CJNR, 2002, Vol. 34, No. 3, 75–102

Navigating Towards a Moral Horizon: A Multisite Qualitative Study of Ethical Practice in Nursing

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Cet article rapporte les résultats d'une étude qualitative portant sur la prise de décision axée sur des principes déontologiques chez les infirmières. Des groupes de discussion rassemblant des infirmières travaillant dans divers contextes professionnels ont été mis sur pied pour explorer la signification du concept d'éthique et la mise en œuvre d'interventions fondées sur des principes déontologiques. Les résultats s'appuient sur la notion d'horizon déontologique (moral horizon) – l'horizon représentant « le bien », l'objectif que les infirmières ciblent dans leur pratique. Les résultats indiquent que les courants du climat moral dans lequel œuvrent les infirmières influencent de façon importante le cheminement de celles-ci vers l'horizon déontologique qu'elles visent. Bien trop souvent, les infirmières ont été forcées à naviguer contre un courant qui privilégie la biomédecine et la culture corporative. Par ailleurs, un courant favorisant le soutien entre collègues, la présence de lignes directrices et de normes professionnelles, et l'éducation déontologique les a aidées à cheminer vers cet objectif. Les implications quant à la pratique infirmière et une compréhension d'une prise de décisions fondées sur des principes déontologiques font l'objet d'une discussion.

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This paper reports the results of a qualitative study of nurses' ethical decision-making. Focus groups of nurses in diverse practice contexts were used as a means to explore the meaning of ethics and the enactment of ethical practice. The findings centre on the metaphor of a moral horizon — the horizon representing "the good" towards which the nurses were navigating. The findings suggest that currents within the moral climate of nurses' work significantly influence nurses' progress towards their moral horizon. All too often, the nurses found themselves navigating against a current characterized by the privileging of biomedicine and a corporate ethos. Conversely, a current of supportive colleagues as well as professional guidelines and standards and ethics education helped them to move towards their horizon. The implications for nursing practice and for our understanding of ethical decision-making are discussed.

The field of health-care ethics[1] has not attended to nurses' concerns very well over the four decades or so of its development.[2] Theory, research, and practice have tended to overlook or trivialize the kinds of ethical problems that nurses confront in their practice and the difficulties they experience in their role as moral agents (Chambliss, 1996; Jameton, 1984, 1990; Liaschenko, 1993a, 1993b; Rodney, 1997; Sherwin, 1992; Starzomski, 1997; Storch, 1992; Warren, 1992; Yeo, 1994). Fortunately, this is beginning to change. Health-care ethics is moving out of the dominance of the biomedical paradigm (Benner, 2000; Churchill, 1997; Coward & Ratanakul, 1999; Evans, 2000; Frank, 1998; Gadow, 1999; Hoffmaster, 2001; Kaufman, 2001; Levi, 1996; Sherwin, 1992, 1998; Winkler, 1993; Wolf, 1994) and nursing is becoming much more engaged in contemporary work on health-care ethics, as this issue of the Journal attests.

Understanding ethical decision-making[3] is an important part of understanding professionals' enactment of their moral agency.[4] That is, we ought to know how moral agents approach and deal with ethical problems in their practice. However, despite the progress made on contemporary work in health-care ethics, we still know little about how ethical decisions are actually arrived at and acted upon, and what moral agents experience when they are unable (or are able) to follow through on their decisions, what they believe the consequences are, and what they have to say about the effects of their practice environments on their decision-making (Calam, Far, & Andrew, 2000; Evans, 2000; Fox, 1990; Hoffmaster, 1990, 1999; Kaufman, 2001; Redman & Fry, 2000; Rodney, 1997; Saks, 1995; Solomon, 1995; Starzomski, 1997; Weisz, 1990).

Our purpose in this paper is to report on a recent study that sheds some light on the complexity of nurses' ethical decision-making. We will explicate our methodology and relevant findings, then use our findings to reflect on the implications for ethical decision-making, relational practice, and policy. Qualitative data such as ours have great promise for the ongoing development of theory and practice in ethics

(Hoffmaster, 1990, 1991, 1993; Jameton & Fowler, 1989; Jennings, 1990; Yeo, 1994). It is therefore our hope that what we have to say will be helpful for our colleagues in nursing as well as other disciplines.

Inquiry: Background for This Study

Focus

Our study constituted the first exploratory stage in a program of research, so our focus was quite broad.[5] Our first research question concerned the *meaning of ethics* for nurses providing direct care, for nurses in advanced-practice positions, and for nursing students. Our second research question concerned the *enactment of ethical practice* by these three groups. Finally, our third research question concerned the *integration of ethical content* in current nursing curricula. The study was therefore conducted in three interrelated parts:

Part 1: Describing community and hospital nurses' enactment of ethical practice. Qualitative data were obtained from nurses involved in direct care to gain a better understanding of the ethics of their practice. This included an exploration of the effect of the practice context on ethical decision-making and interdisciplinary team functioning.

Part 2: Understanding the role of advanced-practice nurses in fostering ethical practice in hospital and community care. Qualitative data were obtained from nurses in advanced-practice positions. The investigators explored how these nurses did (or did not) get involved in ethical practice. This included understanding how advanced-practice nurses foster ethical decision-making while providing support for nursing practice.

Part 3: Examining the integration of ethical theory in the delivery of nursing curricula. Qualitative data were obtained from students in a baccalaureate nursing program to explore their understanding of and involvement in ethical practice. This included inquiry into what students have experienced in their practice, and how this was or was not addressed through the integration of ethical content in their curriculum.

