis for decision making.

Relational ethics could also be considered to be a category mistake. The relationship is the context of the ethical situation, and is the substrate for the problem, rather than a basis for the ethical decision making. In *The concept of mind* (1990), Ryles' commentator saw the colleges, libraries, and students and keeps asking 'but when do I see the university?' He fails to see that these elements are encompassed within the concept of a university. By the same logic the individual sees all the relationships involved in an ethical dilemma and misidentifies them as the source of ethics, as an individual category, rather than the overarching situation within which ethics exists. 'Ethics' cannot exist without a relationship and relationships cannot exist independently of ethics. Perhaps this dilemma is best described by Van der Zalm and Bergum (2000), who state that:

> The knowledge needed to answer the question of 'what is the right thing to do?' cannot be known by only understanding the different philosophical positions or different principles but is discovered in understanding persons, both self and other. Ethical knowledge for nursing practice cannot be known ahead of time. (p. 215)

If we accept the philosophical argument that "...all understanding is self-understanding" (Gadamer, 1976, p.55) then it becomes clear that the other forms the context of (rather than the source of) of ethical decisions. The philosophical positions and principles help us reflect on our own beliefs and the consideration of the other is relevant to our decision making process, but in the end the decision is made by the individual.

Perhaps a comparison with Ricoeur's description of Elias' understanding of civilization would help clarify why the concept of relational ethics is a category mistake. Ricoeur writes that Elias finds two levels of development of civilization as a process: "...on the one hand, the civilizing process is correlated with large-scale phenomena at the level of the organization of society into the state, such as the monopolization of force and taxation and other fees; on the other hand, this process is described as a series of progressively internalized constraints up to the point where they become a phenomenon of permanent self-constraint that Elias names *habitus*. The self is in fact what is at stake in civilization, what civilizes itself, under the institutional constraint" (2004, p. 206-7). This correlates with ethics in that ethics exists at two levels: that of the individual and that of society. The question of whether morality and ethics are interchangeable terms is rooted in this sense of two levels. For the purpose of this thesis, I understand ethics to exist at the level of the individual (encompassing the decisions of the self), and morality to exist at the level of society (encompassing norms throughout a population). This view is supported by Fredriksson and Eriksson (2003) who state:

> Ricoeur means that ethics has primacy over morality because he defines ethics as that which is considered good, while morality is that which imposes itself as obligatory; or,

> put differently, ethics is the aim of an accomplished life while morality is the articulation of this aim in norms. (p. 139)

Ricoeur goes on to find that "The civilizing process is nothing other than this correlation among the changes affecting the psychic structures and those affecting social structures" (2004, p. 208). The process of civilization requires both levels, the individual and the societal to reach some measure of correlation. The same correlation is required in ethics in that the individual and the society must have some level of similarity in order for a coherent measure of ethics to exist.

Relational ethics is therefore a category mistake in the sense Ryle intends: ethics cannot exist without an individual and a population, the 'other' is essential for our understanding of an ethical event. This is not to say that relationships are irrelevant. When action is considered, relationships are among the variables which influence the movement from decision to action (Macdonald, 2007). Relationships affect the outcome of ethical decision making, but are not a source of the decision, that is done at the level of the individual for ethics and at the level of a population for norms. In an attempt to synthesize concepts common to virtue ethics and care ethics, Benner concludes that "...we need to articulate and attend to the moral art of attentiveness and caring relationships that protect patients in their vulnerability while fostering growth and limiting vulnerability" (1997, p. 59). This stresses the importance for nurses of the value of the caring relationship to the process of ethical decision making while acknowledging that the relationship itself is not the basis of the decision making process.

2.1.4 The Anti-Ethics Stance

If these ethical frameworks are accepted as incomplete, does that mean that the study of ethics as a whole is not worthy of consideration? In *Against Ethics*, Caputo (1993**)** argues just that. He states that ethics as a philosophical concept is irrelevant, and that only the fact of obligation to others really exists. Our reaction to this obligation is what is possible to study and therefore worthy of examination. Caputo goes as far as to state that "...the Good, in the uppercase, has become a tall tale (*fabula*) to me, along with Being and the Real World. The Good, the *arche* and *principium*, along with any overarching principle that assigns all things their place and holds them mightily in its sway, has become unbelievable to me and has earned my incredulity" (1993, p. 31). This denial of a basis of ethics, in the name of deconstructionism in the sense of challenging traditional assumptions, serves no purpose other than to stifle any consideration of ethics at all. Endless questioning of causes has been a method of criticism for a long time. Spinoza relates the story of a man being killed by a stone falling off a roof: if one believes that the stone fell "in order to kill the man" (1677/1996, p. 28) then the theory that the stone fell due to wind is countered with the question 'why was the wind blowing' and so on until "they will not stop asking for the causes of causes until you take refuge in the will of God, that is, the sanctuary of ignorance" (p. 28-9).

It is possible to conceive, along the same lines as *Against Ethics*, a text titled Against Nursing. Using the same argument that nursing (like ethics) is simply an extension of obligation it could be argued that there is no overarching concept of Nursing (with a capital N). Health and Illness (like Good and Evil) are not easily defined concepts, and could be abandoned also using the deconstructionist logic Caputo presents. But at the end of the

argument the same issue remains: Nursing, like ethics, exists as a reality for those involved in it, and dismissing either concept because a precise, universal definition is impossible serves no useful purpose. Nurses exist, and they face ethical challenges and make ethical decisions on a regular basis. Every effort should be made to study these situations and promote understanding of these events.

2.2 Advantages of virtue ethics over other frameworks

If we lack the ability to sufficiently explain our moral convictions, as MacIntyre suggested above, and we wish to retain ethics as a valid field of study, we must find a framework within which to advance our understanding (and our self-understanding). Given that principle-based, emotivist, and relational ethics are incomplete methods for ethical decision making, a return to virtue ethics is proposed, both by MacIntyre and within the context of this research, to provide a valid framework for study. Muldoon (1998) points out that even though MacIntyre "does not provide a modern detailed conception of virtues, but merely argues for the possibility of doing so....Macintyre *presupposes* the existence and operative presence of virtue" (p. 301, italics in original).

Cohen writes: "Virtue ethics is not a view according to which moral decision-making becomes automatic or easy. It is more importantly about where the guiding moral principles or bases for decision-making come from, and what their authority is." (2004, p. 49). Virtue ethics is a process of decision making where the decision is made in an effort to be consistent with the virtues of the individual. The goal is not to fulfill an external definition of an ethical action but to act in a way that the decision maker finds to be ethical. Ethical judgement does not exist as a set of rules or a function of the consequences of an action. Ethical judgement is

based in being, in the sense that to decide and act ethically is to decide and act in a manner that fulfills the desire of the individual to express his or her character, to be consistent with self-identity as a good person, and to seek *eudaimonea* in the course of everyday life.

Virtue ethics encompasses a combination of reason and emotion, because both of these factors influence the way we see ourselves. In a virtue ethics framework, "the virtuous person perceives a situation, judges what is right, and wants to act accordingly because it is in her disposition to act well" (Gardiner, 2003, p. 298). The dispositions are a developed over time, as described by Aristotle, and can be cultivated if attention is paid to them. The experience of action is more than an experience of an event or behaviour. Ricoeur states: "Action, in this enlarged sense, also includes the moral transformation of characters, their growth and education, and their initiation into the complexity of moral and emotional existence. It also includes, in a still more subtle sense, purely internal changes affecting the temporal course of sensations and emotions, moving ultimately to the least organized, least conscious level introspection can reach" (1984b, p. 10).

2.2.1. Aristotle's Virtue Ethics

From Aristotle, a life cannot be judged as virtuous or not until completed. The life as a whole is required to be examined. How does this affect individual decisions? Paul Kelly (2003) writes (and sings) "To be good takes a long time, to be bad no time at all". This refers to the ability of morally wrong actions to outweigh morally correct ones. Consider the example of a person who, in the course of a lifetime, commits many acts of courage and benevolence to others. Then, on one day in a particularly emotional moment, he commits a murder and is subsequently convicted and put in jail. Most people would regard the last act as

the defining act of his life: he is a murderer. We don't say 'He is a good man, except for that one instance where he killed someone'. The point here is that each individual action becomes part of our self and our self-identity, with some actions weighing more heavily than others, but all actions considered to some extent in the overall judgement of the character, in a virtue ethics sense, of the individual.

If Aristotle asks the question 'what is a good life?' and concludes that activity of the soul in accordance with virtue leads to *eudaimonea*/flourishing of the individual, over a lifetime, the question 'what is a good nurse?' can conceivably be answered by the conclusion that practice in accordance with virtue will lead to *eudaimonea*/flourishing of the nurse as a whole person, over the course of a career.

2.2.2. Ricoeur and Virtue Ethics

Ricoeur agrees with the idea that the entire life of an individual must be considered in a virtue ethics framework. Ricoeur disagrees with MacIntyre (1984) and his theory of a narrative unity of life in that MacIntyre includes fiction as part of the narrative of a life while Ricoeur does not. However, Ricoeur does agree with MacIntyre in finding that the word life "denotes both the biological rootedness of life and the unity of the person as a whole, as that person casts upon himself or herself the gaze of appraisal" (1992, p. 178). Ricoeur goes on to explain that

> In more modern terms, we would say that it is in unending work of interpretation applied to action and to oneself that we pursue the search for adequation between what seems to us to be best with regard to our life as a whole and the preferential choices that govern our practices. (1992, p. 179)

This means that each action we take must be self-interpreted as a part of our whole life, and is a balance between what is best for a given situation and what is best for one's life as a whole. Each action becomes part of our history, forming part of our narrative, and we must be comfortable with our choice both in a given situation and in the larger context of our entire life story.

CHAPTER 3- Philosophical Roots

This chapter will provide the philosophical foundation for the framework used in this research study. Ricouer's hermeneutics follows his ethical theory of the self, the other, and the institution. The self will be defined using Ricoeur's ideas of *ipse* and *idem* identity, and the concept of the trace will be used to show the historical aspect of self-identity. The other as the recipient of ethical obligation and the inclusion of the institution will complete Ricoeur's framework. The focus on action as an essential component of ethics will be covered and a description of prereflexive and reflexive decision making processes will be presented.

3.1. Self

The concept of selfhood is central to Ricoeur's *Oneself as Another*. The self is considered as two parts: the *ipse* and the *idem*. Identity in the *idem* sense asserts "permanence in time...to which will be opposed that which differs, in the sense of changing or variable" (p. 2). Conversely, "...identity in the sense of *ipse* implies no such assertion concerning some unchanging core of the personality" (p.2). This separation will be shown to be important when considering events occurring over time and relates to the core of selfhood which is critical to the concept of character as it relates to virtue ethics.

This dual nature of the self has also been related to narrative identity, where the *idem* self "responds to the question 'what am I?' in terms of sameness but the sameness of acquired characteristics" whereas "*ipse* means a response to the question 'Who am I?' with the assertion

‘Here I am’ - wherein the person escapes his or her lasting manner of thinking, feeling, acting, and ‘recognizes himself or herself as the subject of imputation; and thereby stops wandering among ‘the multitude of models for action and life’, that is, responds to the expectation of the other” (Sweeney, 1997, p. 200). Our narrative answer to the question of who we are is complex and multi-level. When asked ‘Are you the same person you were 10 years ago?’ the answer could be yes and no. Yes in the sense that there is a core of our being, physically and psychologically, which is unchanged. And no in the sense that all our experience between then and now has had an effect on who we are and how we see ourselves.

Ricoeur describes the link between the self and moral agency as a function of the term ascription. Ascription is a particular connection based on Ricoeur’s concept of self, which follows from P.F. Strawson’s definitions in *Individuals* (1959). Ricoeur develops three claims from *Individuals*: persons as basic particulars, attribution of predicates to the person, and attribution of intentions and motives to the person (1992, p.88).

By basic particular Strawson is defining the concept of person as an isolated entity “to the extent that there is no way to go beyond it, without presupposing it in the argument that would claim to derive it from something else” (1992, p. 31). In this way, the person is delineated as an irreducible being, which can also be referred to as the self in the sense that oneself and others can identify the individual over time as a distinct, self-contained entity. Due to the need to identify the individual as a spatiotemporal being, the body is proposed as containing the basic particular in the same sense as Ricoeur’s *idem* identity as that which others can identify as the same person over time. Ricoeur commonly uses questions about the self to clarify definitions. Selfhood, being closer to the *ipse* identity, incorporates the concept of character in

the Aristotelean sense of dispositions stable over time (Flaming, 2006). Virtue ethics requires a self-reflective process to occur where an individual is aware of his or her own character in terms of what is important to oneself to lead a good life.

Given the irreducible nature of the person as a basic particular, psychological and physical predicates are attributed to the person with no separation of the mental and physical aspects of being (1992, p.88). By extension of this claim, intention, a mental predicate, is also attributable to the person. The attribution of physical, psychological, and mental predicates to the individual being consisting of the self as an irreducible whole is what Ricoeur calls ascription, and is essential to the possession of moral qualities by the self considered as a moral agent.

Ascription to an individual requires an action (Hart 1949). Ascription is the answer to the question 'who did it?', and implies responsibility for the action in question. Ricoeur counters with the proposition that ascription to an individual (which he calls imputability) "can be neither proved nor refuted; it can only be attested to or brought under suspicion" (2007, p. 17-18). The phrase 'He did it' is an ascriptive one, not simply a descriptive one, in the sense that it ascribes responsibility for 'it' to 'him' (Hart 1949). And while it is true that actions ascribed to another cannot be proven, actions that one ascribes to oneself, correctly or incorrectly, have a profound effect on the individual and can be the result of moral courage or the source of moral distress. This is a key point related to a virtue ethics framework. To feel a sense of living a morally correct life the individual must connect action to his or her own responsibility for the action. The acceptance of responsibility results in a new self-understanding of the *ipse* aspect of self-identity.

Ricoeur reinforces this idea of the wholeness of the body and mind in *Freedom and Nature*, in the statement:

> My body is only one source of motives among others, and I can evaluate and measure my life in terms of other goods. However, my body is the most basic source of motives, revealing a primordial stratum of values: the organic values. When I give preference to other values over these - when, as Plato puts it, I 'exchange' my life for justice, for instance - I am no longer carrying on any purely academic debate. I really *stake my existence*, sacrifice myself. This all other values assume a serious, dramatic significance through a comparison with the values which enter history through my body. (p. 85, italics in original)

The body is shown to be a source of motives and a measure of the consequences of decisions. This is relevant to the concepts of moral courage and moral distress (discussed later) where the factors which must be considered affect the body if not to the extent of losing life, at least to bodily comforts and requirements. For example, when faced with the possible consequence of losing one's employment and accompanying income as a result of a decision followed which is considered to be morally correct, there is greater potential for moral distress and greater need for moral courage to follow through with the decision. These consequences are part of the responsibility which comes with the freedom to make choices (Sen 2009). The accountability is a double edged sword, the positive results of the decisions contribute to our striving for the good life in an Aristotelean sense, the negative results contribute to our ongoing level of moral distress, and both are permanently etched into the historical narrative of the life of each individual.

It is useful to note that we cannot ignore this concept of the self as a whole when considering ethical action in a nursing role. Fredriksson and Eriksson (2003) discuss Ricoeur's concept of aiming at a good life, and note that "Ricoeur is of course talking about life as a whole, while we in the present study are restricting it to the professional life of the nurse. Our question must then be: what is a good life as a nurse?" (p. 140). If the above propositions are accepted (physical, psychological, and mental predicates are ascribed to the individual as a whole, person as an irreducible being, moral agency and the consequences of moral decisions are functions of the whole being) then the separation of whole life and nursing life is artificial.

This assumption that nursing life cannot be separated from life as a whole can be easily demonstrated. First, consider the nurse who commits a crime in the act of carrying out professional duties. The individual could go to prison for the crime, and it would not just be the 'nurse' aspect of the person (she would not be allowed to serve her time in jail only when she would otherwise have been on duty as a nurse), but the whole individual loses her freedom: the whole being pays for the crime of the professional. Second, and more relevant to the ethical aspect of this study, the whole being will experience moral distress as a result of actions undertaken as a nurse. She will not feel the distress while at work and completely ignore these feelings while away from her job. By the same logic, I do not believe it is possible to be an ethical nurse if one is an unethical person as a whole. In order to aim for the good life as a nurse it is necessary to aim for the good life as a whole. The two are inseparable.

For Ricoeur, the ethical is a vitally important dimension of self identity, and *Oneself as Another* has been described as a text of "how ethics, morality, and practical wisdom extend, and flesh out, his previous studies of language, action and narration; and moreover, how this

ethicomoral stratum facilitates the transition between the hermeneutics of the self and an ontology in which all his prior analyses are rooted" (Muldoon 1998, p. 303). Thus the ethical dimension of life is seen as the overarching concept involved in self-identity and the study of self. After all, if Aristotle's view of *eudaimonea* as the ultimate goal is accepted, few things should be more important to the individual than to feel as though one has lived a morally good life.

3.1.1. Self understanding

A central concept of hermeneutics is the emphasis on self understanding. Ricoeur asks what the significance of the self in self-understanding by the question "Why is the self that guides the interpretation able to recover itself only as a result of the interpretation?" (1974, p. 17). His answer to this question is to find that the *cogito* which is able to state its own existence is a false *cogito*, and must be recaptured, through the process of reflection, to proceed from misunderstanding to understanding. This alludes to Ricoeur's version of the hermeneutic circle as a back and forth between distanciation and reappropriation, and a process of progression through stages of understanding where one must first identify that knowledge is fluid and changing over time. This is the ontology of understanding, where "it is only within the movement of interpretation that we apperceive the being we interpret" (1974, p. 19). For this understanding and interpretation to take place, reflection on the past must take place. In a framework based on Ricoeur's philosophical hermeneutics, this leads to the concept of the trace as a representation of the past of the individual.

3.1.2. Concept of Trace

In determining what is real in the past, or what we say 'really happened', Ricoeur uses the concept of a trace to describe knowledge of the past for each person. He states "insofar as a trace is left by the past, it stands for it" (1988, p. 143). The trace is then our knowledge that takes the place of the historical past, a current thought which removes the temporal distance between ourselves (the self) and the past (the narrative) to form a re-identification with events of the past. Ricoeur draws from Collingwood's discussion of history "as a 'reenactment' of the past" (p. 144). In this sense, historical events considered in the present consist of an inside face, which is the thought of the event, and an outside face, which is the change in the physical world which has resulted from the event considered. The re-enactment is the "rethinking of what was once thought for the first time" (p. 145), and requires both the inside and outside faces to be considered an action.

This description of the trace as a permanent effect of past events, coupled with the idea that history involves the rethinking of past thoughts has implications for the consequences of ethical decisions made in the past and on the influence of past experience on the process of decision making in the present.

The implications of the concept of the trace relate to the *ipse* and *idem* aspects of the self. These aspects of self lead into a concept of self-identity where, speaking of *ipse* and *idem*, "the self intersects with the same at one precise point: permanence in time" (Ricoeur, 1991, p. 192). This permanence in time is a summary of a series of traces, which are actually expressed

as narratives or the stories of a life. Self identity as a combination of self and same is a narrative identity, which Ricoeur (1991) sees as a continuity of MacIntyre's narrative unity.

For the purposes of this research, if we accept that the narratives of the nurses interviewed are valid descriptions of the events and actions of their nursing careers then we must accept that the narratives are a summary of traces which affect the self-identity of the nurses. This forms the basis of the use of narrative to examine ethical decision making using a virtue ethics framework.

The trace is a reflection of the historical nature of narrative identity. Looking at this from another angle, neuroscientists have examined the brain processes which occur to create (in their view) consciousness. Considering the role memory plays in consciousness and self-identity, Damasio finds that:

> What your life has been, in bits and pieces, is available to you rapidly in recall, and bits and pieces of what your life may or may not come to be, imagined earlier or imagined now, also come into the moment of experience. You are busily all over the place and at many epochs of your life, past and future. But you - the *me* in you , that is - never drops out of sight. All of these contents are inextricably tied to a singular reference. Even as you concentrate on some remote event, the connection remains. The center holds. This is a big-scope consciousness, one of the grand achievements of the human brain and one of the defining traits of humanity. (2010, p. 179)

This view of self-identity, viewed as a neurobiological achievement of evolution, is just another way of saying that traces remain with us, that we incorporate all of our remembered past into our self-identity.

3.1.3. From Trace to Narrative

Why is this of particular importance, the concept of selfhood as Ricoeur sees it, when examining ethical decision making using a virtue ethics framework? If selfhood is seen as a self-identity based on narrative, and the narratives exist as a series of traces, then the traces, or stories, of an individual's life influence character as defined in virtue ethics. As Ricoeur states: "narrative constructs the durable properties of character, what one could call his narrative identity" (1991, p. 193).

Ree begins his discussion of 'Narrative and Philosophical Experience' with the statement: "I am so convinced by Paul Ricoeur's view that narrative is the fundamental structure of the experience of time that I really have nothing more to say about it" (1991, p. 74). By the experience of time he refers to personal history and personal identity. He does, however, have more to say, going on to describe narrative as a situation where "the audience is called upon to imagine, by a kind of projection, a definite person or personality telling the story" (p. 75). This personal quality is what separates a narrative from a list of dates or facts about an event. Every narrative comes from a being who brings the sum of his or her experiences and knowledge to the crafting of the narrative itself. Each word is chosen specifically to serve a purpose. This is the case even more so for writing than for speaking given the opportunity for revision that writing allows the author.

Kierkegaard's *Fear and Trembling* (1843/2003) is a good example of a narrative in which the author's voice shines through in the light of virtue ethics. Rather than being a factual description of the trial of Abraham, asked to sacrifice his son Isaac for God, *Fear and Trembling* is an emphatic narrative of the author's amazement at the extent of Abraham's faith.

The story truly reflects more of the character of the author than it does of Abraham's courage. This is an example of Kierkegaard's judgement of human excellence in the sense of Aristotelean *eudaimonea.* MacIntyre refers to this judgement when he states: "What is alien to our conception of virtue is the intimate connection in heroic society between the concept of courage and its allied virtues on the one hand and the concepts of friendship, fate and death on the other" (1984, p. 122). He argues that contemporary society has lost that connection, which Kierkegaard recognizes and celebrates in the actions of Abraham. *Fear and Trembling*, published in 1843, predates Nietzsche and and the turn away from virtue ethics described by MacIntyre (1984).

3.1.4. Narrative as poetic wisdom

The narrative is in fact a form of poetry. Returning to Aristotle, poetry is described as the act of imitation of life. From the Greek word *mimesis,* translated as imitation or representation (Ricoeur, 1984b), poetry is the use of narration to evoke emotion and understanding in the reader or listener (Aristotle, 1996). The goal of poetry is to satisfy the need for understanding innate in all people. Simply put, "The reason for this is that understanding is extremely pleasant" (1996, p. 7). Poetry is the combination of imitation and rhythm to produce a flowing text which evokes emotion and ultimately understanding at a deeper level. This is more difficult than it sounds, but at the same time more common than often thought. Thoreau writes "The millions are awake enough for physical labor; but only one in a million is awake enough for effective intellectual exertion, only one in a hundred millions to a poetic or divine life. To be awake is to be alive. I have never yet met a man who was quite awake. How could I have looked him in the face?" (1854/2004, p. 87-88). While this rarity may be true of the type of

epics Aristotle refers to in *Poetics*, there is a more common poetry, the poetry of metaphor unleashed by every narrative told.

All people, including nurses, tell stories to illustrate a point. After listening to a problem put forth by a co-worker, the first response is often a story of one's own of a similar situation. The intent is to make the first person know that they are not the only one who has experienced this type of problem and to provide an example of the kind of solution that may be possible. Overall the goal is to help the questioner to a better understanding of the situation at hand. The narratives used in this study serve the same purpose: to enhance understanding of a particular type of situation for the sole reason that understanding in and of itself is extremely pleasant.

Narratives enhance understanding in the manner that Aristotle views poetry as an imitative art. When Ricoeur discusses the manner in which history and historians represent the past he asks "Does the historian, insofar as he does history by bringing it to the level of scholarly discourse, not mime in a creative way the interpretive gesture by which those who make history attempt to understand themselves and their world? This hypothesis is particularly plausible for a pragmatic conception of historiography that tries not to separate representations from the practices by which social agents set up the social bond and include multiple identities within it. If so there would indeed be a mimetic relationship between the operation of representation as the moment of doing history, and the represented object as the moment of making history" (2004, p. 228-9). Narratives, as part of the histories Ricoeur writes of, are not just recounting the events but are an attempt to make the understanding of the narrator become the understanding of the listener or reader. If this understanding cannot be transferred directly,

it can be passed on indirectly using the medium of the text to transfer understanding of an event from one person to another.

This poetic approach to narrative transfers of understanding can be considered to be a form of poetic wisdom. Giambattista Vico, in *New Science* (1744/1999) considers poetic metaphysics to be the origin of poetry. Writing of the pagan philosophers he states "...poetic wisdom must have begun with a metaphysics which, unlike the rational and abstract metaphysics of today's scholars, sprang from the senses and imagination of the first people. For they lacked the power of reason, and were entirely guided by their vigorous sensations and vivid imaginations...." (p. 144). The idea is that people at their most basic level are affected by their sensation and imagination, and that poetry stems from this aspect of human nature rather than reason. Narratives appeal to us if they are poetic, and have that whole human quality that a fully rational depiction of events lacks. Aristotle's description of why poetry appeals to us encompasses this sensory element, Ricoeur's creative mimesis theory includes the poetic aspect of narratives, and Vico's origin of poetry completes the circle by providing the link between poetry and understanding in his statement that: "Great poetry has three tasks: (1) to invent sublime myths which are suited to popular understanding; (2) to excite to ecstasy so that poetry attains its purpose; and this purpose is (3) to teach the masses to act virtuously, just as the poets have taught themselves." (p. 145). The narrative as a vehicle for the transmission of understanding therefore must be poetic in nature, so as to maximize the understanding passed from one to another.

The connection between Ricoeur's narrative and ethics theory is discussed by Atkins (2004). Atkins describes the narrative model as:

> ...not simply a first-person report of an individual's subjective experiences and point of view, it is a complex model that interweaves the first-person subjective perspective with the second-person perspective of the communicative situation of social existence, along with a generalisable or third-person perspective presupposed by a shared world of meanings with public standards of objectivity. (p. 343)

The narrative model is more than just a story, it is an interweaving of the self and the other in society. This mirrors Ricoeur's ethics of "aiming at the 'good life' with and for others, in just institutions" (1990, p. 172) where the self is the first person (who is aiming), the other is the second person, and the just institution is the objective third person perspective. Our self understanding, as told in our narratives, is a complex combination of how we see ourselves, how others see us and how we want others to see us, embedded in the larger perspective of society and its norms. Our ethical decisions are made by us as individuals, but within a complex system consisting of ourselves and others.

The self as the subject of a narrative is affected by the *ipse* and *idem* levels of self as described by Ricoeur. *Ipse*, the first person self constancy, allows us to present narratives as our own, even though time has passed since the events took place. *Idem*, the "sameness of an object from the third person perspective" (Atkins 2004, p. 348), allows the other(s) to see us as the subject of our own narrative even after the passage of time. Even though the stories told are of events in the past, they are linked to our self-identity because we are linked to the person who is/was the subject of the story. If this were not the case, then our stories would cease to be our own and would instead belong to a past version of ourself. By showing both aspects of the self, Ricoeur links the narrative to our sense of self, while allowing for the fact

that while the narrative influences our self, it is not true that we are entirely unchanged by time. The *ipse* self is only one part of our self identity, and does not limit us even as it helps define us to ourselves, and the *idem* self provides external validity of our self over time, but as one aspect of our self identity also does not limit us to what is seen by others.

The narrative approach to understanding the experiences of others is not perfect. Paley and Eva (2005) describes the need for narrative unity, the "sense in which contingent and apparently disparate circumstances are brought together in a single thread" (p. 90) to prevent unfocussed rambling and the introduction of elements which detract from our understanding of the event narrated. He also warns agains placing too much faith in the narrative as a reliable account of actual events, or as a true reflection of the experience of the narrator. However, this can be a strength when using narrative to examine how past experience guides future action, as the narration of the individual, rich with his or her own interpretation and memory of events, may be a better forecaster of future decisions than a more objective account produced by the observation of an outsider.

Part of the interpretation of the research interviews conducted for this study will involve seeing if the narratives told by nurses in their interviews can be viewed as part of their self identity expressed as a narrative identity, and can be shown to be linked to their decision making processes through their character, or developed dispositions, as an expression of virtue ethics in action. If this is possible then the individual nurse's decisions and self-identity will be strongly correlated, and the nurse will express her stories in a manner consistent with a description, explicit or implicit, of her self-identity. Will the nurses, in the manner of Kierkegaard, celebrate the expression of virtue, or will they, following MacIntyre's thesis, be

unable to use the language of ethics to frame their stories? The described decisions and narratives will show examples of moral courage and moral distress, recognized as such or not, which can also be examined in terms of the influence of self-identity. It may in fact be possible to redefine moral distress in terms of self-identity rather than in the emotional terms in which it is currently defined.

3.1.5. Dignity, Moral Distress, and the Self

Both concepts of dignity and moral distress fit into the virtue ethics model of decision making. Dignity is a necessary part of self-identity. Actions which are taken by the individual can either promote or erode a sense of personal dignity, as can the response of the individual to actions of others which may influence one's own sense of personal dignity. Viewing one's own life as a whole, as Aristotle sees necessary when judging the moral quality of a life, is just as important when considering one's own dignity. As with the 'goodness' of a life, the dignity can only be considered when viewing the life as a whole. However, in this case it can be argued that dignity can be recovered if lost, whereas it was discussed above how one bad act during a lifetime can be difficult to recover from in the sense of the individual living a morally correct life.

Moral distress fits into the virtue ethics framework through the idea that moral distress as an incongruence between the action taken and the individual's sense of self is incorporated into the narrative of the individual, and therefore into his or her sense of self. This can affect future decisions taken, and becomes part of the character (in the Aristotelean sense) of the individual. For example, after undertaking an action one feels is inconsistent with one's self-identity, the individual could promise herself not to act in a similar manner in the future. When

faced with a similar decision, the past decision and the moral distress resulting, will be influential in current decision making.

3.2. The Other

Any ethical situation involves both a self and an other. This is a twofold requirement: on one level an event which only affects the self is not an ethical event, but on another level the self cannot be defined without relation to another. Although Ricoeur is focussed on the understanding of the self in his major works, the other is not neglected. In fact, he states: "*Oneself as Another* suggests from the outset that the selfhood of oneself implies otherness to such an intimate degree that one cannot be thought of without the other, instead that one passes into the other..." (Ricoeur, 1992, p. 3). The other and the self are completely intertwined in the course of everyday life.

There can be no ethical dilemmas without an other to consider. Taylor states: "Perhaps the most urgent and powerful cluster of demands that we recognize as moral concerns the respect for the life, integrity, and well-being, even flourishing, of others" (1989, p. 4). He is writing here of our moral intuition, our sense of right and wrong as it relates to our interactions with other people. The key is that an action cannot be considered ethically right or wrong if it does not impact the life of another person in some way. It is interesting to note the use of the word flourishing in this sentence, since Aristotle's *eudaimonea* has been translated as flourishing by some authors.

For Taylor this intuition goes deeper than our feelings about a moral issue (in keeping with the idea that an emotivist basis for ethical decisions is insufficient) to become actually part of who we are:

> So our moral reactions in this domain have two facets, as it were. On one side, they are almost like instincts, comparable to our love of sweet things, or our aversion to nauseous substances, or our fear of falling; on the other, they seem to involve claims, implicit or explicit, about the nature and status of human beings. From this second side, a moral reaction is an assent to, an affirmation of, a given ontology of the human. (1989, p. 5)

This moral reaction, or intuition, may not be acknowledged by the agent, who may seek to rationalize or externalize the decision making process by relying on rules such as bioethical principles, but denial of the ontological nature of moral intuition does not stand up to explicit challenge. Taylor cites the existence of racist regimes, those that existed in South Africa under apartheid and in Russia under Stalin, as examples of attempts to use rules to override moral intuition which inevitably failed when the foundation could not withstand the external examination from a moral perspective. When a conflict arises between one's own moral intuition and the rational rules used to try to justify decisions, ultimately moral intuition cannot be ignored. This will be examined in further detail later when the concept of moral distress is discussed.

Taylor does extend the scope of morality beyond simply an obligation to another. He also finds that "we have to allow that there are other questions beyond the moral which are of central concern to us, and which bring strong evaluation into play. There are questions about

how I am going to live my life which touch on the issue of what kind of life is worth living…" (1989, p. 14). In this he states that as well as considering obligations to others we have to consider our obligations to ourself, and how these obligations to ourselves fulfill the desire for a 'good life' in the sense Aristotle intended. We must balance our own good life with the good lives of those around us, with the expectation that a complementary situation is possible where both are satisfied.

3.2.1. Other as necessary for self and the moral responsibility for other

Levinas turns around the foundation of ethics to focus on the Other in the relationship. The existence of the Other (capitalized in Levinas' writing) is enough in itself to impose on each of us an obligation to act ethically. "For Levinas, to care for the other is more an ultimate responsibility that is not innate but needs to be encouraged" (Lavoie, De Koninck and Blondeau, 2006, p. 228). Each person's reaction in an ethical situation is compelled by the face of the Other. Without the Other, there is no ethics: "the demand to respond to the existence of others is the basic social structure that precedes individual freedom; I become an ethical subject when I respond to this demand" (McCarthy, 2010, 130).

The counter to the argument that the other is necessary for moral responsibility in the form of obligation (from Levinas and Caputo) is found in Thoreau's "the only obligation which I have a right to assume is to do at any time what I think right" (1849/2005, p. 5). Note that it is not 'what *is* right' but 'what *I think* right'. This is a virtue ethics standpoint, not one based on Kantian duty or Levinas' obligation theory. The onus is still on the self to do what he or she believes to be right, not subject to the rules of others.

3.3.Extension of self and other into institutions

Ricoeur's conception of ethics encompasses the self and the other, but also extends to the level of the institution. This extension, considered as a 'just institution', covers the societal level of ethics. The main emphasis for the individual is on the concept of equality, where "equality, which presupposes justice in the non face-to-face encounter of the institution, replaces the asymmetry of solicitude" (Fredriksson and Eriksson, 2003, p. 143). Solicitude in this context concerns the relationship of the individual to the other, and sees "the dialectic of giving and receiving as a fundamental aspect of the ethical relationship" (Olthuis, Dekkers, Leget and Vogelaar, 2006, p. 39). The institutional level goes beyond the interpersonal relationship and considers the impact of broader associations of people. The individual is still important in the context of the institution, as "there is a correlation between this notion of the person as a social unit and the notion of the *common good* as the end of the social whole. They imply one another. The common good is common because it is received in persons, each of whom is as a mirror of the whole" (Maritain, 1966, p. 49). The institution is inseparable from each individual within its own structure.