The main goal of our study was to contribute to a theoretical and practical foundation from which to promote the ethical practice of nurses. Our secondary goal was to contribute to a theoretical and practical foundation to support the ethical practice of professionals in other disciplines. While our findings were multifaceted,[6] there was a significant subset of findings related to ethical decision-making. We learned from our participants how ethical decisions were actually arrived at and acted upon, what they experienced when they were unable (or

were able) to follow through on their decisions, what they saw as the consequences of their decisions, and the effects of their practice environments on their decision-making.

Methodology and Methods

Our study was qualitative in nature and was conducted using the constructivist (naturalistic) inquiry methodology explicated by Lincoln and Guba (1985). We used focus groups as the method of data collection. This method is particularly well suited for qualitative data collection (Morgan, 1997) and has been employed successfully in a study of ethical decision-making around resource allocation (Starzomski, 1997). Moreover, the focus group has several attractive features: researcher influence on the data is limited, participants in the group tend to exercise a good deal of control, and participants can react to and build upon the responses of other members of the group, creating a synergistic effect (Madriz, 2000; Morgan & Krueger, 1993; Wilkinson, 1998). Our study benefited from all of these features. For instance, both practising and student nurses in the focus groups generated rich reciprocal dialogue. At the same time, we were aware of some of the inherent limitations of the focus-group method, including "groupthink," uneven participant contributions, and replication of organizational power dynamics in the group (Madriz; Morgan; Morgan & Krueger; Starzomski, 1997; Wilkinson). We attempted to attenuate such limitations by having at least two researchers present — one to facilitate the group process and one to observe, take field notes, and contribute as necessary. We also attempted to make our focus groups homogeneous; members of the group were usually known to each other and were not (as much as possible) in hierarchical relationships. Further, we ensured that the designated facilitator had expertise in group process and interpersonal dynamics.

Approximately half the focus groups were conducted in a mid-sized metropolitan area with one health region and half in a large metropolitan area with several health regions. Administrative and ethics approval was obtained from the University of Victoria and from the research ethics committee of the region in the case of the mid-sized metropolitan area and each of the regions in the large metropolitan area. Data collection took place from January 2000 to January 2001 inclusive.

Guided by a process of theoretical sampling (Strauss & Corbin, 1998), we formed 19 focus groups, for a total of 87 participants. Once research ethics and administrative approval had been obtained, nurses from the identified clinical areas were invited to participate in focus

groups through a variety of means. In most cases, a clinical supervisor or clinical resource nurse was approached and asked to facilitate one of the researchers attending a staff meeting to discuss the study and invite staff participation verbally and through a letter describing the study. Usually this method was effective, but sometimes repeated contact was needed to arrange a focus group. Our agency contacts always expressed interest in and support for the study, but it took time to negotiate the logistics of setting up focus groups in busy practice environments.

Three focus groups were conducted with advanced-practice nurses, 12 with other practising nurses, and four with nursing students at a local university school of nursing in the 3rd or 4th year of their baccalaureate program. Open-ended trigger questions were posed. These questions, which varied in phrasing and timing, asked the participants what they understood good (ethical) practice to be, what helped them in or constrained them from engaging in good practice, how they felt about their practice, and, finally, what their experience had been as focus-group participants. It is important to note that we introduced each focus group by setting guidelines for confidentiality and respectful participation. We also said at the outset that we were not interested in a particular theoretical approach to ethics or a "list" of particular issues. We explained that we saw ethics in terms of good practice, and wanted participants to explore that subject in whatever way was relevant for them, providing examples as needed. Our rationale for this preamble was based on our past experiences with research studies as well as with clinical and educational seminars — as soon as we began to ask about ethics, the nurses assumed we had a list of issues in mind.

The practising nurses came from a variety of settings, agencies, and units: maternity, pediatrics, medicine, surgery, critical care, emergency, operating room, oncology, psychiatry, rehabilitation, long-term care, home care, and community care. Meetings and focus groups were held on-site in a cafeteria or meeting room, or, in the case of student focus groups, a classroom. At the beginning of each focus group, the participants were asked to read/discuss the consent form regarding data collection. The participants were assured of confidentiality by the research team and were asked to respect the confidentiality of the group. Subsequently, identifiers were removed from the transcribed interviews and field notes.

All focus groups were audiotaped and transcribed and detailed field notes were taken. The investigators, joined by four graduate students in nursing (two of whom were also research assistants), met monthly to guide and facilitate the data collection and begin the analysis. Data

analysis commenced with each member reading pre-assigned transcripts and conducting a thematic analysis. Then the team met and discussed the themes, modifying them as the data were reviewed within a given transcript and across transcripts. Field notes were used to supplement this process. Gradually, relationships among themes were identified and descriptions of the findings developed. An overview of the findings was prepared for a summary paper (Varcoe et al., 2002). Further analysis was conducted by smaller teams to enhance our understanding of particular aspects of the findings, which generated other papers (e.g., Hartrick, in press; Storch, Rodney, Pauly, Brown, & Starzomski, in press), including the present one.

We will now present those findings that shed light on nurses' engagement in ethical decision-making. We will conclude by reflecting on some of the implications for nursing practice and for our understanding of ethical decision-making.