The narrative of the individual is influenced by the institution in which it takes place. This is where professional ethics overlaps with individual ethics in the sense that the actions of the individual are expected to conform to norms set by the institution. It remains to be seen how strongly actions are influenced by each level.

3.3.1 Justice and the Institution

In his criticism of Rawls conceptualization of justice, MacIntyre states that the veil of ignorance, which is seen as promoting equality of basic liberties, and the distribution of goods

according to Rawls' system, where the equality of distribution is paramount, are ahistorical in nature. While justice defined this way is internally consistent at a given moment in time, historical, and by extension relational, aspects of justice are neglected. Rawls (1971) argues that desert, the idea that one person might deserve a specific distribution of goods based on some prior action which produced or contributed in some way to the gaining of said goods, can only be considered after his principles of justice are applied. MacIntyre sees Rawls' justice applying in and only in a situation where "we had been shipwrecked on an uninhabited island with a group of other individuals, each of whom is a stranger to me and all the others" (1984, p.250). It is clear from this example that relational aspects of the situation are irrelevant. However, MacIntyre states that a combination of Rawls' principles "with an appeal to desert exhibits an adherence to an older, more traditional, more Aristotelean and Christian view of justice" (p.251).

3.4. Ricoeur on Ethics

For Ricoeur, ethics and morality are not interchangeable terms. Ethics is the foundation of our individual moral actions, whereas morality is the set of ethical norms which the individual is expected to follow in a given society or institution. Kemp describes how Ricoeur's ethics can be seen as presented in three parts, the ethical intention, the moral norm, and the practical wisdom used to apply the norms (2002, p. 40).

The ethical intention refers to Ricoeur's stated goal of ethics: "aiming at the 'good life' with and for others, in just institutions" (1990, p. 172). Ethics is teleological by this definition. The good life referred to is individual, in the sense that "whatever the image that each of us has of a full life, this apex is the ultimate end of our action" (1990, p. 172). This is consistent

with a virtue ethics framework, where the source of ethics is the self and the character of the self. By positioning ethics as the primary point, ahead of morality or moral norms, Ricoeur identifies the self as the most important component of ethics. For Ricoeur "the *positive* character of ethics (the teleological or *eudaimonic*) gives it a certain priority over the deontological with its negative character in the sense of constraint" (Sweeney 1997, p. 199). The ethical self aims for the good life for positive ends rather than for fear of rules imposed by others.

Schopenhauer and Ricoeur agree on the difference between ethics and morality. Schopenhauer (p. 201) finds that the "concept of *ought"* should really be found in the realm of morals, the prescription for how we should act. Ethics should be seen as a way of interpreting the actions of individuals and trying to determine if any actions have intrinsic worth, what he calls "genuine moral worth". Ricoeur finds that the term ethics should be reserved for the teleological aim of a life as a whole and morality for the practical application of this aim in the course of living (1992, p. 170). Ricoeur sees ethics as superior to morality, whereas morality relies on ethics to justify its existence. The moral 'norms' of a society are subject to and derived from the ethical aim of the life of each individual. He goes on to say that "one can expect that the teleological conception by which we shall characterize ethics will link up in a direct way with the theory of action and its extension in the theory of narrative. It is, as a matter of fact, in the immediate evaluations and estimations applied to action that the teleological viewpoint is expressed. In contrast, the deontological predicates belonging to a morality of duty appear to be imposed from the outside of - or from above - the agent of

action, in the various forms of constraint which, precisely, are termed moral ones, all of which lends weight to the thesis of the irreducible opposition between ought and is" (1992, p. 171). This statement summarizes how focussing on ethics and the actions of the individual through the use of the narrative can situate the source of ethical action within the individual and not outside the individual in the codes or rules under which he or she lives. The moral code of a society depends on the ethics of the individual and not the other way around.

The good life, or full life, refers to the life as a whole, in the same way that Aristotle states that an individual cannot be judged as virtuous or not until the whole life can be examined (350/1955, p. 22). Ricoeur identifies two levels of action in this respect, the level of the particular action and the ends towards which it is directed, and the way that each particular action fits into the life of the individual as a whole. He states: "this finality within finality, however, does not destroy the self-sufficiency of practices as long as their end has been posited and continues to be so" (1992, p. 179). The particular action can be judged ethical or not, but the individual can only be judged ethical or not based on the life as a whole, the finality within which particular decisions are made.

Ricoeur's ethics is an integration of the question of self identity and the importance of action in ascribing ethical decision making to an individual. Ricoeur's primary question is 'who acts' rather than the theoretically based question 'who thinks' (Latona, 2001). In his overall view of ethics, "aiming at the good life" does not refer to thinking correct thoughts about an event, but acting in a manner which promotes "the good life", in oneself and others. It is not enough to know what the right course of action is, one must act on this knowledge in order to behave ethically and be internally consistent with one's own self identity. The

emphasis is on the idea that “action (and ultimately action in its most concrete form) is the means by which the self is first revealed and constituted” (Latona 2001, p. 108). Nothing affects our self identity in the way that our actions do. Descartes might be disappointed to have probably the best know philosophical quotation rewritten as ‘I act therefore I am’. This tenet provides the basis for a reexamination of the concepts of dignity and moral distress.

Why are actions the basis of ethics? Actions are more definitive than words. words can be ‘taken back’, denied (even in writing) more easily than action. Why do we shake hands to seal an agreement? The action affirms and makes concrete the intention. One might consider an example of a nurse being asked by a family member to withhold information from a patient ‘in their best interest’ when the nurse disagrees with this choice. Having a discussion is important, saying you will tell the patient anyway is a strong step towards an ethical choice, but the action of telling is the ‘point of no return’ which defines the ethical activity. It is not the choice which is at stake, but the action and the result of the action. In the long run, nurses are not experiencing moral distress due to choices that they have made, but from actions and the resulting sense of self arising from the actions.

There is a link between action and language that is built into who we are. Wilson (1998) describes the convergence of language and action by describing how infants learn language because of action. Movement and sensation are combined with action in early childhood in order to develop as an individual who understands the surrounding world. This is a necessary antecedent to understanding language. However, the meaning of language is subject to interpretation to a greater extent than action is.

Dignity can be considered to be the state of the self when the way the self is viewed by others is consistent with the self-identity of the individual. Put another way, I feel a sense of dignity when you see me, and more importantly act towards me, in a manner consistent with the way I see myself. The actions are the key to producing the effect on the recipient. For example, if a nurse treats a patient like they are a child incapable of making his own decisions, and the patient sees himself as an adult capable of deciding how he wants to live his life, then the incongruence in how he is seen and how he sees himself erodes his sense of dignity. In this view, dignity is a property inherent in all people, since all people have a self identity that they believe others should respect.

The idea of internal consistency with one's own self-identity can also be used as the basis for a reconceptualization of moral distress. The generally accepted definition of moral distress comes from Jameton (1984) that states that moral distress is the discomfort an individual feels when he or she knows the correct action to take but "institutional constraints make it nearly impossible to pursue the right course of action" (p. 6). Viewed from the perspective of self identity, moral distress can be defined as the feelings of discomfort resulting from *actions* one has taken which are in conflict with one's own sense of self. For example, if I as a nurse am pressured by another to lie to a patient when I believe it is not in the patient's best interest to be lied to, the resulting moral distress is not a quality of the institutional environment, but a realization that the way I have acted is not consistent with my sense of self as a morally good being.

3.5. The Decision Making Process

The importance of decision making in ethical theory is easily summed up by Schopenhauer's dictum that "responsibility presupposes the possibility of having otherwise" (Schopenhauer, 1840/2010 p. 184). The 'possibility' of acting otherwise is distinct from the statement 'as one is, so must one act' (see above) in which the word must does not refer to an action that is not TRULY involuntary in the literal sense of the word. The overwhelming influence of character in an Aristotelean sense affecting one's ability to make decisions results in moral distress when one actually acts in opposition to that which is demanded by character.

Decision making can be considered on two levels: the prereflexive and the reflective. Prereflexive decisions are those which are made instantaneously, at the moment in which the choice becomes apparent. In order to satisfy the condition of voluntariness as defined by Aristotle and Ricoeur, there must be more than one course of action available to the individual. This will be echoed later in the discussion of moral courage. In both types of decision the self and the self in relation to the other are central to the process of decision making.

3.5.1. *Prereflexive decisions*

The self is foundational to decision making, as shown by Ricoeur's statement that for decision making, the "prereflexive imputation of myself...implies a self-reference which is not yet self-observation, but rather a certain way of relating oneself or of behaving with respect to oneself" (1966, p. 58). The imputation is the designation of the self as the answer to the question 'who is acting', a self-reference which acknowledges the voluntary nature of the

action. The stress is on the active nature of the self-imputation, as opposed to simply being an observation. This active acceptance, a form of ascription, is especially relevant in moral decision making, where the consequences of the decision are also imputed or ascribed to the self.

These prereflexive decisions are not the end of the decision making process. Since the influence of rational processes is an integral part of some decisions, a period of reflection is often needed. Even our instinctive, or prereflexive, decisions can be evaluated after the fact. There needs to be a balance between accepting our decisions as stemming from our self-identity and rationally assessing the consistency of decisions with that self-identity. This process is needed so that we are "not giving our unscrutinized instincts an unconditional final say" (Sen, 2009, p. 51).

Lehrer, in *The decisive moment* talks about how 'moral emotion' affects our interest in particular ethical dilemmas. For example: "...we are riveted when one child falls down a well but turn a blind eye to the millions of people who die every year for lack of clean water" (2009, p. 181).The scale of the event must be within our capacity to feel emotion. Again it is true that action (falling down a well) produces more reaction than inaction (lack of access to clean water). We respond and reflect more on action than the absence of action.

This is a reflection again of Ricoeur's ascription of action to an agent. When an action takes place, the sense of responsibility is greater. Someone can be identified as responsible for the outcome of the action. It is more difficulty to ascribe responsibility for the absence of an action than for an action itself.

3.5.2. Reflexive decisions

Reflexive decisions are those which are not made immediately, but after a period of examination or reflection on the issue has passed. This is where the alternative frameworks described in Chapter 2 of ethical decision making are primarily employed. A principle based approach is an attempt to remove the prereflexive choice as an option for problem solving, replacing it with a more 'rational' system. However, the influence of the initial impression (pre reflexive choice) is difficult to ignore. This then becomes a case of having to overcome the first choice, which is based more on a virtue ethics standpoint, by argument for and against certain actions.

The use of a virtue ethics framework does not imply that decision making is easy, or that one will always act in accordance with virtue. As Caputo describes "Events demand something of us, here and now. But an event is an idiosyncratic situation, a just slightly unprecedented configuration that we have never quite met before, unique and not exactly anticipated. Each event sets its own requirements, its own idiom, demands that we invent a new idiom, not an absolutely new or absolutely idiosyncratic idiom, but new enough, idiosyncratic enough." (p. 99). This is accomplished, Caputo decides, through "*phronesis*....the ability to bring to bear a general schema upon the particularities of the situation" (p.99). *Phronesis* requires a degree of reflection in the application of past principles to current situations, but also incorporates the concept of character, where acting against ones disposition will be difficult.

The importance in nursing of reflective practice and the role of reflection in decision making is shown in research by Pask (2003), who describes how nurses value reflection as a means of clarifying decision making processes. Pask states that "nurses' apparent willingness

to reflect on their experience and to seek to learn from it" is critical to their own self-image as a nurse. This reflection is incorporated into self-identity, and helps to guide future decision making. Critical reflective practice has also been shown to increase work engagement for nurses, which in turn decreases levels of moral distress (Lawrence, 2011). This reflective practice could be either a self-reflection or a discussion based approach.

Reflection need not be an internal event. Storytelling among colleagues is another important element of reflective practice. The simple experience of a group of nurses sitting down and telling stories about events they have each encountered in practice is a powerful tool for furthering self understanding. I have had many experiences where one nurse has told a story about a particular patient interaction or nursing action they found difficult, only to have one or more other nurses say 'That happened to me once....' and go on to tell their own story. The comparison of the stories provides insight into the situation, as well as into potential alternate solutions to dilemmas. If nothing else, it serves to reassure all involved that they are not alone in their experiences and that others have the same type of problems as they do.

This act of storytelling can be seen from a hermeneutic perspective also. Ricoeur states "between a narrative and a course of events, there is not a relation of reproduction, reduplication, or equivalence but a metaphorical relation" (1988, p. 153-4). By telling the story we are producing a metaphor based on our own understanding of the event. No narrative is ever a complete rendition of the absolute wholeness of the event described. Each narrative is based on the narrator's individual interpretation of the events at the time of narration. This refers back to the concept of the trace as an element of self-identity: the story as told is a reflection of the self-identity of the narrator rather than a reproduction of a past event.

Daniel Kahneman (2011) describes prereflexive and reflexive decision making as the processes he calls System 1 and System 2 . Kahneman states that when faced with a choice in any situation, two systems act to produce our decision. First, System 1 provides an intuitive, immediate answer based on first impressions, and is not under voluntary control. In many cases, after this decision has been made, we stop thinking about the question. However, in some cases we recognize that further deliberation is necessary, and System 2 kicks in. This system requires attention and focus, and a deeper investigation of the problem. In many cases, System 1 is easily influenced by our preexisting bias, and the context has greater influence on decisions. An example of this is the concept of search satisfaction: if we find an 'easy' answer which is acceptable (whether or not we suspect there is a more difficult solution) we are more likely to accept the easy solution if offered and stop looking.

The line between the two systems blurs when we examine the concept of intuition. Over time, we follow a process where, when faced with a decision, initially "a tentative plan comes to mind by an automatic function of associative memory - System 1" (2011, p. 237). This tentative plan is deliberated upon, and a decision is made whether or not the plan is correct. Over time, given repeated examples of similar decisions, we recognize the events as similar without even realizing it, and the decisions are made intuitively, without the long deliberation of System 2. Even though each intuitive decision is thought to be primarily a System 1 decision, the influence of prior System 2 processes is very present even if unrecognized.

This recognition can be interpreted as a function of self understanding influenced by past experience. Even when reflective decision making is not overtly applied, the traces of past reflections affect the decisions made.

3.5.3. Link between decision making and self

There is a twofold link between decision making and the concept of self. First, the self is seen as the source of decision. While context and external factors are important, the ultimate decision will be shown to reside in and be produced from the self. Second, the self is, as a consequence of being the source of decision, responsible for the results of said decision.

3.5.4. Self as source of decision

Perhaps the simplest statement of why the self must be the source of a decision in a virtue ethics framework can be attributed to Schopenhauer, who writes "As one is, so must one act" (1849/2010, p. 186). This does not deny the fact that choices exist in a given situation, and does not prevent the possibility of acting wrongly. Schopenhauer finds that

> Hence, for a given individual in any given case, only *one* action is possible: 'doing follows essence'. freedom belongs not to the empirical, but only to the intelligible character. A given person's 'doing' is necessarily determined externally through motives and internally through his character; hence, everything that he does occurs necessarily. But in his 'essence', there lies freedom. He could have *been* another, an in that which he *is* lies blame or merit. (p. 186, italics in original)

This is consistent with the idea that the self is the source of action, and that action is ascribed to the individual.

Accepting the idea that the self is a transcendent being which persists over time in a historical sense is crucial for acceptance of the idea of personal responsibility for actions. It can be said that "responsibility presupposes a conception of personal identity consisting in

psychological connectedness and continuity" (Glannon, 1998, p. 231). This is not to say that a person who makes a decision is a static, unchanging being. Connectedness and continuity relate to the *ipse* self rather than an identical *idem* self. The *ipse* self is that self which can identify an individual over time without reference to identical aspects of the self. This concept of self is a whole being self which both is and is not the same as a previous self.

If this were not the case, then individuals could not be held responsible for actions which occurred in the past if the self at a future time is not seen as sufficiently similar to the self at the time of the decision for actions to be ascribed to that person. For example, a person who commits a crime in his 30's is tried for his actions forty years later is still seen as the same person, now in his 70's, in the sense of being responsible for his earlier crime. The self must be seen as a historical being, with some element of continuity over time. The answer to the question "Who am I" persists over time, in a similar way that the original obligation to the other persists over time. The concept of the trace is relevant again here. The trace serves to remove the temporal distance between the event and the present through the memory of individuals involved in the event.

Glannon states:

> Responsible behaviour is not a momentary snapshot of action but a temporally extended and causally connected complex process involving both mental events and actions identified with voluntary bodily movements. Processes are composed of events and are temporally continuous insofar as each event in the process is causally dependent on each preceding event in the process. (1998, p. 243-4)

This description speaks to several points. Responsibility for actions extends over time and involves the self as a whole being in terms of relying on mental and physical processes. The events for which the self is responsible are connected through time and are dependent on and influenced by prior events. As a result of these conditions, the self must be seen as a historical being, influencing and being influenced by actions and events over time. It follows that dispositions, or character in the Aristotelean sense, is developed over time as a consequence of the same connectedness that the individual has to these events. Responsibility, or response to ethical obligations acting on an individual, serves to reinforce positive character development. By accepting responsibility for actions, one is acting as an ethical being.

There is a point at which the decision can be seen as a 'leap' from information processing to action. After all the thought has been put into a situation, a time comes when a decision has to be made. However, this decision is in some regards a guess (Ricoeur, 1990) because we cannot know for certain the outcome of our action, whether it will accomplish our goal or not. This lack of ability to predict the consequences of actions is well described by Kahneman (2011) who uses multiple examples from psychology and economics. No matter how certain we are of our decision it is always the best of a range of guesses available to us. This is a parallel to the hermeneutic idea of interpretation as the best guess of the meaning of a situation/phenomenon. At some point, we have to take the 'leap of faith' that our action is the best one possible and follow through with it. When the choice is truly what we want to do but the consequences are unclear or potentially negative, this is when moral courage is important.

3.6. Conclusion

This chapter has provided an overview of Ricoeur's concepts of the self, the other, and the institution as they relate to ethics and ethical decision making. The focus on action and the prereflexive and reflexive nature of decision making has been described.

CHAPTER 4: Hermeneutics and Research

This chapter will show why hermeneutics is an appropriate philosophical framework for this research study and will describe Ricoeur's own take on hermeneutics. Also, the background on moral distress and moral courage will be discussed as they relate to the question of how nurses make ethical decisions in practice.

4.1. Ricoeur's Philosophical Hermeneutics

Ricoeur uses hermeneutics as a method of understanding the world, especially those areas which are difficult to understand. However difficult ethics might be, hermeneutics is appropriate for this study because "hermeneutics begins with the premise that the world is interpretable" (Moules, 2002, p.4).

One description of why hermeneutics is an appropriate philosophy from which to study ethics is found in Rorty's (2009) discussion of the distinction between subjective and objective knowledge:

> 'Objectivity' in the first sense was a property of theories which, having been thoroughly discussed, are chosen by a consensus of rational discussants. By contrast, a 'subjective' consideration is one which has been, or would be, or should be, set aside by rational discussants- one which is seen to be, or should be seen to be, irrelevant to the subject matter of the theory. To say that someone is bringing in 'subjective' considerations to a discussion where objectivity is wanted is, roughly, to say that he is bringing in considerations which others think beside the point. If the presses these *outré* considerations, he is turning normal inquiry into abnormal discourse - he is either being

> ‘kooky’ (if he loses his point) or ‘revolutionary’ (if he gains it). For a consideration to be subjective, in this sense, is simply for it to be unfamiliar. (p. 338-9)

If objective knowledge can be applied, and “rational agreement can be reached on what would settle the issue on every point” (p.316), then the discourse is considered to be commensurate, and falls under the realm of epistemology. By contrast, the subjective is necessary for those situations where knowledge cannot be said to be a function of consensus gained from rational discussion. These situations are what Rorty calls incommensurable discourses, of which ethics is an obvious constituent. Given that “hermeneutics is only needed in the case of incommensurable discourses” (p. 347), if there is any subject that hermeneutics is ideally suited for it is ethics with its never-ending supply of incommensurable dilemmas. Although it may be ideally suited, hermeneutic research is not without its challenges. Specifically, “the challenge of research inspired by philosophical hermeneutics is to articulate a meaningful and useful alignment of elements among the infinite possibilities of individual experiences and cultural and historical interconnections in which the topic lives” (McCaffrey, Raffin-Bouchal, and Moules, 2012, p. 218). Ethics as a research topic certainly contains infinite possibilities, and abounds with cultural and historical interconnections.

Schopenhauer states: “This is how all peoples, all times, all languages have grasped the concept of reason, namely as the faculty of universal, abstract, non-intuitive representations, called *concepts*, which are denoted and fixed through words” (1840/2010, p. 160). The following sections will describe several concepts important to Ricoeur’s version of hermeneutics.

4.1.1. Event, discourse, and the text

This research will use texts from interviews of practicing nurses, and will focus on situations encountered in the nurse's practice, which will be presented by the interviewee as a narration. These narratives need to be defined in terms of the dialectic of event and meaning, the self reference of discourse, and the autonomy of the text with respect to the event.

An event is simply what happened, as described. In order to have meaning, there must be an interpretation of the event by someone. This is the dialectic: "If all discourse is actualized as an event, all discourse is understood as meaning" (Ricoeur, 1976, p.12). An example of this in nursing may be the administration of a narcotic to a patient. The event can be the action itself observed by another, or a written description of the action in the form of charting. If this is the only information we have of this event, interpretation is difficult because many explanations are equally valid, most common would be relieving pain. However, with more information the event could be interpreted as contributing to the death of a palliative patient. In this case, the intent of the action is subject to interpretation. The event becomes an action, because "what distinguishes action from all other events is, precisely, intention" (1992, p. 74-5). At a basic level, this stems from what Ricoeur calls the dialectic of event and meaning. The "unity of the event and meaning in the sentence" (1976, p. 11) is what creates discourse. Analysis consists of filtering through the event, using the text as the source of potential meaning, then proceeding to interpretation, which is the ultimate goal of study and analysis.

However, in the situation where a speaker or writer tells of an event, the discourse itself becomes an event, which is subject to interpretation. Once spoken or written, there exist two

separate meanings associated with the speech or text: what the speaker meant and what the sentence means (Ricoeur, 1976, p. 29). The event of speaking is what connects the speech to the speaker, therefore the meaning is irretrievably tied to the speaker in this sense, but once spoken (especially if recorded and transcribed) the sentence has a meaning independent of that originally intended by the speaker. This is what Ricoeur calls the autonomy of the text (1976).

Discourse in this sense is different from language. Discourse is "realized temporally and in the present, whereas the system of language is virtual and outside of time" (1973, p. 131). Discourse can be related to the speaker, while language has no subject. Comparing discourse to language, Ricoeur identifies four distinct areas of difference: discourse is temporal, has a speaker, refers to an event, and exchanges a message, whereas language is virtual (outside time), has no subject, has no world in the sense of of an event, and is a "preliminary condition" of the communication of messages (p. 131). These characteristics are what distinguish discourse as an event rather than simply an expression of language.

In the act of speaking, when the listener is in the presence of the speaker, there are several characteristics of speech which are important to consider, organized into three levels (Ricoeur, 1973). The first is the locutionary act, defined as the proposition or what is said. At this, the most basic level, there exists the broadest range of interpretations of the text, and the least information available to support the validity of the interpretation. The next level is the illocutionary act, or the force with which the words are said. This provides another level of information to support interpretation. Words spoken softly can have a very different meaning than the same words shouted forcefully, and the listener gains information about meaning from the delivery of speech. The final level is the perlocutionary act, which is the effect the words

have on the listener, provoking emotion or response. This level moves the focus from the speaker to the listener. Two people listening to the same speech may have very different interpretations based on their own perspective, past experience, and background knowledge. Two nurses listening to a patient describe her experience with illness will have their interpretation affected by all three levels of speech, with the greatest difference in interpretation coming from the perlocutionary level.

In contrast to the immediacy of speech, movement from speech to writing produces the key concept of Ricoeur's hermeneutic analysis: distanciation. Spoken discourse provides an immediate reference back to the speaking subject, where :

> ...the subjective intention of the speaker and the discourse's meaning overlap each other in such a way that it is the same thing to understand what the speaker means and what his discourse means. (1976, p. 29)

This refers back to the locutionary, illocutionary, and perlocutionary aspects of speech, where the meaning of the words is (tied together with) the action of speech.

4.1.2.The Autonomy of the Text

In writing, however, there is a separation where "...the author's intention and the meaning of the text cease to coincide" (1976, p. 29). This separation is called the "semantic autonomy of the text" (Ricoeur 1976, p. 30). The concept of the autonomy of the text underlines the basic difference between speaking and writing. Writing is not just the transcription of a speaking act, it is the separation of the author from the discourse itself. The writer of a text is not present when the text is read, does not participate directly in the event, and is not available

for dialogue. This separation provides the conditions for the process of distanciation, which is a key component of Ricoeur's hermeneutics (Smith, 1987).

The importance of the separation is summarized in the following statement:

> Once again the dialectic of meaning and event is exhibited in its fullness by writing. Discourse is revealed as discourse by the dialectic of the address, which is both universal and contingent. On the one hand, it is the semantic autonomy of the text which opens up the range of potential readers and, so to speak, creates the audience of the text. On the other hand, it is the response of the audience which makes the text important and therefore significant. (Ricoeur, 1976, p. 31)

The autonomy of the text provides the distanciation, and the response of the audience, which is the interpretation of the text, provides the appropriation. When I read a text, I do not have the author reading over my shoulder so that when I pause to consider a point he or she can say 'What I meant by that was.....'. The text is separated from the author by distance and time, and can never be fully reclaimed by the author as solely representing any one interpretation. In this way, "because writing frees discourse from the intention of the author as well as from the original audience and situation, it makes discourse an object with its own riles and codes and therefore an object susceptible to immanent analysis" (Gonzalez, 2006, p. 319-20). In fact, this autonomy can also be thought of as a source of the hermeneutic idea that "when we read a text, we are interpreting it in our own particular way; therefore to read a text is to (re)write it, as it were" (Van Manen, 1997, p. 361). The text no longer belongs to the author, it is solely the property of the reader in all senses.

In *Joseph Anton*, an autobiographical account of his years in hiding due to the response to his book *The Satanic Verses*, Salman Rushdie provides a vivid description of the process of distanciation, writing:

> When a book leaves its author's desk it changes. Even before anyone has read it, before eyes other than its creator's have looked upon a single phrase, it is irretrievably altered. It has become *a book that can be read*, that no longer belongs to its maker. It has acquired, in a sense, free will. It will make its journey through the world and there is no longer anything the author can do about it. Even he, as he looks at its sentences, reads them differently now that they can be read by others. They look like different sentences. The book has gone out into the world and the world has remade it. (2012, p. 90, italics in original)

This is a beautiful description of the distanciation of a text from its author, the manner in which the text becomes subject to the interpretation of the reader regardless of the intent of the original author. In the case of *The Satanic Verses*, the reaction of some members of the Muslim world was to pronounce a *fatwa*, a call for Rushdie to be killed. This is an extreme example of how the intent of the author obviously does not match the interpretation and reaction of his audience, since the book was most likely not written with the intention of provoking a death sentence against the author.

The above passage by Rushdie describes the separation of the text, but the fact that Rushdie is still the author of the text is important. It is essential to not slip into "...the fallacy of hypostasizing the text as an authorless entity". (Ricoeur, 1976, p. 30). If the authorship of a

text is denied, the text becomes something which is not man-made, and this is of course never the case. This becomes more important later, when the interpretation results from the reappropriation of the meaning of the text by the reader, which constitutes the hermeneutic process according to Ricoeur. The interpretation is informed by the knowledge of the author with respect to the text.

4.1.3. Distanciation and Reappropriation

The importance of the concept of distanciation to the hermeneutics of Ricoeur cannot be overstated (1973; 1976). Ricoeur states "for me the text is much more than a particular case of interhuman communication, it is the paradigm of the distanciation in all communication" (1973, p. 130). The function of distanciation is broken into four themes: the relationship between speech and writing, the text as a structured work, the text as a projection of a world, and the text as mediating self understanding (p. 130).

The first theme is the relationship between speech and writing. This returns to the dialectic of event and meaning: discourse is actualized as event and understood as meaning (Ricoeur, 1973). The shift from speaking to writing shifts the emphasis from the first pole of discourse as event to the "second pole, that of meaning", and "the distanciation which makes writing possible, and the production of discourse as a work, and all the other factors that enrich the notion of distanciation, come from the tension between these two poles" (p. 131). Distanciation is a characteristic of text, more so than of speech, and must be overcome in order to produce an interpretation by the reader, but it is also what makes interpretation possible, by providing a distance between the writer and the reader.

The second theme of distanciation is the production of the text as structured work. The genre, or style, of the written work provides a distance between the author and the reader. Discourse, as a produced work, or event, is "not merely a sequence of sentences on equal footing and separately understandable. A text works on the first con-text for each partial meaning." (1973, p. 135). This can be described as the artistic or aesthetic side of the event of discourse, and provides a substrate for recontextualization by the reader.

The text as the projection of a world is a return to Heidegger, with the idea that "to interpret is to explicate a sort of being-in-the-world unfolded in front of the text" (1973, p. 140). This relates to the level of reference associated with hermeneutic inquiry. The interpretation is no longer a search for the authors meaning, but a search for the meaning of the text to the reader. The text becomes a "proposed world" (p. 140) which the reader lives in, a function Ricoeur relates back to the *mimesis* of poetry described by Aristotle. The text is a reflection of reality which is separated from the author and becomes the appropriated world of the reader.

The final theme of distanciation is the mediation of self-understanding via the "distanciation of the subject from himself" (p. 141). This Ricoeur sees as the most fundamental level of distanciation, whereby "the last act of understanding is the *appropriation* of the meaning of the text" (p. 141). The appropriation is only possible if there is distanciation on the other three levels. The hermeneutic process depends on the separation of event and meaning, and the appropriation and distanciation inherent in textual analysis result in the interpretation of the event.

Distanciation is a property of the text itself, and is not a function of the method of interpretation. This allows "interpreters to approach the text without concern for authorial

intent" (Geanellos, 2000, p. 113). The move to interpretation allows the reader to undergo a process or appropriation of meaning from the text rather than from the author, and the resulting interpretation changes the understanding of the reader as an individual. The hermeneutic focus on self-understanding as an endpoint of the interpretive process is reinforced by the levels of distanciation involved in the process itself and the emphasis on the interpreter being changed by living in the world of the text is maintained (Charalambous, Papadopoulos and Beadsmoore, 2008).

Ricoeur then asks us to "reflect upon what the self of self-understanding signifies" (1974, p. 17). The desire for self-knowledge drives the interpretation of the text, rather than the author being the initiator of the the change in understanding. This process is described as how "the interpretation of a transmitted sense consists in (1) the conscious recovery of (2) an overdetermined symbolic substratum by (3) an interpreter who places himself in the same semantic field as the one he is understanding and thus enters the 'hermeneutic circle'" (p. 55). In this way understanding is a function of the self and interpretation is the end result of discourse understood as meaning.

The distanciation and reappropriation of the text as interpretation also fits well with a self-referential quality of hermeneutic interpretation. Ricoeur points out that "the concept of distanciation is the dialectical counterpart of the notion of belonging, in the sense that we belong to an historical tradition through a relation of distance which oscillates between remoteness and proximity. To interpret is to render near what is far (temporally, geographically, culturally, spiritually)" (1981, p. 110-111). The back and forth interpretive process mirrors the back and forth relationship we have with our historical tradition and the

world around us. Each person is at the same time present in the world and a function of his or her identity, which is a result of the past and the self-reference of narrative identity.

Philosophical hermeneutics as a whole shares an emphasis on the ontological over the epistemological. In contrast to the epistemological, "ontological questions force one beyond method and logic to the underlying question of meaning. Hermeneutical inquiry pertains to ontological understanding and is concerned with interpretation as opposed to methods of logic" (Allen and Jensen, 1990, p. 245). This originates from the work of Gadamer and Heidegger, as for them also "meaning lies in the individual's transaction with a situation such that the situation constitutes the individual and the individual constitutes the situation" (Annelis, 1996). Even Levinas, whose emphasis is on the relationship the individual has with others as a means of self-definition states "doesn't knowledge, in the last analysis, pass through the consciousness of self?" (1972, p. 46).

Interlude

In his wonderful book *In The First Circle*, Aleksander Solzhenitsyn writes of life in the Soviet Union in 1949. Central to this book are descriptions of life in the *gulags*, the camps for prisoners of all kind, including political prisoners. Two of these prisoners, engaged in a conversation about happiness, discuss where the meaning of happiness can be found. In the midst of the debate, one exclaims:

> Don't try to confuse the issue, Lyovka, it isn't like that at all! I draw my conclusions not from the philosophical works I've read but from the life stories I hear in prison. When I need to formulate my own views, why should I set out to discover America all over

> again? There are no unexplored countries on the planet Philosophy. I turn the pages of the wise men of old, and I find my own most recent thoughts. (2009, p. 40)

Nerzhin, the speaker of these words, is very much in the world, as are all Solzhenitsyn's characters. He believes in his own interpretations, and discounts the philosophizing of others. While it is true that interpretation has to come from within oneself, guidance in the search can be useful. While the philosophical foundations are useful, it is in the examination of life experiences that understanding comes forth.

4.2. Hermeneutics, Ethical Decisions, and Nursing

The study of ethics is clearly of importance to nursing as a discipline, as it is to everyday life. It is true that "the ethical as such is the universal, and as the universal it applies to everyone, which can be put from another point of view by saying that it applies at every moment. It rests immanently in itself, has nothing outside that is its *teleos* [end, purpose] but is itself the *teleos* for everything outside, and when that is taken up into it, it has no further to go" (Kierkegaard, p. 83).

The condition of the self as an ethical being is affected by the specific nursing setting. In this research, intensive care settings were chosen due to the author's experience within that setting and the ability of the units to produce unique and intense ethical issues as well as a large number of smaller everyday ethics situations. The critical nature of the patients increases the frequency of life threatening and end of life events, and ethical decisions related to these events are of high importance to the nurses who work there. Because of the highly complex nature of the nursing care given, innumerable decisions are made in the course of daily practice which can affect patients' well being and contain ethical aspects which would fall into

the ‘everyday’ ethics category. O’Keefe-McCarthy (2009) has pointed out some of the unique characteristics of intensive care settings which make ethical decision making challenging, most notably the intrusion of technology into the nurse-patient relationship and the potential for this technology to distance the nurse from the patient. This highlights the need for embodied reflection as a means to reintegrate the patient into the moral agency of the nurse.