Findings

Given the exploratory nature of our study, it is not surprising that our findings were multifaceted. Overall, the practising and student nurses described ethics in their practice as both a *way of being* and a *process of enactment* (Varcoe et al., 2002). They described drawing on a wide range of sources of moral knowledge in a dynamic process of developing awareness of themselves as moral agents. Enacting moral agency involved working within a shifting moral context and working "in between" their own values and those of their employing organization, "in between" their own values and those of others, and "in between" competing values and interests. The moral identities of the participants emerged and evolved as they navigated their way through the contextual and systemic forces that shaped the moral situations of their practice (Hartrick, in press). We also learned about practice realities that created a climate for moral distress, and the ways in which nurses attempted to maintain their moral agency (Storch et al., in press).

Our findings include insights that are significant for an understanding of ethical decision-making. What was most striking about the nurses' engagement in ethical decision-making was the processual and contingent nature of their decisions and subsequent action. Their decisions and actions evolved over time and were not always in a straight line. We therefore concluded that a nautical metaphor, navigation, best reflects the nurses' ethical decision-making: they were navigating towards a moral horizon, but their course was often not smooth or certain.

The Moral Horizon

In our analysis, the horizon[7] reflected a notion of "the good"[8] towards which the nurses were navigating. The horizon was not a fixed point, but a negotiated direction. Nurses' descriptions of the horizon suggested that this direction was co-created by patients, families, and teams (see Table 1) — that is, the horizon was not necessarily set as an objective, but, rather, emerged in the context of treatment and care.

Table 1 *The Moral Horizon for the Patient, Family, and Health-Care Team*

Features of the Moral Horizon
Relief of suffering
Preservation of human dignity
Fostering of choice
Physical and psychological safety
Prevention and minimization of harm
Patient and family well-being
Choosing Alternative Routes
Waiting a while
Having others act
Shifting course away from the horizon
Reaching the Horizon
Feeling you care
Being able to cope
Coming together
Feeling respected and heard
Feeling good about the decision
Being able to let go
Being heard
Creating a sense of home
Not Reaching the Horizon
Being dehumanized
Not being valued
Suffering unnecessarily
Being punished for being ill or old
Being let down
Broken up
Feeling unsafe
Feeling powerless

For example, in a focus group of nurses working in intensive care, the participants indicated that their treatment and care made sense only in relation to the patient's illness trajectory and personal background and goals, rather than in relation to just the particulars of the disease process.

The nurses' navigation was guided by different features of the horizon — each representing a moral good. The features included relief of suffering, preservation of human dignity, the fostering of choice, physical and psychological safety, the prevention and minimization of harm, and patient and family well-being. For instance, an operating room nurse said, "I've often wondered whether the patients in these situations have been adequately informed by the physician or the surgeon. I know for a fact, in a lot of cases, that they haven't been." Choice was evident in her description of the moral horizon, as were relief of suffering caused by the surgery and prevention of harm caused by unnecessary intervention. Family well-being and choice were prominent features of the horizon described by a pediatric nurse: "Part of feeling good about what we do is when the family takes control and they are empowered to be looking after this child at home."

The features of the horizon suggested by the words of these nurses were consistent across all focus groups, albeit expressed in different ways by different groups of practising and student nurses. However, it is important to note that negotiating a shared horizon was not easy. Members of the health-care team (including nurses) were often headed in different directions. Family members were also often headed in different directions, both from each other and from members of the health-care team, as recounted by a pediatric nurse:

> *Not that long ago we had a premature baby who had a huge bleed in the head. [The physicians] talked about discontinuing life support. And the [mother] couldn't do it; she could not live with herself. So we cared for the child for 2 more days and the baby died on the ventilator. For the nurses, that was really hard...because they believed it should just end.*

The nurses saw continuing treatment as causing suffering and threatening the dignity of the newborn, while the mother may have constructed the treatment as preserving life and family. In this example the nurses' notions of the moral horizon needed to be negotiated with the mother. This case shows that the direction of those involved in a situation was not necessarily shared.

At times the nurses chose to or were forced to take an alternative route to the horizon, such as having other team members act in their stead or waiting a while. Another pediatric nurse, for example, told the

story of supporting the mother of a brain-injured newborn who was to be discharged. The nurses and physicians tried to impress upon the mother the severity of the child's condition and the consequences of treatment. After waiting a while, the nurse realized that her initial course (providing the mother with as much hospital and home support as possible) was not what the mother actually needed — she needed to be able to do as much as possible independently for her child. At other times, nurses veered away from the horizon. This shift occurred if they judged someone as undeserving of their care, usually described in terms of "distancing" themselves or "not caring."[9] For instance, in a focus group with emergency nurses, a nurse spoke of distancing herself from patients who came in repeatedly with problems related to substance use.

The nurses constructed their success in terms of reaching the horizon or making the best progress possible. Success was defined as the patient "feeling you care," the family "being able to cope," the team "coming together," and nurses "feeling respected and heard," "feeling good about the decision," "learning to let go," and "being heard." Learning to let go, for instance, is evident in the above story of the pediatric nurse realizing that the mother of the newborn needed to make her own choices about coping at home. They also spoke of reaching the horizon in terms of "creating a home" for patients — a point emphasized in our focus groups with nurses working in long-term care and rehabilitation. Success in reaching the horizon was usually associated with satisfaction and fulfilment. One 4th-year nursing student said, "You just know it. You can see it in your patient's face, your client's family's face, whoever it is, and you can feel it inside you that you've done the right thing." And an emergency nurse affirmed, "I'd say I love my job, I still love my job."

On the other hand, some nurses spoke of not getting close to or arriving at the horizon in terms of the patient being "dehumanized," not being "valued," "suffering unnecessarily," or being "punished for being ill or old," the family being "let down" or "broken up," and nurses feeling "unsafe" or "powerless." A nurse working in intensive care expressed it this way:

> *Ethics was a frustrating issue in the sense that you would come on a shift and the decision [to withdraw treatment] had [not been] made...that seemed apparent to me should have been made, and we sustain them through the night until maybe the next day. And that seemed to be the primary sort of dilemma that I faced. Because I'm casual, I also found that I didn't have a lot of continuity in looking after the same patients, so these issues would come up...over the course of a shift...unless the patient had*

been a long-term, chronic-care patient in the unit, so I never really got to address them because we had what was required (kind of reports and rounds in the early evening) and then over the course of the night some things would become sort of questions, but, you know, we never had an opportunity then to go on [to resolve the issues].

This nurse's sense of powerlessness and her concerns about suffering and harm are evident. Such concerns about not reaching the moral horizon were echoed by nurses from widely divergent practice contexts, as shown by comments made in a focus group with community nurses:

First community nurse: *The maternity client is a very complex client because they're in need of a lot of different programs, not just [like] someone who has abdominal surgery coming out [of hospital] and they need a dressing change and they have a family and they go through home care. [A complex maternity client] in the community — they're a breastfeeding client, they're bipolar [have a mental health condition] and they have no family support.*

Second community nurse: *But nobody recognizes that. The maternity client is [supposed to be] "just a piece of cake." "Birth is normal," you know.*

Third community nurse: *It happens everywhere. Breastfeeding is [assumed to be] automatic.*

First community nurse: *I think the mental health [aspect] is really important to keep in mind too. And I think of our partners in the social services ministry and the difficulties sometimes that have been demonstrated around being able to have an appropriate plan. I can think of an occasion where we had a family whose children were apprehended…the family were not able to provide enough resources themselves to be able to care adequately…mother [maternity client] had become psychotic in hospital, and of course English is a second language, which made it…more difficult. So, what ended up happening, because the resources weren't available, those children ended up being apprehended…when what needed to happen was that family needed to be supported in order to be able to remain together… I think ethically we really failed this family. Not just community health but the whole health-care system, including the social services ministry, because what happens time and time again is that the social services ministry holds the resources, we're here saying people need the resources, and then the fight begins in terms of trying to seek out those very few resources to keep that family together for the period of time it takes to get better. And it doesn't happen in 2 days, 3 days, a week. It takes a longer period of time for some stability and for the crisis to ease. And to me that's very distressing.*

This segment reveals a great deal about the moral horizon of nurses' work. The features of the moral horizon included meaningful

choice in childbearing, the physical and psychological safety of the woman, newborn, and family, appropriate social services intervention, and the long-term well-being of the family unit. Waiting a while (an alternative route) was not an option. This nurse did not feel that she had arrived at — or even come close to — a moral horizon for the woman, her newborn, or the family. She felt that the family's unique needs were not being valued, that they were suffering unnecessarily, and that they were being let down and broken up as a family unit. In fact, the participant who related the story later said, "It's like being punished for being ill. Bottom line. You're ill, you can't cope, that's it, end of discussion."

In summary, we have used the metaphor of moral horizon to describe nurses' understanding of the good in particular practice situations — an understanding that was shared with others and developed through a process of negotiation, and that provided direction for practice.[10] This is not to say that the nurses always negotiated effectively, or that their horizon was not overly circumscribed, or that they were accurate in identifying when (if ever) they arrived. Those are questions for further research and theoretical inquiry.

Currents Affecting Navigation

Many of the insights we gained concerned the complex and pervasive influences on nurses' ability to move towards their moral horizon. Throughout our study, nurses in every practice context identified their practice as frequently constrained or facilitated by influences beyond their immediate control. We came to understand such influences as currents affecting navigation and, thus, affecting progress towards the moral horizon (see Table 2). In what follows we will articulate those currents that nurses identified as having the most profound influence on their practice.

Table 2 *Currents Affecting Navigation*

Currents Constraining Navigation
Privileging of biomedicine
Corporate ethos
Currents Facilitating Navigation
Supportive colleagues
Professional guidelines and standards
Education in ethics

One current the nurses often found themselves navigating against was a privileging of biomedicine and a corporate ethos. A segment of a focus group with operating room nurses will serve to illustrate:

> First OR nurse: *I don't feel that my nursing work is complete, because I don't have the time to provide the caring emotional support that I think this particular kind of patient requires. You feel like it's a race…truly, you are ruled by the clock and not by what your patients' needs are. [There is rarely] a case where you feel that you can actually do something for your patient or make a difference to them. I feel that every minute with your patient before they're put to sleep is a bonus for that patient when they wake up, everything you can do for that person. And when you have less than 2 minutes in a less than ideal, busy hallway… then it's a very unsatisfying experience, because I just know I haven't done a good job.*

> Second OR nurse: *Ethically, how can I say I'm the bad guy? I'm not the bad guy. The work environment is the bad guy…I can speak to having to do 10 cataract extractions every day, and feeling as though you're working with a gun at your head. Literally, that is the emotional feeling that I have, that the surgeon is holding a gun at my head and I am under constant pressure. So, I say I am extremely dissatisfied with my job when I have to work like that. I hate it.*

These OR nurses were trying to navigate to a place where they could spend time with and support their patients through the experience of surgery. However, the privileging of biomedicine meant that the focus was on surgical procedure. The corporate ethos meant that nurses' time spent caring was not counted or planned for, and as many procedures as possible were pushed through. The corporate goal of efficiency took precedence over patient well-being, interdisciplinary team cohesion, and nurse satisfaction. Time for quality nursing care became a prized and contested commodity. No member of the research team will ever forget the comment of the OR nurse who felt as if she was practising with a gun to her head. For her, the consequences of being unable to move towards a moral horizon were more than just dissatisfaction: she felt unsafe, exhausted, and demoralized; it was almost impossible for her to make any headway against the current.