In a study which explored “the meaning of ethics and the enactment of ethical practice in nursing” (2004, p. 316), Varcoe *et al.* stressed the importance of connecting the ethical self of the individual nurse to the process of ethical decision making and ethical theory. They found that their study “calls for a move beyond a distant, disengaged approach to ethics to one that is close to and inseparable from nurses’ moral experiences, and contextual realities of practice. In particular, the study implies that nurses need to understand ethical theory through connection with their everyday practice, practice that is socially and organizationally mediated” (2004, p. 323).

Ethical decision making and the resulting stress is an important factor affecting nursing as a profession. Various studies have shown that high levels of moral distress lead to an increased level of burnout in nurses and can cause nurses to leave positions or even nursing entirely (Epstein, 2012).

Through examination of narratives of individual nurses’ experiences of ethical issues, this study will strive to elucidate the nurses’ moral experiences in the context of practice, and through the use of a virtue ethics framework interpret those experiences to further the understanding of how ethical theory is incorporated into the nurses’ self-identity.

4.3. Nursing literature review

Moral courage and moral distress are two phenomena well documented in nursing literature . These two concepts will be of critical importance in the interpretation of the narratives of ethical decision making processes. Their current definitions and understanding will be described here so that the texts of the interviews can be seen in light of the current conceptions of moral courage and moral distress, and interpretation of the text will be used to expand and refine these definitions.

4.3.1. Moral courage in Nursing

Although the distinction has been made above between the terms ethical and moral (following Ricoeur) with ethical being the teleological aim of the individual and moral being the societal or collective rules agreed upon as the means of carrying out the ethical aim, in the nursing literature the terms ethical and moral are most often used interchangeably (Oberle and Raffin-Bouchal, 2009, p.3). Although the term ethical courage may be more accurate in the virtue ethics framework used for this study, to be consistent with nursing literature the term moral courage will be used in this discussion.

From a perspective of virtue ethics the concept of courage can be traced back to Aristotle. He finds that the essence of a virtue consists of the avoidance of either excess or deficiency of a particular characteristic. This condition, called the doctrine of the mean, can be applied to courage. Whereas a cowardly individual displays an excess amount of fear and a rash one displays an excess of confidence, the courageous person displays an appropriate balance between the two extremes (Aristotle 350 BCE/1955, p. 43). In the case of moral courage, the

balance between rashness and cowardice applies in a situation where the question of good or bad arises, where there is an ethical dilemma and courage is needed in order to act appropriately (Olsthoorn, 2007). As Olsthoorn (2007) points out, physical courage (where the direct risk is of physical harm) is the other common form of courage an individual can display. By contrast, the risk that is faced in situations requiring moral courage is more often not physical, but most likely involves one or more of shame, humiliation, or social disapproval, or could even potentially include damage to or the loss of career or of relationships, all of which are more social in nature (Clancy 2003; Kidder 2005, Lachman 2007). These consequences are not negligible, and the greater the consequences the greater the moral courage needed to do what the individual believes to be right (as Thoreau would put it). The development of moral awareness has been identified as the necessary first step toward moral decision making (Holt and Convey, 2012).

In addition to an ethical context and an element of risk, in order for moral courage to exist there must be a degree of freedom to make a choice. Once again, the difference between the voluntary and the involuntary is applicable. If there is no choice available, and any action taken is truly involuntary, than no moral decision has been made (Aristotle c. 350 BCE/1955; Ricoeur 2007). As well as being voluntary, the choice must obviously be a conscious one (Sekerka and Bagozzi, 2009). The conscious nature of the decision means that the risks have been considered and balanced against the obligations the individual feels.

The risk in a moral dilemma does have the potential to be a physical risk. For example, the choice all health care workers face is whether or not to participate in the care of those patients who pose a physical risk to the caregiver (Tomlinson, 2008). The conflict is between the care

needs of the patient versus the safety of the caregiver. In the case of severe infectious disease issues such as the recent outbreaks of SARS and the H1N1 influenza pandemic (Singer et al. 2003; Tzeng, 2004). This conflict is more internal in the sense that the risks are largely borne by the individual, but transmission of illness to family members is a concern for those who choose to continue working with these patients. There is a risk associated with refusal to care, as the loss of jobs and/or social standing was very real. All of these risks need to be considered when nurses are faced with ethical dilemmas related to caring for patients who pose a physical risk.

The final requirement for moral courage to exist is an opportunity for this choice to result in an action. Without action, there can be no demonstration of the courage needed to make the decision. This requirement for action can cause particular difficulty for nurses, where the constraints of their position in the hierarchy of health care can cause feelings of impotence. For example, Lachman (2010) finds that even though nurses are ideally positioned, due to their close relationships with patients, to initiate end of life discussions, this role most often falls on the physicians due to their traditional place as the primary decision maker with respect to health care issues. Nurses are required to show their moral courage in acting against this tradition in the best interests of their patients.

Moral courage is a requirement for all nurses. Day (2007) discusses the necessity for moral courage in the defense of nursing as a profession in the face of outside influences (such as institutional practices and constraints) that discourage the provision of optimal nursing care. The duty to provide the best care possible is the goal, and nurses are required to at times "...act courageously when they slow down the efficient machinery of acute care in order to attend to

the personal and particular needs of one patient and family" (p. 616). Note again that it is the action of providing care that demonstrates the moral courage. Deciding that individuals *should* be a priority is not enough to demonstrate courage, action is needed. Lachman (2007) concludes that:

> The individual with moral courage knows the rewards are unlike those that come from blind resolve or from safe harbours. He or she abides by principles in the face of danger, taking the time to determine the right thing to do. This nurse knows his or her professional obligations and stands firm in core values that honour patients, profession, and self. The nurse has not acted impulsively, but has assessed the risk of action, used effective conflict resolution skills, and sought moral resolution. The nurse with moral courage is willing to endure the fear and act, even at personal cost. (p. 133)

This is an excellent summary of the conditions for moral courage to be exhibited: the ethical dilemma, the existence of a level of risk, the need for a decision, the freedom to make a choice, and the need for action.

Moral courage as a virtue is part of each individual's character. The ability to own ones own moral courage is validated by the opposing idea that an external source of morality weakens the claim of the individual to the possession of moral courage. Ives finds that:

> Conversely moral cowardice, in the sense that I am talking about here, would occur when a person relies on a source external to themselves to determine their moral beliefs and who, when asked to justify their moral convictions, does so by appealing to the authority of that external source. In doing this a person is in a very real sense failing to take responsibility for their moral choices. (2008, p. 65)

In a practical sense these moral convictions are largely implicit, and the justifications for our actions are not always evident or even considered until our actions are challenged by others or at the time when a particularly difficult decision is required (Taylor 1989, Chapter 1) . The need for moral courage often provides the stimulus for a period of self-reflection.

This courage is present to a greater or lesser extent in each person, however the potential exists for the development of increased courage over time. Modeling and mentorship have been identified as two particularly powerful techniques for the growth of moral courage (Aultman, 2008). Something as simple as storytelling could have a large impact on others. Returning to *Poetics,* Aristotle points out the value of poetry and epic storytelling. The mimetic nature of the tragedy, for example, is expressed by the passage:

> Tragedy is not an imitation of persons, but of actions and of life. Well-being and ill-being reside in action, and the goal of life is an activity, not a quality; people possess certain qualities in accordance with their character, but they achieve well-being or its opposite on the basis of how they fare. So the imitation of character is not the purpose of what the agents do; character is included along with and on account of the actions. So the events, i.e. the plot, are what tragedy is there for, and that is the most important thing of all. (p. 11)

The description of the actions of a story are what inspire others to attain the level of character of the the protagonists of the story.

4.3.2.Moral Distress in Nursing

Moral distress is the antithesis of moral courage. One definition of moral distress commonly found in nursing literature is attributed to Jameton (1984) where he states that moral distress is the discomfort an individual feels when he or she knows the correct action to take but "institutional constraints make it nearly impossible to pursue the right course of action" (p. 6). This definition externalizes the source of the distress and does not fit well with a virtue theory of ethics and ethical decision making.

Moral distress has been studied in various settings, including medical/surgical units (Rice, Rady, Hamrick, Verheijde and Pendergast, 2008), perinatal nursing (Tiedje, 2000) and intensive care (Elpern, Covert and Kleinpell, 2005; McClendon and Buckner, 2007). Each of these studies found that nurses experience a significant level of moral distress in their work setting but that the level of distress varied between individuals. In an overview of the nursing literature, Burston & Tuckett (2013) found four individual characteristics that influenced the variance in levels of moral distress between nurses: character traits, world view, experience, and relationships. Character traits included factors such as knowledge, authority, and perceived skill level. World view includes moral sensitivity and individual ethical perspective. Experience included both work experience and general life experiences, while relationships covered mainly the hierarchical nature of health care settings. In addition to these individual factors, site specific factors were identified including resourcing, staffing levels, care delivery method, and "world of work", a factor which the authors state covers the unique nature of nursing practice settings (p. 317).

There is some debate over whether moral distress as a concept is actually helpful to nursing as a whole. Johnstone and Hutchinson (2013) declare that

> A preoccupation with moral distress in nursing will not pave the way for improving the quality and safety of ethical decision-making, ethical conduct and ethical outcomes in nursing and healthcare domains, nor will it reduce the incidence and impact of preventable 'moral mistakes' in healthcare. (p. 8)

They advocate for better understanding of the basis of the ethical decisions made by individual nurses and how nurses "perceive and understand ethics" (p.8). This is precisely what this thesis is attempting to undertake.

4.3.3. Ethical decision making in Nursing

There is a distinct lack of literature in nursing on the philosophical foundations of ethical decision making by individual nurses. Most research focusses on the role and use of decision making models for nurses (Garity, 2009) or on how the decisions made by nurses are affected by factors such as education and professionalism (Cerit & Dinc, 2012). While the overall importance of ethics in nursing is well established (Day & Benner, 2002; Doane et al*., 2004),* the source of ethical decision making is less well studied. Research on ethical decision making often attempts to provide guidance for how to use various methods to make ethical decisions (Garity 2009; Rejno, Danielson, & Berg 2013; Zutlevics 2009). While these are useful for practical purposes, they do not provide any help in describing the philosophical foundations of ethical decision making for nurses.

CHAPTER 5: Study Design

5.1. Introduction

As a hermeneutic inquiry, this study used research interviews to obtain narratives from Registered Nurses who work in intensive care settings. The interviews were then analyzed using a model described by Sorlie, Kihlgren & Kihlgren (2005). The first analysis involved a naive reading for overall impression, then a more detailed reading for structural analysis of the text, followed by the production of an interpreted whole "based on the naive reading, the structural analysis, and the authors' preunderstanding" (p. 135). Although the philosophical hermeneutics of Ricoeur were used as a guiding framework, Ricoeur provides no practical method of analyzing data.

5.2.Research Sample

Six Registered Nurses were recruited from three Intensive Care Units (ICU's) in the city of Calgary. The recruitment was restricted to critical care registered nurses. The range of critical care experience ranged from two to thirty-one years, with a mean of ten years. The range of overall nursing experience ranged from two to thirty-three years, with a mean of fourteen years. RNs were recruited by way of posters placed away from public areas at each of the units (see Appendix B). The critical care units chosen were at or equal to the highest level of care units at each hospital. All units accepted only critically ill patients including those on ventilators and advanced inotropic support.

5.3. Research Design

The purpose of this research was to investigate how nurses interpret their ethical decision making processes and actions in a critical care area. Philosophical hermeneutics has been

chosen as a basis for this study due to a congruence between the philosophical background and methodology and the nature of the study of ethics. Philosophical hermeneutics involves the relationship of action, text, and interpretation using the hermeneutic circle, while the practice of ethical development involves a sequence of action/reflection/character development/new action, developed from the nature of virtue ethics. The ontological nature of ethical action was examined within the context of a virtue ethics framework. Using a philosophical hermeneutics approach to analyze texts generated from interviews with critical care nurses, the goal was to further our understanding of the decision making processes and actions of nurses working in critical care.

5.4. Data Collection Methods

Interviews consisted of one meeting lasting between eighteen and twenty-six minutes, with a mean of twenty-four minutes. All transcriptions were done by the author, with the transcription comprising sixty-eight pages in total. Each interview took place at a mutually agreed upon place, which included at the home of the interviewee (3), the home of the student researcher (1), a private meeting room in a hospital (1), and a private room at the University of Calgary (1).

Four guiding questions common to all interviews were used (see Appendix A), with follow up questions used based on the responses to the guiding questions. These follow up questions were essential to providing the depth of answers necessary for good data. The questioning process itself has been compared to the hermeneutic circle, in the sense that the questioning is a continuous process:

> Given the importance of the *question*, discussed earlier, a limitation could be that the researcher is limited by the questions one is able to ask. Is the researcher open to further questions? Does the researcher allow the text to ask further questions of her or himself? Is the researcher aware of one's own preconceptions? are the questions reflecting one's own presuppositions? This form of questioning must be a continuous process, even after the interviewing is complete. Questioning is the opening up of a topic, to reveal new possibilities. If such a view is not conscientiously followed, the questioning practice of the researcher could be a limitation. (Binding & Tapp, 2008, p. 128, italics in original)

Given that I am a novice interviewer, it is probable that some information was missed that could have been gleaned from follow-up questions that were not asked. Also, the statement above emphasizes the need for acknowledging preunderstanding in the selection of questions. If "the researcher is considered inseparable from assumptions and preconceptions about the phenomena of study" then I must pay careful attention to how my responses and choices of follow up questions may influence the further responses of the interviewees (de Witt & Ploeg, 2006, p.216). My critical care experience both helped and limited the selection of the guiding questions and the choice of follow up questions during the interview. I was able to use my own experience to decide which parts of the narratives the participant might find most ethically distressing and use my follow up questions to fill out those sections of their responses.

5.5. Data Analysis and Synthesis

All interviews were transcribed verbatim from the digital recordings by myself. Once transcribed, the interviews were analyzed following a method described by Sorlie, Kihlgren, and Kihlgren (2005). The first stage is a naive reading, which in the case of this study is an

extension of the transcription, performed immediately after the transcription to gain a sense of the text as a whole. Then a structured analysis was undertaken, which is "aimed at identifying patterns and parts of meaningful consistency and to seek explanation of the interview text" (p. 135). This involves the identification of common themes within and between individual texts from each interview. The final stage, called by Sorlie et al. "the interpreted whole" (2005, p. 135) is a synthesis of the naive reading with the structured analysis, taking into account the preunderstanding the author brings to the study. This is the equivalent of Ricoeur's reappropriation stage of textual analysis (Ricoeur, 1976). In this stage the interpretation of the text is taken up by the reader and incorporated into his or her own self-understanding. Ricoeur has also described this process as "(1) the conscious recovery of (2) an overdetermined symbolic substratum by (3) an interpreter who places himself in the same semantic field as the one he is understanding and thus enters 'the hermeneutic circle'" (1974, p. 55). This process of interpretation is also seen as "...the work of thought which consists in deciphering the hidden meaning in the apparent meaning, in unfolding the levels of meaning implied in the literal meaning" (1974, p. 13).

As suggested by Wiklund, Lindholm, and Lindstrom (2002), this method of interpretation can be modified slightly by the inclusion of a theoretical framework:

> The authors then suggest that the interpretation process be taken a step further when the interpretations derived from the text are reflected upon in relation to both the context of the participant and to a theoretical frame of interpretation. That could be described as one way to approach the hermeneutic circle and a way to relate the parts (interpretations derived from analysis of the text) to the whole (the participants' context). The theoretical

> framework can contribute with other dimensions and expand understanding further. (2002, p. 116)

In this case, two theoretical frameworks contributed to the interpretation: the virtue ethics approach and Ricoeur's theory of self-identity. There is good synergy between the method based on Ricoeur's hermeneutic philosophy and his theory of self-identity, and these mesh well with virtue ethics which focuses on the self and self-identity, in this case narrative self-identity, as the source of ethical decisions.

The interpretation of the themes and sub-themes consists of more than a simple description of the text. Although it is true that "This focus on the thematic aspect of the text is primarily concerned with *what* the text says, its semantic, linguistic meaning, and significance" (Van Manen 1997, p. 246), the hermeneutic approach of Ricoeur as outlined above goes beyond description and incorporates the interpretation of the themes through the distanciation/ reappropriation process.

5.6. Research Ethics Considerations

This study was approved by the University of Calgary Conjoint Health Research Ethics Board (CHREB). Each participant was required to sign an written consent (Appendix C) explaining purpose of the study, the conditions of their participation, and the potential harms and benefits of the study. Potential harm from the study is mostly limited to the possibility of the questions causing anxiety or distress when situations were remembered and recounted, and the possibility of misrepresentation of the interviewee by the researcher in the written material (Richards and Schwartz 2002). All interviewees were made aware that they could withdraw

from the study at any time. Any recordings already completed would, however, remain part of the results.