While the words of the OR nurse are particularly poignant, similar concerns were expressed in every focus group with nurses involved in direct care. For instance, in the segment with community nurses cited above, the privileging of biomedicine meant that the intersection of a mental health problem with a birth experience, inability to speak English, and poverty fell outside the scope of agency policies,[11] and the corporate ethos meant that resources were squeezed and traded off

between health and social services. Time for quality nursing care was also contested, even if not as urgently as in the operating room.

Comments from a focus group with nurses practising on a medical unit in the large urban hospital illustrate the effect of the constraining current on nurses' well-being:

> First medical unit nurse: *We're not getting anything back and...it depletes us. And it's the depletion, and the burnout and the quitting and the three-career kind of thing. How are we...going to help our nursing profession when we're not working with [adequate] staff?...Everyone's so distraught on the unit, and I find myself, I am like that, and I try to be a really positive, energetic person. At 27, I'm starting to dwindle away, thinking what am I going to do with my life? At 27. If I'm feeling that now, I don't want to be burnt out in 5 years.*
>
> Second medical unit nurse: *[It's difficult to find the time to] participate in things like this [focus group] and things like in-services...it's frustrating when you can't get 20 minutes to go to an in-service...because you haven't finished your charting, or because you've got your vital signs to take and because you've got a new admission coming in and you know you can't get away on the floor.*
>
> First medical unit nurse: *There's no administration support.*
>
> Second medical unit nurse: *I think that's what it is. They want you to attend them but...*
>
> First medical unit nurse: *...on your own time, energy, etc., etc. I find that there's not a lot of support. I don't think that they [administration] don't want to give it, I don't think they have the availability to give it to us.*

The workload on the acute-care medical unit where these nurses practised was increasingly demanding, and resources to support staff (such as in-services) were described as largely unavailable or inaccessible. The above statement "I don't think they have the availability to give it to us" suggests that the corporate ethos was controlled at a level beyond first-line management. In the province where our study was conducted, the provincial government distributed funds to regional boards, which then made allocation decisions.[12]

Fortunately, there were also situations in which the prevailing currents facilitated nurses' attempts to navigate towards a moral horizon. Supportive colleagues in nursing and other disciplines were a major influence. One nurse practising on a maternity unit put it this way:

> *For me a problem shared is a problem halved. I have shared it and [got] someone else's perspective on it, and maybe it wasn't really that*

> *huge a deal. When someone else's perspective comes to it...all of a sudden it isn't such a huge problem any more — "gee, it's not just me that felt this way, it's a more common feeling than I realized." I guess it gives me permission to have felt that way, knowing that other people have the same issues. It just cuts it down inside.*

Likewise, in a focus group with emergency nurses, the participants spoke of situations in which interdisciplinary team work generated mutual respect with their medical colleagues. In fact, when we asked participants in all of the focus groups what helped them to deal with ethical problems in their practice, the consensus was "supportive colleagues."[13]

Nurses in advanced-practice and management positions told of numerous initiatives they had taken to improve the moral climate of the workplace. These initiative included a focus on interdisciplinary team work, the establishment of accessible practice guidelines and policies, and education in ethics, all three of which were affirmed by other practising nurses as improving the moral conditions of their work (Storch et al., in press). An advanced-practice nurse explained:

> *I think...of the patient consults that I get involved in, there's always a huge element of ethics involved, and many times the reason why I'm there is because there's some sort of breakdown in the system and there's a perception that there's a gap in service...so the whole notion of being an advocate for patients [is part of it]...promoting the team unity and collegial relationships...fostering and maintaining those relationships but at the same time recognizing what is happening with the patient, that things are not going the way they should...that can be quite stressful at times...and it really involves a lot of courage and sometimes standing up and being the voice calling out in the wilderness with not a lot of backup until you manage to convince people to go along with you.*

The actions of this advanced-practice nurse no doubt helped the nurses and other team members to move towards their moral horizon. Dealing with "gaps" in service and "being an advocate for patients" would do much to counteract the privileging of biomedicine and the corporate ethos. By "fostering and maintaining those relationships," this nurse was helping colleagues to be mutually supportive, "recognizing...that things are not going the way they should" indicates that she was attentive to professional standards and guidelines, and managing to "convince people to go along with you" certainly reveals at least some informal education in ethics. While this is the story of just one advanced-practice nurse, it is reflective of what we heard from her colleagues in nursing leadership positions (Storch et al., in press).

Implications for Practice

The findings from our study shed some light on the process of ethical decision-making and nurses' experiences in terms of their ethical decisions and the role of ethics in their practice environments. We have used a nautical navigation metaphor to describe the processual and contingent nature of the nurses' experiences. The notion of a moral horizon reflects "the good" towards which the nurses were navigating. The horizon was not a fixed point but, rather, a direction negotiated by patients, families, and teams. Currents within the moral climate of nurses' work significantly influenced their progress. All too often, nurses found themselves navigating against a current characterized by the privileging of biomedicine and a corporate ethos.[14] Fortunately, supportive colleagues as well as professional standards and guidelines and ethics education constituted strong currents, helping nurses to move towards the horizon.