Since the research consisted of interviewing individuals about potentially sensitive topics, the interviews were conducted in private and the transcripts available only to the researcher and research supervisor. Interviews were electronically recorded without using the name of the participant. Anonymity was protected by the use of a pseudonym (an initial not standing for the name of the participant) for the interviewee and any persons named during the interview. Also, given the small population from which the nurses were taken, any information which could potentially identify the nurse or anyone described in the transcripts was not included in this paper. The recordings were available only to the researcher and direct supervisor. Data was and will be stored in a secure location until destroyed.

5.7. Trustworthiness

Any qualitative research method is subject to questions of validity and rigor. This must be an ongoing concern during the research process, since "validity from an interpretive perspective becomes a moral question that must be addressed from the inception of the research endeavor to its completion (Angen, 2000, p. 387). When presenting the criteria for evaluating the validity of qualitative research, Levy-Malmberg and Eriksson (2010) reintroduce Levinas into the discussion:

> According to Levinas and Buber the post-modern political affinity to ethical relations is that 'another' is the 'complete other' in a face-to-face relationship. Similar to Buber, Levinas maintains that this relationship arises from ethical affinity. An evaluator must be aware of moral responsibility, by means of which we may draw conclusions in both

> moral and personal fields, which are required for explaining the phenomena in the research field and development in the field of knowledge. Therefore, ethics, first of all embodies relating personal responsibility towards 'the other', who is evaluated face-to-face as a sublime value. (p. 112)

This means that the validity of the study must be evaluated considering the experiences of the participants rather than attempting to force an external measure of validity on the subjects. The narrated experiences of the participants are valid partly because they are presented as true experiences to the best recall of the individual.

Having said this, it is still necessary to have some measure of rigor to the study. Although Sandelowski, one of the early leaders in evaluating qualitative research in nursing, has regretted using the word rigor due to the rigidity implied by the word itself (2006, p. 643), she agrees that some evaluation of quality criteria is necessary if the research is to be useful to others. The most common measures of validity for qualitative research include credibility (the extent to which the results of the research are believable to others), transferability (the extent to which the findings can be generalized to other populations), and dependability (a parallel to reliability in quantitative studies), all of which must be included in an assessment of the validity of a study (Thomas & Magilvy, 2011; Koch 2006).

For the purposes of this study, credibility was addressed by extensive reporting of direct quotations from the interview transcripts to ensure accurate representation of the ideas of the interviewees. This will allow the reader to see directly what the narratives are, which allows the reader's own interpretations to be compared to mine. Transferability will be addressed by selecting from a variety of ICU settings to avoid a local selection bias. Transferability will be

accordingly limited to other ICU type settings, and the interpretations of ethical decision making in other nursing areas may not be as relevant. Dependability will be enhanced by clear and concise descriptions of the steps from the transcript results to the interpretation of the answers from the interviewees. This will be accomplished in the analysis and the interpretation sections of this manuscript, and again having access to direct quotations from the narratives produced by the interviews added to the dependability of the interpretations.

5.8. Summary

This study used a hermeneutic approach based on the philosophy of Paul Ricoeur to examine narratives generated by interviews of critical care nurses to understand the philosophical basis of their ethical decision making processes. Transcripts were generated from the interviews and analyzed using a method from Sorlie, Kihlgren, and Kihlgren (2005) to produce an interpretation of ethical decision making processes based on the transcripts. This process follows the distanciation and appropriation concepts described by Ricoeur, especially in *Oneself as Another* (1992).

CHAPTER 6: Findings

The next two chapters will follow the interpretive process outlined in the methods. First, the results of the interviews will be presented as a summary of the responses to the questions asked. These narratives will be analyzed and key themes identified. The themes will be interpreted and contextualized within nursing practice. The interpretation will be used to provide implications for nursing and recommendations for practice and finally to provide directions for future research.

6.1. Results

In their response to the first guiding question (Can you describe a time when you were involved in or affected by an ethical decision related to your practice? What happened, what decision was made, and how did the decision affect those involved?) all six nurses interviewed presented as their first story a description of a time when a patient was being kept alive beyond what the nurse thought to be appropriate. Three examples are presented below.

> *J: Well I had a patient, probably three years ago or so now who had had a personal directive stating that he did not want any life sustaining stuff done to him, and I can't remember what his diagnosis was, it wasn't good, he was very sick, I know he had peripheral vascular disease pretty bad, and the doctors actually disregarded his personal directive, and, his blood pressure I think had been dropping for me on a night shift, and I informed the fellow, who knew he had a personal directive, um, saying that he didn't want anything done, and he disregarded it and started levophed on this man*

and the personal directive was actually pretty straightforward that he didn't want stuff done and the fellow's answer to my telling him that he didn't want stuff done was "well, his wife wants this to be done" but the son of the man was absolutely irate that we were sustaining his.. or basically prolonging his death so that really bothered me because I think we see that happen a lot on our unit. Where they just prolong death.

J saw this as an example of life sustaining measures being initiated by the physician against the explicit wishes of the patient. B describes a situation in which the wishes of the family were being followed while the wishes of the patient were not:

B: So, we had one patient with us for quite a long time, he had cancer, a lot of co-morbidities, chest tubes on and off, every orifice had a tube, essentially his cancer would kill him in the end, but his family was very adamant we kept going and going and going, which we felt was torturing the poor man, when his family wasn't around he wanted to be an R2, but when his family was there he wanted an R1 because they would kind of sway him to make that decision. So it was really hard for us to put him through things, cause you know, for almost a year that he was with us if something went wrong here we were forced to put another tube in, and you could tell he just didn't want it.

In each of these stories, the nurse is in a situation where the wishes of an individual to discontinue therapy which will keep him alive in order to alleviate suffering are not followed, putting the nurse in a position where she feels like she is doing harm to a patient with no outweighing benefit.

In a slightly different case, G describes a time when the wishes of the patient were unknown, but given the situation the assumption was that the patient would not have wanted the extended resuscitation that was undertaken.

> *G: I can say it was as early as last night. Where kind of a hopeless older case came in and we just worked and worked and worked and it was just such an undignified way to die. And it bothers me, it grates me that there wasn't more preparation for this eighty-four year old man to say 'I don't want this', nobody knew anything of what his wishes were.*

Again the nurse is in a situation where she is performing treatments that are probably not in the best interests of the patient, in this case because the wishes of the patient, although highly probable, are not explicit and therefore are overridden by the protocols of the health care system.

The second guiding question (What, if any, long term effects did this decision have on those involved? Did your practice change as a result?) was designed simply to elicit descriptions of how the stories given in response to the first question affected the nurses involved. Here the responses were more varied. For example, J states:

> J: *You know that nothing good is going to come of it, you know that you are just prolonging the inevitable, and it doesn't make you feel good about your job. It doesn't make you feel like you are doing a good job because maybe I...in [his] case I mean I think he was fairly comfortable, but.....at the same time he wasn't because he'd been in bed for probably a month and he was starting to get skin breakdown, and I mean, yeah, it's futile, why are we doing this, why don't we send him to a palliative floor, give him*

some medication to make him comfortable, give him good end of life care, it's going to happen anyway, he's going to pass away at, we know this, why, why you know, fight it?

This distress caused by a difficult moral situation is echoed by M in her description of how dealing with the difficult decisions coming from the H1N1 influenza pandemic and the end-of-life care affected the nurses involved:

M: I think that it takes a huge toll on the nursing staff, and the physicians, and well anybody who is working in the ICU and has contact with these patients. It takes a huge toll, unless you come to terms with what is happening. And so I can remember being quite, I don't know if the right word is distressed, over these situations where you know someone's brain...there's clearly brain death but their not brain dead, but the family insists on the patient, you know, being ventilated and trached, and continued with care. There's a lot of people even now in my practice who I see are clearly new into their career and they're very upset and they don't think this is right, you know we have all these quality of care issues and quality of life issues and as I've developed as a nurse I think I understand...this is my own personal take on things....I cannot define what your quality of life is.

M has reached a point where she feels she is capable of dealing with the emotional fallout from these cases, but worries that:

M: Now, I've worked as a nurse for a long time, and it's taken years to come to that point. My concern with that outlook is 'am I in a winter of moral distress' like I just don't care anymore and I don't think that's it.

M recognizes the distress and feels that she has the experience needed to effectively cope with these situations but recognizes that it is possible that she withdraws from the situations a little in order to protect herself from the moral distress.

In another situation, W describes caring for a patient with a very poor prognosis, and the frustration arising from the lack of agreement between the family, the patient, and the health care team regarding the correct approach to the the care of an eighty-four year old man with multiple organ failure who was mechanically ventilated and on CRRT (a continuous dialysis process used for those patients who cannot tolerate conventional dialysis).

> W: *We weren't able to ask him without the presence of his family if he wanted to continue everything so really we were only going based on the family wishes. And then at the end of the three months he developed a new infection, it was a simple bladder infection but unfortunately it was resistant to everything and so the doctors went in with a family meeting and explained that these new infections come about when you've been in ICU for a long time and you don't have the defense systems and that the medications, the antibiotics will be even worse than the ones before, and that likely we're going to start seeing these patterns now. And they said "no, do everything, it's just an infection". And so, I felt as a nurse I was already frustrated with the situation, and not necessarily that I know better, or I can see what's going to happen, but just I felt like our communication with the family was part of the problem, but then the second part was we change doctors every week, and one of the doctors decided to change the code status without the knowledge of the family and that was very hard for me because was it in the best interest of the patient, possibly. I mean, being a full code...on this patient would it*

really get us to where the family thought we were going anyway, no. But I think that that, as a nurse, was really hard. Because you want to advocate for your patient, but at the same time advocating for my patient may not have been a full code on this particular patient. We subsequently ended up coding him two times that following week and he ended up passing away. But, do I feel like he suffered for the end of his life? I feel like he suffered every day through the end of his life, but not necessarily for his benefit but for the benefit of his family.

When describing the long term effects of repeated events like this, W stated that although she felt she was too new to nursing to have felt the long term effects, she had seen the changes in other nurses:

W: I think because I'm still a fairly new nurse, I've only been a nurse for three years and I've been in critical care for three years that's really all I know. I did my final placement there, and so I think I've seen other nurses change their practice over a long course of time, like a lot of the senior nurses. I don't think I've changed yet but I do notice that I start to have negative feelings say toward certain families. I think a lot of times I get frustrated with the families, whereas before I might not have because I feel like they don't have the full picture. And not necessarily like it's their fault, maybe we don't communicate as well as we could. But that... I start to feel that and I take it home with me too, when I've had upsetting days.

This acknowledgement of the distress felt by nurses at different stages of their career also works in reverse, with more experienced nurses seeing the distress felt by new nurses as an

acute event rather than a chronic burden. W describes how her attitude changed once she had more experience working in intensive care:

> *W: Well I remember when I first was a nursing student and my first nursing instructor worked in the ICU and he said he was quitting because of the ethics, and I was like, hmmph, the ethics, like it's all science and technology, what are you talking about. Like, that's the best place to be. And then I started nursing and I didn't realize it was affecting me as much as it was, the first year hit me really hard, and I was bringing it home, but I wasn't dealing with it, like I didn't have good coping strategies, and it was upsetting me, like to the point of crying, or not wanting to go to work or whatever, so I actually had to start like old school, like start exercising regularly, and eating better, and sleeping, and saying no I can't go out, you know what I mean, because I have this day off, I need it for me. And so I actually had to go back to a lot of basics. I mean I considered changing jobs too, and again it wasn't because of the work, it was because of the stress.*

When describing situations in which nurses are called upon to make difficult decisions with the potential of repercussions, J found that:

> *J: Well it definitely makes you kind of, I think at times it makes you second guess what your decision is, because, you know, sometimes you have to weigh things, maybe I shouldn't do this for these reasons or maybe I should do this for these reasons, then when you make a decision then you're sometimes worried that "why the hell did she do that?" "what was she thinking?" you know. And you probably shouldn't care so much what people say about you, but I mean, if it's all the time then it can get a little bit discouraging. you know, instead of being encouraged, you know, like with new grads up*

there right now I don't know how they are coping because the acuity is so high, you don't know what you don't know, and even though I've had some experience up there, I mean the patients are sick and you're trying to make decisions....

Here J highlights the inner conflict of being unsure in your decision making, with the threat of social consequences of what are perceived to be wrong decisions.

One nurse interviewed did not find that repeated exposure to moral decision making processes caused increased stress over time:

I try to keep just as much compassion for the whole. And it honestly I don't really go home and think about it too much, it doesn't keep me up at night. You know, like I'm still just giving care for my patients. I don't disagree with when doctors say that, you know "Oh, they're refusing to go to a level one" or level two or whatever. I'm not, I don't really have a problem with that. Like it doesn't keep me up at night.

However, this nurse, with roughly ten years of experience, also could not identify many ethical issues faced over the course of her practice:

T: I'm not really sure if I've been involved in too many things, obviously you can take ethics to a whole new level. I guess one main one, there was a recent one where there was hearsay about this man's care, he was, he was apparently had decided that he was wanting to, like not have any more, like he was going to pass on or whatever, and the family didn't really want to decide. And you really run into that a lot. With him I didn't actually have him as a patient, so I'm not sure, but you hear things a lot coming forward and backward. But you do run into that a lot with patients, just with regards to death and dying, sometimes you don't really know, you know, if the family should have the

right to say, you know when they've signed their donor card and they don't want to donate, or you know, yeah, or those kind of things. But I don't actually remember a specific time that made me really think hard.

This may be an example of a lack of moral awareness, where the individual fails to identify her moral conscience and take an active role when faced with ethical dilemmas (Lemonidou, Papathanassoglou, Giannakopoulou, Patiraki and Papadatou 2004).

In response to question three (When you have to make an ethical decision in your practice, how do you come to your decision? What resources/influences are taken into account in the process?) and particularly in response to question four (Why do you think different people come to different decisions regarding similar issues? Can you think of a time when there was disagreement among those involved in a particular situation and why others did not see the situation the same way you did?) all nurses interviewed identified experience in varied forms to be the primary influence on their ethical decision making. B identified a broad range of experiences that could play a role in the differences between people when decisions need to be made:

B: I think past experience plays into it, it could be work experience, it could be personal experience, could be religion in it, you know, cultural differences. I mean I think it's all what you've been exposed to. I don't know if I've ever met anyone who has a different work ethic that's not influenced by parts of their personal life. I think that all comes into play. I think in my personal experience, seeing over two years, you know, how people suffer or don't suffer, that really plays a big part. Cause you get to the point where you kind of know the outcome for the patient medically, that actually drives feelings in the

situation, so you have to be careful not to think this is just futile, because you do have to give the family time to say you need to try everything and it's when you have tried everything and nothing's working and they still want to plow ahead that's where it kind of....that's where it becomes difficult. Cause they don't know, they've never seen this before, so how would they know.

As well as identifying differences between the experiences of nurses in similar situations, B also points out the difference between the experience of the nurse contrasted with the experience of the family where futile medical situations are concerned. J, W, and M all identified nursing experience as a critical factor in guiding decision making processes. J highlights experience on a particular unit:

J: Well, that's, a lot of that's experience, and if you haven't been on the unit very long then you don't really know what you should be getting. So in that way it's experience on the unit. And a lot of it too is just years of experience as a nurse, and knowing what kind of order to expect and what's not right.

W describes the role of experience in providing courage to challenge physicians when needed:

W: I think from a naive perspective it's experience. Like they've done it so many times and they've seen it happen so many times that they don't believe things could be different. And then I think from a standard point I think they are a little bit just like me in that they don't have the courage to go to the attendings and say hey...even though in a code situation they would say hey, that's the wrong drug, or hey, that's the wrong....you know....but in an emotional perspective I think they're just as....because you don't have a medical basis to go to them on this, it's more a you're affecting the staff basis.

M emphasizes the need for learning from experience, rather than simply having the experience over time:

> *M: Um, a lot of my experiences in the past. So just watching, watching and learning how things evolve. Right? Like I said, twelve years ago, I think I'm a slightly different practitioner than I am even today, and I think that's the cool thing about nursing is, is you have to open your eyes and your soul and your mind to experiencing different things, and making different decisions. I think that history helps me with making decisions today.*

When questioned about what it takes to stand up and disagree in an ethically challenging situation (a hypothetical case where the nurse is the only individual to whom the patient has expressed wishes to not be resuscitated), G identifies courage as a key factor:

> *G: I think it takes a great deal of courage. And it also takes not necessarily only courage, but it takes the facts. Like you have to be armed with knowledge. This person told me that...but you can't be the only person, we're not isolated health care providers. So you could express that just before this patient told me I don't want this. But they may do it anyway. And then when you say that they'll take it to the family and they'll take it to other people and maybe as a group you can make that decision, but not as an individual.*

When asked where this courage comes from, G responded:

> *G: I think experience. And a certain trust in the system too. To know that maybe things don't happen right away the way you expect them to, that sometimes things take a little time, and certainly I know people say wow, the money, the money. Cause, you know, we*

spent a bazillion dollars last night to I don't think a very good outcome, but we tried. And we had to. And sometimes maybe we do things because we can, but I don't think so, I don't think anybody ever starts procedures that are extreme because we can. You know, I think it's because in the heat of the moment the decision is made and you know, backtrack or make other decisions to clarify that.

Toward the end of her interview, J described how she sees some other nurses as having an easier time making decisions than she herself does:

J: Oh yeah. Like I can think of one nurse off the top of my head who kind of is like that. You know, doesn't have that much more experience than me but that's just the way her personality is. Yeah, cause there's varying degrees of personality too, right? Some people are quieter, some people....like I would say I'm kind of middle ground, I'm not super quiet but I'm not like a loudmouth who's going to challenge every single thing that comes to me. But, if my patient's sick, then I'm not going to just sit in the corner and not say anything about it.

This emphasizes that even though she sees herself as a somewhat quiet person, when her patient needs her she will take a stand.

The interviews conducted for this research provided rich, wide-ranging texts. These texts are valuable in the interpretation and understanding of the ethical decisions faced by nurses and their approach to the decision making process, as well as providing insight into the long term effects of these situations. The challenge is to determine what is useful and relevant to the discussion at hand and what is not. The interpretation is the key. It is true that "there is nothing intrinsically liberating or democratic about narrative itself. It is just another linguistic

form whose significance varies with context - sometimes honest, moving, and revealing, but at other times disingenuous, unedifying and beside the point" (Paley, 2004, p.114). The goal is to provide a valid analysis of the narratives and produce a better understanding of the topic.

6.2. Analysis of Narratives

The naive reading brought to light several related overall impressions. The nurses predominantly discussed end of life issues even though these were not explicitly asked for in the questions. Distress over timing of death, relationships between family, patients, and nurses, and overall feelings of futility were evident. None of the nurses identified a formal decision making model or referred to the any type of code of ethics at any point in their answers.

The structural analysis produced three main themes: time, experience, and communication. Time (e.g. timing of end of life) was the biggest cause of ethical distress. Experience was given by the nurses as a huge factor in decisions and in courage based on sense of self as a participant in the process (but not the main protagonist). Communication was mainly based on the role of the 'other' in ethical situations

Time can be divided into sub-themes of timing of events, such as decisions on end of life issues, and lack of time for decisions to be made. Each of these will be considered in the interpretation of the main theme of time. End of life issues predominate all: timing of action, waiting, are constant sub-themes, as is suffering (as it relates to prolonging events and wasting time). The theme of experience produces sub-themes of sense of self and role of the self in decision making processes. The self is seen as having varying roles depending on the interview participant, the role of the self in moral courage, 'danger' to self in repercussions of

action. The theme of communication embraces the other as object of moral dilemma. Since the patient (the other in intensive care nursing interactions) is often not an active participant, this is partially the cause of the distress.

Each of these themes relates to self-identity as proposed by Ricoeur. Time is inseparable from narrative self-identity: “time becomes human time to the extent that it is organized after the manner of the narrative; narrative, in turn, is meaningful to the extent that it portrays the features of temporal experience” (1984a, p. 3).

Time, and particularly the concept of the trace, is important in a historical sense. Our self identity has a historical aspect. Without memory of our own past we would not know who we are in the *ipse* or the *idem* sense.

Experience is another way of saying history, and relates back to the self. When narrating our experience Ricoeur states that we expect “ a certain correspondence between our narrative and what really happened. At the same time, we are well aware that this reconstruction is a different construction of the course of events narrated” (1988, p. 151-2). Our experience is not a strictly objective, factual version of the past, it is *our* experience. It is individually coloured by our own remembrances and interpretations of the events. When we relate these events to another we are, consciously or not, embracing Atkins’ (2004) idea of the first-person version influenced by our knowledge that we are attempting to convey to the second-person a story that fits into a third-person objective world.

The concept of communication requires a sense of self since communication implies an other to communicate with. Our own sense of our communication is dependent on our acknowledgement of the other person in the action. Communication in ethical dilemmas is

often part of the actual action of the ethical decision, and therefore self identity is absorbed into the ethical decision making process via communication.

6.3. Interpretation

6.3.1. The Role of Time

The first major theme identified, arising primarily from an examination of the responses to the first question is the role of time in ethical decision making processes. Time must be considered on three levels: the level of the situation, the level of the event, and the level of the individual.

At the level of the situation, the occurrences where a patient was seen to be suffering unjustly for a prolonged period were repeatedly brought up by the nurses. When J says "*...so that really bothered me because I think we see that happen a lot on our unit. Where they just prolong death.*", or W finds that " *I feel like he suffered every day through the end of his life, but not necessarily for his benefit but for the benefit of his family.*" there is a sense that the timing for decision making has passed, by days or even months. The time these patients have is not seen as a benefit, but rather as a harm, since they spend a lot of time suffering and pass away in the end without any clear consciousness or awareness of their own situation. The extreme situation described is when B says "*...essentially his cancer would kill him in the end, but his family was very adamant we kept going and going and going, which we felt was torturing the poor man*".

Alternately, while a prolonged situation can cause stress, the suddenness of many ICU admissions can also cause ethical issues. When G describes her situation with an elderly man who was admitted to her ICU, she states " *And it bothers me, it grates me that there wasn't*

more preparation for this eighty-four year old man to say 'I done want this', nobody knew anything of what his wishes were". Since no patient plans to have a sudden, life-threatening crisis, many are not prepared with personal directives or well-informed family members. This puts a certain amount of stress on those making the decisions to make them quickly with limited information.

At the level of the event, an individual resuscitation effort or a particular health crisis can cause ethical conflict and trigger frustration with the ethical decision making process. G's phrase "*we just worked and worked and worked and it was just such an undignified way to die*" is a good example of the implied resistance to the length of time spent on resuscitations that are felt to bee hopeless from the start. This is repeated in M's statement that:

> "*... I almost think that at times we shouldn't have code blues in the hospital because if we don't get there within those two minutes and we don't know how long they've been down we're making the families go through the death all over again, and that's where I have that ethical discrepancy, I really feel bad for the families and I really feel bad for this patient who was dead and we were able to bring him back to life".*

This describes an event when time becomes a significant factor, the decision to perform a resuscitation (Code Blue) on the patient who was already dead reintroduces a new time frame into the dilemma, now a patient who does not survive in the end has to go through a needless period of suffering, we have taken even the timing of death away from the patient.

Sometimes this is a good time to stop and reflect on the decisions made, making a conscious effort to move from System 1 decision making to System 2. In poetic terms, consider Robert Frost's *Stopping by Woods on a Snowy Evening:*

Whose woods these are I think I know.
His house is in the village though;
He will not see me stopping here
To watch his woods fill up with snow.

My little horse must think it queer
To stop without a farmhouse near
Between the woods and frozen lake
The darkest evening of the year.

He gives his harness bells a shake
To ask if there is some mistake.
The only other sound's the sweep
Of easy wind and downy flake.

The woods are lovely, dark and deep,
But I have promises to keep,
And miles to go before I sleep,
And miles to go before I sleep.

I have always interpreted this poem to be about an individual who is tempted to give in to death, to enter the woods, a metaphor for the afterlife, and eternal sleep. But his horse, the part of him who feels the need to continue on, influences his decision to keep his promises. These promises are all the things he wanted to do in this life, the miles to go are the time needed to fulfill these tasks. So although the woods are 'lovely, dark and deep', he continues on. But the pause is necessary. This is a conscious decision, made upon clear reflection on the options. He is not just blindly continuing on his current path. Stopping at critical points to reflect and make sure that the subconscious decisions made are validated by conscious ones is the hallmark of System 2 decision making, and is necessary whenever an important decision, such as an end-of-life decision, is to be made.

Reflection on a decision is a link between the past and the future. Ricoeur describes the measurement of time as an extension of the mind itself, where "what is measured is neither future things nor past things, but their expectation and their memory" (1984a, p. 21). Our experiences in the past (discussed in the next theme of self) affect our actions in the future through our character in the sense or Aristotelean virtue and through our conscious decisions for future action based on our whole life narrative as a series of traces.

On the level of the individual, time plays a very specific role in contributing to moral distress and influences moral decision making. The best example of this is M's story of how a patient with Amyotrophic Lateral Sclerosis (ALS), a progressive neurological disease, chose the day on which she wished to be disconnected from her ventilator, essentially withdrawing care from herself to end her life:

> *M:" and I mean these are some of the bravest patients I've ever seen: ALS patients who decide that today's the day they are going to die. And it's like, do I have any moral distress over that, no. I think that that takes a lot of inner strength and, um, I can remember having a patient that had ALS and her day was tomorrow. Her day was going to be tomorrow. I wasn't going to be her nurse tomorrow, so I did everything I could for her that day, I was, I said do you want to go outside, do you want to do all this stuff , but she was in so much pain she couldn't do these things, but I tried to. And I made sure I picked the nurse I wanted to be taking care of her tomorrow. And that nurse actually, this is actually going to bring tears to my eyes, that nurse stayed with her past her shift change."*

Nursing in critical care is usually done on a twelve hour shift pattern. This means that the time you spend with a particular patient will be a large part of your waking life for several days in a row and then you may be off for a longer period. M knew that she would not be working when her patient had chosen to die, but she knew that the decisions she made the last day she worked would influence the quality of the end of life care her patient received. By choosing the nurse for the next day, M overcame some of the inherent constraints of the shift pattern she was working and had a positive effect on the outcome for the patient. This is not always possible, and the individual nurse may have to accept the fact that she is only one of several caregivers for a particular patient.

6.3.2. The Role of Experience

The second major theme identified was experience, which primarily encompasses the role of the self in the decision making process and the way the self was identified as a participant in the ethical dilemmas. This was evident in both general statements about nursing and nurses and in the descriptions of specific events experienced by individual nurses.

M spoke in general terms about what affects her decision making when faced with difficult ethical situations.:

> " *Um, a lot of my experiences in the past. So just watching, watching and learning how things evolve. Right? Like I said, twelve years ago, I think I'm a slightly different practitioner than I am even today, and I think that's the cool thing about nursing is, is you have to open your eyes and your soul and your mind to experiencing different things, and making different decisions. I think that history helps me with making decisions today".*

The idea of being openminded and reflective in practice is evident in her self-awareness, indicated by the following statement:

> *"I may not always win, and I very rarely...WIN....but I think if I advocate on behalf of my patient then I've done my job. And I can only present the information that I know, and that I feel, at the end of the day the physician is still the physician, and I'm still....I'm not going to say just the nurse because I'm not just the nurse, but I've advocated on behalf of my patient. And that, at the end of the day, if I've done that I know I've done my job*."

This self awareness and comfort in her own self-identity leads to a decrease in overall moral distress and supports the moral courage needed to advocate for patients.

J related a specific story of when she was asked to give a medication she was not comfortable giving because of possible adverse effects. In her clinical judgement, she should not have given the medication due to an increased risk of bleeding to that particular patient. She was instructed by her charge nurse to give the medication, and she did. Describing her thoughts afterwards on the event, she states "*I just didn't have it in me that night, but after I was like oh, why didn't I, say, put my foot down and say I'm not giving it*." When questioned over whether reflection on this event would influence her future decisions she replied: : *Oh yeah, the next time I would be like, no, I'm not giving it, yeah...I'm not giving this....".* Reflection can definitely change future practice.

Towards the end of her interview, when J was asked if she thinks others find it easier than her to make decisions in difficult situations, she replied:

J: Oh yeah. Like I can think of one nurse off the top of my head who kind of is like that. You know, doesn't have that much more experience than me but that's just the way her personality is. Yeah, cause there's varying degrees of personality too, right? Some people are quieter, some people....like I would say I'm kind of middle ground, I'm not super quiet but I'm not like a loudmouth who's going to challenge every single thing that comes to me. But, if my patient's sick, then I'm not going to just sit in the corner and not say anything about it.

This statement shows an important facet of nursing. The last sentence demonstrates how even nurses who feel they personally are not particularly assertive have a metaphorical 'line in the sand' when they see the need to advocate for their patients: "*But, if my patient's sick, then I'm not going to just sit in the corner and not say anything about it."* In any situation, if the need is great enough, the moral courage to act will often be found.

Perhaps the most poignant example of a story of how self-identity influences practice was the final story told by M, as part of an answer to a somewhat unrelated question. M was describing how, during a family conference in which she was a dissenting voice, the position of the other health care providers was such that she was seated at a table with the family and everyone else was standing in front of the table, leaving her feeling like her position physically in the room was inferior. When asked how she felt about this subtle intimidation tactic, she added a story that explained some of the background to the situation from her own perspective:

"It was after the fact when I realized everyone in the room had positioned themselves that way. And it was like I was kind of like shocked, and I'm going "Oh well, we know

what side of the stand I'm laying on here, or standing on". I didn't take it personally, you know, I was advocating for the family. This is what they saw, this is what they believed. Who am I to say this isn't quality of life. And so I think that's where that initial thing started. I'm wondering though, when I look back at my full practice, we had a baby on our unit who was combined immune deficiency, so basically he was like, it was like autoimmune. And he had come to us, he was on our unit for nine months. And he came, and he lived on our unit, and he died on our unit. And it was the most horrible thing I had had. And it was year five in my nursing career, or year three. The most traumatic thing that had ever happened to me, to us. They literally had to shut down the unit because we were all so, so taken back by this. Actually even all the patients on the unit knew that something had happened. It was only a twelve bed unit. They all knew that our little B died. And basically so that we could all go to the funeral, they shut admissions down, they had relief staff come in and run the unit so we could all go to the funeral. And I think that plays somewhat into my way of approaching things. This kid was our kid. Like he was every single one of our kids. And it took a long time for all of us to get over it. We were a really young staff, we were all of childbearing age. Here's this little baby that's, you know, eighteen months old. He knew every one of us. Everybody in the hospital knew this kid. They would come through the unit and B would be sitting, let's say this was his room, he would be in a wheelchair, or his rocking chair, tied in of course because we wouldn't want him to fall out, and he would watch everybody, and everybody would say good morning to him, or hi. He couldn't talk, because he always had to wear a mask, but he got, you know, we ordered a tv for him,

and the doctors, even the doctors were buying Christmas gifts for him. None of the nurses did, this was just before Christmas that he died, I think the fourteenth or fifteenth of December, the physicians had actually bought all Christmas gifts, but the nurses hadn't yet. I always found that strange, that the nurses hadn't, because we would have. But I took pictures of him, like a day in the life of B, and I got the pictures back after he died and I went "This is not the kid that I saw every day". This kid was a little skeleton that was yellow, and I remember B as being blue eyed, blond haired, fat and chubby. And I think that was, that was kind of the groundwork of how I approach things. I wanted that kid to live though. If he could have lived in that hospital in that bed that would have been his bed until the very end. And it was, and that room was his room. And I remember the horror of somebody being admitted to that room. Like that was horrible to me. I think that was the basis of how I approach things now."

Here we see that an event from close to thirty years ago, at the beginning of her career as a nurse, still had a profound influence on her practice and her decision making. This narrative had become part of her self-identity. The way she saw herself caring for this child was carried over and became a standard for how she believed she needed to care for others in similar situations. To act otherwise would go against her self-identity, her being as a nurse. And at the same time this story is a source of moral courage for her, a story which can inspire her to this day, and has an obvious effect on her even this far along in her practice. Here the role of Ricoeur's trace is very apparent. This event made such an impression that it has become part of the narrative self-identity of the nurse, and is more than a story from her past. It influences

who she is and how she practices nursing, as true an example of *phronesis* as it is possible to see.

The role of the self in ethical decision making parallels the role of the self in other areas of life. Decisions are made in congruence with our own sense of self-identity. The importance of this is eloquently stated in the advice of Polonius to his son Laertes in Shakespeare's *Hamlet*:

> *This above all: to thine ownself be true,*
>
> *And it must follow, as the night the day,*
>
> *Thou canst not then be false to any man.* (1602/1853, p. 603)

We are historical beings, and this sense of self can change over time. When M said (see above)*"... twelve years ago, I think I'm a slightly different practitioner than I am even today"* and relates this to decision making during practice and difficult experiences, this shows Ricoeur's *ipse* side of self identity. Although M identifies herself as the same person, she recognizes that she has changed while retaining the experiences that make her who she is today. All her narratives become part of her self-identity, and influence her nursing ethical decision making today.

6.3.3. The role of communication

The theme of communication embraces the other as object of moral dilemma. Since the patient (the other in intensive care nursing interactions) is often not an active participant, this is partially the cause of the distress. Lack of communication is a context which at times cannot be helped. In intensive care units patients are often not capable of speech due to their current medical condition and families are not always available. This makes not only the quality of

communication an important factor but simply the availability of communication itself at times.

How positive or negative the communication between health care team members is has a great effect on ethical decision making. If communication is ineffective or absent, there is a higher level of moral distress. T provides a blunt summation of the cumulative effects of moral distress on critical care nurses. Asked if, in her opinion, more outspoken nurses are drawn to critical care or if critical care makes nurses more outspoken she emphasizes the need for communication as a tool for decreasing moral distress:

> *T: ....you know, the ones that do well and stay long are the ones that are generally I would say outspoken. You don't see too many that have been in ICU for ten years and can't communicate an issue. And generally unless it's like, oh my gosh the patient's coding right now, generally the concern can be communicated fairly clearly, and without like feelings or you know, for those ones that are kind of moderate to like excellent, you know, for experiences. I would say the initial ones, when you first go, maybe they're being drawn because you only have one patient, they think it's easy here, or it's a specialty so you can go anywhere, it opens doors, so I think that's initially why people go into it, but the ones that thrive are the ones that have communication, they can deal with ethical stress, they.....and truly there are some that just can't. And you do find that there are some that you know, they go home and they take it home with them, and it's unfortunate because we still have to go to work, and if you took every patient home with you you'd have a pretty shitty life. Cause it's not all happy fabulous in the*

ICU. It's probably like seventy percent bad. So that's what I think, I think most people that are long term are fit well for the team.