We emphasize, though, that the nurses in this study, as moral agents, often experienced a great deal of difficulty navigating. One nurse working in long-term care said: "Not being able to make decisions is like atrophy of a muscle. I can hardly remember being in control of nursing practice, of my ethics, of making these decisions — it's eroding." People in nursing and other health-care professions, health-care ethics, and health policy need to take such comments seriously. We have argued elsewhere that strengthening nurses' moral agency means attending to nurses' personal needs while at the same time improving the moral climate of their practice (Hartrick, in press; Rodney, 1997; Rodney & Varcoe, 2001; Starzomksi, 1997, 1998; Storch, 1999; Storch et al., in press; Varcoe et al., 2002; Varcoe & Rodney, 2002). While there is some research identifying and implementing positive workplace initiatives,[15] much more is needed. In the meanwhile, we will highlight some of the practice implications of the present findings.

It is not surprising to find that the currents constraining the nurses' moral agency were so pervasive. Today's practice environments pose myriad ethical challenges, including increasing complexity of patient, family, and community needs, escalating biotechnological advances, a rightward shift in socio-political climate, and increasingly stressed nursing workplaces (Adams & Bond, 2000; Aiken, Clarke, & Sloane, 2000; Barry-Walker, 2000; Canadian Nurses Association, 1998a; Duncan et al., 2001; Health Canada Office of Nursing Policy, 2001; Mohr, 1997; Nagle, 1999; Oberle & Tenove, 2000; Redman & Fry, 2000; Rodney & Varcoe, 2001; Varcoe, 2001; Varcoe & Rodney, 2002). While we do not claim to have identified an exhaustive list of currents, we believe that

those we have identified are salient ones. Understanding how such currents affect nurses' progress towards a moral horizon provides a foundation from which to improve the moral climate of nursing practice.

One improvement we can make is to *enhance the quality of the relationships* between nurses, other health-care providers, patients, and families. The interpersonal context in which ethical decisions are made is profiled in our study. Negotiating a shared horizon was often difficult, requiring effective communication among all the various parties involved. Further, the current created by the privileging of biomedicine and the corporate ethos disrupted interdisciplinary team functioning. This is evident in the OR nurse's comment that she felt as if she was practising with a gun to her head — a gun held by the surgeon but put there by an organizational mandate to process as many patients as possible. Conversely, positive relationships with colleagues in nursing and other disciplines have tremendous potential to help nurses stay on course. While there is growing attention in the health-care and ethics literature to the role of trust in resolving end-of-life issues (Burgess, Rodney, Coward, Ratanakul, & Suwonnakote, 1999; Kuhl & Wilensky, 1999; Rodney, 1994, 1997; Solomon et al., 1993; Starzomski, 1997, 1998; Taylor, 1995; Tilden, Tolle, Nelson, Thompson, & Eggman, 1999), not enough has been written about the role of trust in day-to-day processes.[16] We need to better articulate — and subsequently defend — the day-to-day relational processes that influence the moral climate of nursing practice and interdisciplinary team functioning (Bergum, 1993, 1994; Gadow, 1999; Hartrick, 2002; Jameton, 1990; Liaschenko, 1993b; Liaschenko & Fisher, 1999; Sherwin, 1998).

Secondly, we can help nurses to *use the language of ethics in a way that supports their practice.* Throughout the focus groups, nurses told us that their voices were seldom heard as they confronted everyday as well as quandary ethical problems. To some extent, they were not heard because they tended not to explicitly flag a problem as ethical. While all of the nurses spoke about good practice, most did not consciously speak of it in terms of ethics. For instance, a maternity nurse referred to the embeddedness of ethical decisions in her practice:

> *You make so many decisions, it sort of comes from the heart...almost automatically...I don't think we can, it would be very difficult to just try and label...to try and figure this was an ethical decision, this was a decision that was totally governed by my profession or my obligation to the situation. I'm not sure that I can verbalize [it].*

Their failure to use ethical language is no indication that the nurses were not making ethical decisions or practising ethically. Indeed, as is

indicated by our horizon metaphor, they were almost always aware of (though not necessarily following) a value-based direction in their practice. A number of participants spoke of formal education in ethics having helped them to find their voice. Thus, one of the implications of our research is the need for more formal and informal nursing education in ethics (Storch et al., in press). Such education ought to attend to the relational context of nursing practice and everyday as well as quandary ethical problems.

Thirdly, we need *to improve the moral foundations of health policy*. In our study, health policy influenced the nurses' ability to work towards a moral horizon at every level of practice — from staffing decisions to resuscitation guidelines to discharge criteria to relationships between government departments. We need nursing expertise and nursing leadership to analyze the moral foundations of health policy (Malone, 1999; Mitchell, 2001; Storch et al., in press). And we need to involve nurses at every level of practice in re-shaping health policy so that it is more supportive of the ethical practice of nurses and other health-care providers.

We realize that our recommendations for improved practice will not be easy to implement. In the words of an advanced-practice nurse cited earlier, it will also take courage on the part of individuals and groups (Storch et al., in press). However, as one intensive-care nurse said:

> *Well, we have to have some hope. And so that's how I look at it. ...I am in no way thinking that there's not more work to be done. There definitely is. But I have seen successes, and so I think it is possible. But we need to engage everybody...it has to be a level playing field. So people have to have — all people, physicians, nurses...and our health-care team — ...basically the same values and mission, really, about what we're trying to do.*

Nursing has tremendous capacity to make a difference, to move towards moral horizons for the benefit of patients, families, and communities.