It is easy to say that communication is essential for decreasing moral distress and promoting moral courage but more difficult translate this to practice. W describes what happened in one critical care unit after a particularly difficult case:

W: A lot of nurses think if you can't cut it then get out. They don't respect nurses that leave. And so when I wanted to start out I wanted to think like that too, like when other fellow new people were struggling I was like....but now when I've found myself in that very situation it would....for me it would be easier to leave. It's twelve hour shifts, we work nights, just the job itself is tough, let alone anybody who's dealing with the stress, we have horrible support for that type of emotional problem at our job. And I mean, I really like those nurses. I mean if I was struggling I would never tell them, like I would be so embarrassed. You know, because their answer would be like good, leave. You're obviously not cut out for this. It's not for everyone. And I know that they struggle with it too, so why do they pretend that, you know, it doesn't affect them. So I think we have horrible, horrible support systems for that. I know, we had this one family that turned into a horrible scene and he passed away and the management offered a debriefing session and I thought it was a really good idea, but nobody would go because then it would be admitting....

Interviewer: They were embarrassed to go?

W: Too embarrassed to go. And then a lot of the younger nurses wanted to go, but then a lot of senior nurses say that's why you nurses shouldn't be here. So no, I would say on

our unit absolutely horrible support. Could there be better ways? Oh, absolutely. Being allowed to be open about having an effect of a patient, or being comfortable to go to a debriefing session. And they were provided, do you know what I mean, it's not like they don't provide options, it's that you're frowned upon for taking those avenues.

Interviewer: As part of the culture?

W: Yeah, I would say it's our work culture. I've seen a lot of good nurses, better nurses than I am, leave because of the stress of it. And because they didn't feel supported in it. And not leaving because of the job, they were phenomenal ICU nurses.

These two examples highlight the importance of communication at the level of the individual and also at the level of the institution. Strategies to decrease moral distress, such as debriefing sessions, are only effective if the individuals feel able to access them. Here moral courage is required to utilize the tools that could decrease moral distress. So the problem becomes circular: if you need to be courageous enough to attend a session which has the goal of decreasing your moral distress, where does that moral courage come from?

Self-identity, moral courage and moral distress

Ethical decisions, particularly those related to end of life care, are part of ICU nursing. The ethical decisions made by different nurses will vary, with experience cited as the main differentiating feature. In the case of ethical decision making the failure to act is also a decision. This may be as simple as not speaking up when an ethically challenging event occurs. Certainly in the narratives provided by the nurses interviewed in this study there were times when the individual spoke of a regret over not challenging a colleague when an ethical

dilemma was identified. Choosing to remain silent is definitely an example of a possible decision in any situation.

Experience is not just being present, but must include reflection and personal identity as part of the experience if it is to have any value. If current self-identity is considered as the source of future *phronesis,* or practical wisdom, that self-identity must be the subject of self-examination. Ricoeur considers the relationship of narrative to action as one of presupposition and of transformation (1984a). The presupposition is that the narrative is understood by the listener. In the case of a self-narrative this means that one's own narrative has been considered and reflected upon. The transformation is the ability of narrative to incorporate the narrative into a world-view. Narrative self-identity is the solution to the problem of ascribing actions to an agent and in turn is the source of future actions or, in this study, ethical decisions.
Time is an integral part of the narrative, the concept of the trace covers the requirement that these experiences be incorporated into self identity. Time and narrative are intertwined in Ricoeur's philosophy to the point where he cannot envision one except in terms of the other.

Moral courage is a function of self-identity. Even nurses who don't have the experience in a certain situation have the capacity to make decisions with courage. Courage requires acting in accordance with self-identity in the sense that one must act in a manner consistent with one's own sense of character. This can also be related to the concept of dignity. I feel a sense of dignity when I am treated in a manner consistent with my own sense of self, but my own sense of self is based on my understanding of the narrative of my life.

Moral distress can also be redefined. Instead of Jameton's definition, which externalizes the source, moral distress can be thought of as a consequence of failure to act in accordance with

self-identity. Moral distress is not related to the decision that is made, but to the action taken. If I decide what I believe is the morally correct action and then perform a different action the fact that I knew what I believed the correct action was is no consolation to me. Moral distress can therefore be redefined as a disruption of narrative unity, or a conflict between action and self-identity resulting in a crisis of self-identity (I acted in a way that does not reflect my character, etc.). This leads to a sense of loss of self in terms of continuity and consistency (a discordance) of narratives associated with my self identity.

Narrative self-identity and it's relationship to moral distress and moral courage root ethical decision making firmly in the ontological sphere. With the goal being to enhance moral decision making skills, maximize moral courage, and minimize moral distress it is important to: 1) encourage reflection and recognition of personal identity as part of moral decision making, and 2) encourage discussion of moral events, recognition of distressing situations, peer support, promote courage by atmosphere of support from those with social/political/ employment power over the individual. These are two fairly simple and inexpensive mechanisms which can easily be instituted in any practice if the awareness of the need for them is present. There is no complex system needed, it is only necessary to be mindful of these ways of increasing moral awareness in order to promote ethical development in nurses.

6.4. Implications for Nursing Practice

There are many ways of looking at ethics in practical situations, from Aristotelean virtue and the emphasis on character of the individual to Levinas and his focus on obligation to the other, echoed by Caputo whose obligation excludes the need for ethics. None of these systems

are particularly wrong, in order to find what we agree with it is necessary to see what resonates with one's own views of the world.

Thoreau describes the need for an open mind in his essay "Life Without Principle" when he writes:

"I hardly know an intellectual man, even, who is so broad and truly liberal that you can think aloud in his society. Most with whom you endeavour to talk soon come to a stand against some institution in which they appear to hold stock,-that is, some particular, not universal, way of viewing things. They will continually thrust their own low roof, with its narrow skylight, between you and the sky, when it is the unobstructed heavens you would view. Get out of the way with your cobwebs, wash your windows, I say!" (1863/2005, p. 127-8).

Thoreau is describing the importance of keeping an open mind when conversing with others, and not allowing their interpretations of events to cloud your own, but he is equally describing the need to recognize that there are many interpretations of the same event. While we need to be aware of our own preconceptions, the 'skylight' through which we each view the world, we should strive to widen our view as much as possible to allow for other interpretations than our own to flourish.

How does this interpretation help nurses today? This research serves as a validation of the involvement of the nurse herself as source of ethical decisions. Acknowledging the role of the character of the individual promotes moral courage in practice, increases sense of responsibility, re-embeds the individual in nursing care, and provides a basis for reengagement with practice**.** Schick Makaroff, Storch, Pauly and Newton (2014) emphasize the need for ethical leadership in nursing on an everyday basis. They believe that formal nurse leaders as

well as frontline nurses need support from organizations to promote ethical awareness in practice settings. They also conclude that ethical leadership needs to be more visible and support the use of formal training in ethics for all nurses in leadership positions. This reflects the thoughts of John Dewey who states that "example is more potent than precept" (1910, p. 37). This is also reflected in the theme of experience (elucidated in the research above) where nurses identify those in leadership positions, such as nurse clinicians, as a source of examples of how to make ethical decisions.

In a practice setting, this research provides some guidelines for a new perspective on how to promote sound ethical decision making on a day to day basis. Using the interpretation of ethical decision making as a function of self-identity, nurses can be encouraged to be more reflective both during and after ethical situations arrive. Considering the three factors identified in the analysis (time, experience, and communication) the nurses can reflect on how decisions made fit into her own sense of self identity, and decide if there is congruence between her decision and who she sees herself as a person. Recognizing that acting in a manner which is inconsistent with her own sense of self has the distinct possibility of causing ethical distress can influence the final decision made. Recognizing that ultimately *eudaimonea* comes from acting in a manner consistent with her self-identity can promote moral courage, which can in turn influence others to also act on their own ethical decisions.

This thesis also highlights the idea that recognizing that moral distress exists in nursing is one step towards promoting a practice setting where moral awareness is encouraged. In order for nurses to be comfortable talking about ethical issues it is necessary for each person to feel

supported and safe when raising issues and questioning decisions. Leadership by example is definitely an asset in practice.

The final question to be considered in this thesis is whether the process followed answers the question of 'Who acts?' in situations requiring moral courage. The narratives of the individual nurses were transcribed into texts, which satisfies Ricoeur's requirement for distanciation in hermeneutic inquiry. The texts were analyzed and interpreted by the author of this thesis to satisfy the requirement for reappropriation. For me, the themes of the role of time, the role of experience, and the role of communication encapsulate how the self-identity of the nurses interviewed is re-presented in their narratives. Is it useful to ask if my interpretation is a true reflection of what they intended when they answered my questions? In a very real sense their answers will be entirely a reflection of their narrative selves, since the questions were not asked about specific events, but only about their general experience. Any specific examples they provided were a result of a trace which they have had the opportunity to reflect upon. These traces are part of their narrative self identity and therefore an answer to the question 'Who acts?'.

The hermeneutic circle has been expanded, however, since you are reading this and forming your own interpretations, based on a text produced from primary texts. This second-order interpretation (an interpretation of my interpretation) forms another layer in the hermeneutic circle of distanciation and reappropriation. If you were to write a summary of your thoughts on this thesis, it could be read by another, and so on. At each stage the reappropriation is subject to the biases and preunderstanding of the author, and a new interpretation is created. Each interpretation, if it is a true representation of the thoughts of the

author, is an equally valid and valuable stage in the process. I have come to a new understanding of who acts in the sense of which person will act and who that person truly is, and in this sense the hermeneutic approach and the overall process of this thesis has indeed worked for me. Ideally this thesis has created new interpretations not only for myself but also for subsequent readers of the ethical decision making processes and the role of self identity and virtue ethics in the everyday practice of Registered Nurses in ICU settings.

There are several limitations to this study. The first is the small sample size of nurses interviewed, which was limited by the time allowed to complete this research. The six interviews did however generate a manuscript which is sizable enough to produce a valid interpretation. The second limitation is the inexperience of the author in the area of research. While this may be partially compensated for by my experience in intensive care settings and direct participation in similar types of ethical decision making situations, the interviews themselves and the selection of questions will be affected by my lack of experience in these areas. The final limitation, as stated above, is that the generalizability of this study is somewhat limited to intensive care settings. Due to the unique nature of these settings extrapolation of the results and interpretation to other settings may not be appropriate. However, the essential concepts of this thesis including moral courage, moral distress, and the themes identified from the interviews are common to all nurses. Anyone, especially nurses, should be able to come to his or her own interpretation of self-identity and the role of reflection based on this research.

6.5. Further Research

The primary questions evolving from this research would address the problem of how to support nurses in these decisions, how to include self identity in ethical decision making models, and how to incorporate a stronger self into practice. Some suggestions for how to support nurses in individual decisions through reflections on past decisions have been provided here, these could be tested empirically through implementation of practices and determining if they have any measurable benefit to individual nurses. Attempts to include self identity in ethical decision making models would most likely involve the generation of a new model or an attempt to add a self identity dimension to an existing model. Incorporating a stronger sense of self into practice could be studied by instituting teaching sessions about the role of self identity in ethical decision making into nursing practice. The efficacy of these classes could be evaluated by the participants themselves as well as those they work with to see if others see a difference in the individuals after they complete the class. This study was primarily a philosophical reflection on self-identity as a source of ethical decision making for nurses. Further studies could be more oriented towards finding practical ways of supporting and encouraging moral courage and minimizing moral distress in real life practice.

6.6. Conclusion

This research study and thesis used the philosophical hermeneutics of Paul Ricoeur as a basis for studying the ethical decision making processes of nurses. Narratives obtained from individual interviews were used to answer the question ‘who acts’ in the sense of self-identity but also in the sense of who has moral courage and why. The analysis found the key themes of time, experience, and communication to be central to the ethical decision making process. The

process of reflection on past decisions was identified as critical to improving practice patterns. Nurses should be encouraged to understand the importance of self-identity as a factor in ethical decision making processes in their own practice.

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Appendix A

Guiding Questions

1. Can you describe a time when you were involved in or affected by an ethical decision related to your practice? What happened, what decision was made, and how did the decision affect those involved?
2. What, if any, long term effects did this decision have on those involved? Did your practice change as a result?
3. When you have to make an ethical decision in your practice, how do you come to your decision? What resources/influences are taken into account in the process?
4. Why do you think different people come to different decisions regarding similar issues? Can you think of a time when there was disagreement among those involved in a particular situation and why others did not see the situation the same way you did?

Each question could have follow up questions regarding the answer to the guiding question.

Appendix B

Research Poster

Volunteers Needed

for a nursing research study

Do you want to help advance research in nursing ethics?
Volunteers are needed to participate in short (30-60 minute) interviews about their experiences with decision making in ethical dilemmas.

Requirements: Must be Registered Nurses (RN) in a critical care setting Must be willing to participate in an interview on your own time, away from your workplace. All RNs can contribute, there is no need to have any experience with any one specific ethical situation.

All interviews are strictly confidential, you will not be identifiable in any data/written material resulting from the interview. This study has approval from the Calgary Conjoint Health Research Ethics Board
Ethics ID # REB13-0028

Please contact: Roy Poules B.Sc., B.Sc.N., RN
(Study supervisor Dr Shelley Raffin-Bouchal, University of Calgary Faculty of Nursing)

Appendix C

TITLE: **Ethical Decision Making Processes In Critical Care Nursing**
SPONSOR: **None**

INVESTIGATORS: **Principal Investigator: Dr. Shelley Raffin-Bouchal Ph.D. RN, Associate Dean (Graduate Program), Faculty of Nursing, University of Calgary.**

Student Investigator: Roy Poules B.Sc., B.Sc.N.RN, Masters student, Faculty of Nursing, University of Calgary.

This consent form is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, please ask. Take the time to read this carefully and to understand any accompanying information. You will receive a copy of this form.

BACKGROUND

Nurses make ethical decisions in the course of their everyday practice. While models to support ethical decision making exist, less well studied is the process nurses use to make these decisions. Ethical decision making models focus on providing guidelines for rational decision processes and tend to minimize the role of the individual.

WHAT IS THE PURPOSE OF THE STUDY?

The purpose of this study is to examine how critical care nurses make ethical decisions in the course of their practice. A philosophical hermeneutic approach based on examination of the texts of transcripts of interviews of critical care nurses will be used to produce an interpretation of the ethical decision making process.

WHAT WOULD I HAVE TO DO?

For the participant, this research consists of a 30-60 minute interview where you will be asked about your experiences with ethical decision making. Follow up interviews will be possible if agreed to and/or requested by the participant if further elaboration or clarification of the initial interview would be beneficial. Interviews will take place outside of work hours, at a mutually agreed upon location where adequate privacy can be ensured. The interviews will be electronically recorded.

WHAT ARE THE RISKS?

There is a potential risk for emotional harm if the interview is distressing to the interviewee. This risk is mitigated by the option to terminate the interview at any time, and answering any individual question is entirely voluntary. You may end your participation in this study at any time, however any data collected may still be used in the analysis. All employees of Alberta Health Services have access to free counseling through the Employee and Family Assistance program if needed.

WILL I BENEFIT IF I TAKE PART?

There is no monetary compensation for participation in this study. You may benefit from an opportunity to reflect on your practice and discuss potentially sensitive topics in a safe and controlled setting. The information you provide will be used to further the research on ethical decision making, and may benefit other nurses or yourself in the future.

DO I HAVE TO PARTICIPATE?

Participation in the interview(s) is fully voluntary and you may withdraw at any point without any adverse effects for you.

WHAT ELSE DOES MY PARTICIPATION INVOLVE?

This research requires only your participation in the interview. Follow up interviews will be available to clarify points from the original interview if requested.

WILL I BE PAID FOR PARTICIPATING, OR DO I HAVE TO PAY FOR ANYTHING?

You will not be paid for participation in this study. The interview will not take place during your work hours, and no time away from work will be required. You will be reimbursed for the cost of parking if required at the location of the interview.

WILL MY RECORDS BE KEPT PRIVATE?

Interviews will be transcribed by the student investigator named above, and will be available only to him, the Primary Investigator (PI) named above, and the University of Calgary Conjoint Health Research Ethics Board. The transcripts will be kept in a locked file cabinet in the Student

Investigators home and held according to University Regulations. Digital recordings of the interviews and original copies of the consent form will be kept in the same location. The data obtained from these interviews will be used for preparation of the student investigator's thesis, and possibly also for publication or public presentations.

In the event that you suffer injury as a result of participating in this research, no compensation will be provided to you by the University of Calgary, Alberta Health Services or the Researchers. You still have all your legal rights. Nothing said in this consent form alters your right to seek damages.

SIGNATURES

Your signature on this form indicates that you have understood to your satisfaction the information regarding your participation in the research project and agree to participate as a participant. In no way does this waive your legal rights nor release the investigators or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time without jeopardizing your health care. If you have further questions concerning matters related to this research, please contact:

Dr. Shelley Raffin-Bouchal (xxx) xxx-xxxx

Or

Roy Poules (403) xxx-xxxx

If you have any questions concerning your rights as a possible participant in this research, please contact the Chair, Conjoint Health Research Ethics Board, University of Calgary at xxx-xxx-xxxx.

Participant's Name		Signature and Date
Investigator/Delegate's Name		Signature and Date
Witness' Name		Signature and Date

The University of Calgary Conjoint Health Research Ethics Board has approved this research study.

A signed copy of this consent form has been given to you to keep for your records and reference.