Reflection: Ethical Theory and Ethical Decision-Making

We will close by reflecting back on theory and practice in health-care ethics. Our findings show that ethical decision-making is much more than the rational, objective application of ethical principles that traditional ethical theory implies. Traditionally, ethical problems in health care have been seen to collapse into dichotomous (yes/no) questions about what a moral agent (usually a lone physician) should do with a

patient, usually in a life-or-death situation. The answers have been seen as residing in the application of foundational ethical principles — autonomy, beneficence, nonmaleficence, and justice (Beauchamp & Childress, 1989). It is assumed that an objective, rational, analytic process will furnish a concrete and correct answer, outside the familial, social, cultural, and political context of the problem (Baylis, Downie, Freedman, Hoffmaster, & Sherwin, 1995; Burgess et al., 1999; Churchill, 1997; Evans, 2000; Fox, 1990; Gadow, 1999; Hoffmaster, 1990, 1999; McDonald, 1999; Stephenson, 1999; Weisz, 1990; Yeo, 1994).[17] At the same time, much of the early nursing research on ethical decision-making was based on theories of moral reasoning, applying principles of justice and/or care to hypothetical situations (Cameron, 1991; Cassidy, 1991; Cooper, 1991; Fry, 1987; Georges & Grypdonck, 2002; Ketefian, 1989; Munhall, 1983; Omery, 1983; Penticuff, 1991; Rodney, 1997). The participants in our study, in contrast, portrayed decision-making as processual and highly contextual. Decisions were gradual and constituted a journey towards a mutually constructed and pluralistic moral horizon. This finding is consistent with those of other nursing studies. When studies began to move from hypothetical situations to accounts of *practice*, ethical decision-making came to be seen as more nuanced and contextual (Benner, Tanner, & Chesla, 1996; Chambliss, 1996; Fry, 1999; Gaul, 1995; Georges & Grypdonck; Rafael, 1996; Redman & Fry, 2000; Rodney, 1997; Sherblom, Shipps, & Sherblom, 1993). Our findings thus support those of nursing studies on moral reasoning and ethical decision-making that emphasize context and action.

Nursing research on ethical decision-making that emphasizes context and action parallels current theoretical shifts in health-care ethics. These shifts entail a proliferation of alternatives to principlism, and include (but are not limited to) a revival of casuistry, the call for an inductivism based on empirical information or ethnography, interest in narrative bioethics, the articulation of care-based ethics, and relational ethics (Wolf, 1994, p. 400; see also Bergum, Boyle, Briggs, & Dossetor, 1993; Churchill, 1997; Gadow, 1999; Hoffmaster, 1999; Levi, 1996; Omery, 1983; Starzomski, 1997; Yeo, 1994).[18] Each of these alternative approaches to ethical theory can be considered a form of *contextualism*. Contextualism takes into account the reciprocity of facts and values: "moral problems must be resolved within concrete circumstances, in all their interpretive complexity, by appeal to relevant historical and cultural traditions, with reference to critical institutional and professional norms and virtues" (Winkler, 1993, p. 344). In other words, contextualism transcends the reductionist tendency of principle-based ethics by

focusing on particular people and particular relationships in particular contexts.

The rise of contextual ethics has been associated with approaches to ethical decision-making that are more sensitive to context (see, for instance, Jonsen, Sieglar, & Winslade, 1986; Keatings & Smith, 2000, pp. 42–43; Kuhl & Wilensky, 1999; McDonald, 2002). Theorists and health-care providers who use a contextual approach to ethical decision-making aim for a "philosophical understanding of the fundamental concepts used in moral analysis and the tensions between them" in order to "sort out confusions, clarify disagreements, and promote creative problem-solving" (Yeo, 1996). Contextual ethical theory therefore corresponds with models of ethical decision-making that are more attentive to the real world of clinical practice. Such models can be used to help nurses to participate with patients, families, and other providers in working towards a moral horizon. For example, McDonald's model provides guidelines for a group to move towards conflict resolution and consensus.

Further, insights from nursing research can help to shape the evolution of ethical decision-making models. Nurses, other members of the health-care team, and patients and families are engaged in multiple decisions as they work their way towards a horizon. Not all of the decisions are life-and-death (Benner, Tanner, & Chesla, 1996; Canadian Nurses Association, 1998b; Chambliss, 1996). In the account by the pediatric nurse cited earlier, for instance, the mother taking her seriously ill newborn home had made some initial decisions about life-saving treatment (a quandary problem); subsequent decisions about support at home (everyday problems) would follow, and would take time. Current models and frameworks are not sufficient. We need more research into decision-making approaches that will address the interface of everyday and quandary ethical problems and their evolution (Rodney, 1997; Storch, Rodney, & Starzomski, 2002). Nurses are in a good position to contribute to such research.

Notes

1. The terms biomedical ethics, bioethics, and medical ethics are often used to refer to ethical differences between health-care providers (usually physicians) and patients. Our preferred term is health-care ethics, as it encompasses ethical concerns related to providers, patients, families, communities, health organizations, and society as well as biomedicine — all of which are relevant for nursing.
2. Ethics is a branch of philosophy that focuses on questions of right/wrong, value or disvalue. The widespread application of ethical theory to health care is a recent phenomenon. The term bioethics first appeared about 30 years ago with the publication

of a text on biological knowledge and human values (Roy, Williams, & Dickens, 1994, pp. 3–4; see also Jonsen, 1997; Pellegrino, 1997; Storch, Rodney, & Starzomski, 2002) and came to represent academic and professional efforts to address ethical issues posed by developments in the biological sciences (Roy et al., p. 4). With roots in medical ethics, philosophical ethics, and religious ethics, bioethics flourished and diversified as a result of rapid advances in medical science and technology and societal changes (Evans, 2000; Fox, 1990; Jonsen; Pellegrino; Roy et al., pp. 4–13).

3. Ethical decision-making has traditionally been thought of as a structured form of moral deliberation. Moral deliberation occurs when a moral agent confronts an ethical problem and asks the question "What ought I to do?" (Beyerstein, 1993, p. 422).
4. Traditional perspectives on moral agency reflect a notion of individuals engaging in self-determining value-based choice (Sherwin, 1992; Taylor, 1992). Newer perspectives see moral agency as enacted through relationships in particular contexts (Mann, 1994; Rodney, 1997; Sherwin, 1992, 1998; Taylor, 1992). For discussions of moral agency in nursing, see Benner (2000), Georges and Grypdonck (2002), Jacobs (2001), Raines (1994), and Varcoe and Rodney (2002).
5. "The Ethics of Practice: Context and Curricular Implications for Nursing." Principal Investigator J. Storch; Co-Investigators G. Hartrick, P. Rodney, R. Starzomski, & C. Varcoe (July 1999). Funded by Associated Medical Services Inc. (Bioethics Division) and internal University of Victoria Social Sciences and Humanities Research Council grants.
6. For other findings, see Hartrick (in press), Storch et al. (in press), and Varcoe et al. (2002).
7. Our notion of moral horizon is informed by Bernstein (1991) and Taylor (1992). Bernstein speaks of a moral horizon as a moral point of view, while Taylor speaks of negotiating a value-based direction.
8. Our understanding of this term is influenced by Patricia Benner and her colleagues, who build on Aristotle's work. We understand ethics in terms of *good practice* — practice that comes from good character and good action (Aristotle, c. 320 BC/1985; Benner et al., 1996). In other words, "one's acts are governed by concern for doing good in particular circumstances, where being in relationship and discerning particular human concerns are at stake and guide action" (Benner, 2000, p. 5). In nursing, we use various principles or concepts to help us to articulate ethical goods (e.g., autonomy, beneficence/nonmaleficence, justice, fidelity, care); importantly, ethics is part of our daily work, not just in life-and-death situations. "Even in clinical situations, where the ends are not in question, there is an underlying moral dimension: the fundamental disposition of the nurse toward what is good and right and action toward what the nurse recognizes or believes to be the best good in a particular situation" (Benner et al., p. 6).
9. For discussions of deservedness, see Rodney and Varcoe (2001), Varcoe (1997, 2001), and Varcoe and Rodney (2002).
10. Sally Gadow (1999) calls this type of negotiation a "relational narrative": "Ethical narratives created by patient and nurse from the homeland of their engagement are...more than individual accounts: they are relational narratives" (p. 65).
11. Cassidy, Lord, and Mandell (1995) offer an insightful analysis of intersectionality and oppression.
12. See Brown (1996) for an interesting analysis of the power relationships between provinces and regional boards.

13. See Rodney (1997) for similar findings from an ethnography conducted on two acute-care medical units.
14. See Rodney and Varcoe (2001), Varcoe (2001), and Varcoe and Rodney (2002) for similar findings from ethnographies conducted in two acute-care medical units and two emergency units.
15. See Laschinger, Finegan, Shamian, and Casier (2000) for an insightful research study on the effects of organizational trust and empowerment in restructured health-care settings on staff nurse commitment. See also Aroskar (1995), Corley and Goren (1998), Jameton (1990), McDaniel (1998), and Olson (1998) regarding strengthening nursing as a moral community.
16. For a notable exception, see Peters and Morgan's (2001) exploration of trust in a home-care context.
17. Such criticisms of principle-oriented ethics sometimes have more to do with how the principles have been traditionally used in health-care ethics than with a weakness in the principles themselves (Churchill, 1997; Rodney, 1997). The principles have been somewhat unfairly caricatured (Levi, 1996; Wolf, 1994; Yeo, 1994). Beauchamp and Childress (1989) make it clear that they view principles in terms of what they call "composite theory" (p. 51). They explain that "each basic principle [has] weight without assigning a priority weighting or ranking. Which principle overrides in a case of conflict will depend on the particular context, which always has unique features" (p. 51). In other words (and contrary to what many critics imply), the principles are "binding but not absolutely binding" (p. 51). The principles can thus be viewed as useful heuristic devices (Stevenson, 1987) rather than as rigid prescriptions.
18. Casuistry is an inductive approach to ethics that proceeds through case analyses (Arras, 1991; Jonsen, 1995; Jonsen & Toulmin, 1988; Levi, 1996; Toulmin, 1981). Inductivism is a more general term referring to the use of qualitative and quantitative data to inform ethical theorizing (Hoffmaster, 1991, 1993; Jameton & Fowler, 1989). Narrative bioethics has emerged as the use of story to inform ethical practice (Frank, 2001; Nisker, 2001). The primary focus in care-based ethics is relationships and care (Flanagan, 1991; Gilligan, 1982; Sherwin, 1992), while in relational ethics it is human meaning and connectedness (Bergum et al., 1993; Sherwin, 1998).

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Authors' Note

We would like to thank all the nurses and student nurses who participated in this study. We would also like to thank Dana Kemes, RN, MSN, and Lian McKenzie, RN, BSN, who contributed as research assistants. We are grateful for grant monies received from Associated Medical Services, Inc. (the Bioethics Program) and from the University of Victoria internal Social Sciences and Humanities Research Council program. Finally, we wish to thank two anonymous reviewers and the Journal's editors for their constructive feedback on this paper.

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