Modifying autonomy – a concept grounded in nurses' experiences of moral decision-making in psychiatric practice

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Authors' abstract

Fourteen experienced psychiatric nurses participated in a pilot study aimed at describing the experiential aspect of making decisions for the patient. In-depth interviews focused on conflicts, were transcribed, coded, and categorized according to the Grounded Theory method. The theoretical construct, 'modifying autonomy' and its dimensions, such as being aware of the patient's vulnerability, caring for and caring about the patient, were identified. The findings in this study make clear the need for further research into the experiential aspect of ethical decision-making in psychiatric practice.

Introduction and purpose

The psychiatric patient is in a vulnerable position since mental illness impairs the capacity to understand, reason, choose, or act (1,2). The health care worker who is professionally obligated to care, has, when caring for such a person, metaphorically speaking, the life of another person in his or her hands (3). Thus, finding ways to respond to the needs of a patient without threatening his or her integrity can be conceived as a moral issue. Although decisions concerning the 'right' medical treatment of mental illness must be based on professional codes of ethics (4), it may not always be possible to make decisions pertaining to 'good' nursing care on the basis of rules and regulations (5). All health care professionals are either directly accountable or indirectly involved in making or carrying out decisions in the patient's best interest. The nurse, by nature of her close proximity to, and therapeutic involvement with, the patient, is often confronted by problematic moral issues where she is personally accountable for decisions made on behalf of the patient.

In an earlier theory-generating study (5), aimed at exploring the meaning of the nurse-patient relationship as perceived by nurses in a psychiatric setting, the role of 'moral sensing', a type of

sensitivity to, and awareness of, actions which limit the patient's self-choice and threaten his or her integrity, was identified. In that study, the nurses perceived that the main conflict involved maintaining the patient's trust while at the same time carrying out actions which were not made on the basis of the patient's self-choice.

The purpose of the present study, based on nurses' experiences of conflicts involving the nurse-patient relationship, was to gain a deeper knowledge of the nature of moral decision-making as experienced by nurses in psychiatric settings. It should be pointed out that our intention was not to identify typical situations, but rather to identify and describe commonalities in ways of thinking and dealing with difficult decision-making. The focus was on situations where the patient was not certified.

The research method used was a naturalistic 'grounded theory' approach (6,7). In brief, this method uses in-depth interviews and observations in the natural setting for the purpose of developing inductively derived categories that conceptualize a particular social or interpersonal phenomenon. The main strategy of 'constant comparative analysis' entails the systematic and simultaneous collection and analysis of data grounded in empirical reality. One of the benefits in using a grounded theory approach is that it provides a structure for collection, coding and categorizing of data. Another feature of grounded theory is that the purpose of the literature review is to promote 'theoretical sensitivity', ie, to delineate pertinent research questions about the phenomenon of interest and to serve as a source of data (6,7).

Review of literature

The literature shows that Kohlberg's (8) theory of moral judgement and moral development has predominantly been applied in research focused on moral decision-making in nursing (9,10). Central to Kohlberg's theory is that an individual's level of moral development is sequential and consistent with age and level of education. The highest level of moral reasoning, from the perspective of cognitive development, is characterized by impartiality and

Key words

Autonomy; moral decision-making; psychiatric ethics; nursing ethics; modifying autonomy.

the use of universal principles. In research, a person's level of moral reasoning is determined by the use of hypothetical situations and follow-up questions. According to Kohlberg, the theory of moral cognitive processes can be universally applied irrespective of context, and of the person's culture or gender. Moreover, a person's moral thought is presumed to dictate his or her moral behaviour (8).

Research on nurses' moral reasoning, based on Kohlberg's model, has revealed that nurses sometimes do not obtain the expected score (9). In one study, for example, it was found that the nurses' years of experience were related negatively to moral reasoning (10). How can these low scores be explained? One explanation is that nursing experience may increase the use of context in moral reasoning. Contextualism, or sensitivity to details of a particular situation, according to Kohlberg, limits a person's ability to apply universal principles, and as such, exists at a lower level of moral reasoning (8). A contrasting view is that moral problems are embedded in a contextual frame and that both experience and contextual sensitivity are necessary in order to understand the complexities that moral issues entail (11,12). In nursing, experience is gained when the nurse's understanding of a situation alters and when he or she learns to recognize that salient ethical distinctions are present, in practice, with each particular patient and his or her family (13).

A context-sensitive approach to moral commitment may also be the consequence of nursing education, because many nursing programmes emphasize the need for contextual knowledge (as well as the application of theory and principles) in order that nurses give individualized nursing care (13). Thus, ethical comportment in nursing is viewed from an experiential perspective, meaning that moral reflection originates in the clinical context.

Contemporary ethical issues in the practice of medicine and nursing seem to have kindled a need for an ethics grounded in personal relationships and context as a complement to abstract and objective models for solving medical (and nursing) issues, especially in psychiatric practice. Pellegrino and Thomasma, for example (14), argue for a new conceptual framework for medical ethics that includes aspects such as 'compassion' and 'doing for another what he cannot do for himself because of illness'. From this perspective, medicine is viewed not only as a science, but also as a value-laden practice, involving personal relationships. The claim that 'health and virtue are fundamental aspirations of human beings', means that the moral enterprise of health care need to develop a theory of ethics that is based on the realities of everyday practice.

More recently, the morality of care and responsibility, introduced by Gilligan (11,12) and Noddings (15), has served as an alternative to

Kohlberg's approach to ethics. Nurse theorists such as Nokes (10), Sarvimäki (16), Watson and Ray (17), and Benner (13) have also defined the concept of care in terms of moral value. The relevance of a caring ethics for nursing seems to rest on the emphasis on interpersonal relationships and context. However, an ethics based exclusively on care can also be challenged because it rejects the need to subject moral decisions to the 'scrutiny of universal reason' (18). The various views on how a framework for nursing ethics should be conceived, demonstrate the need for an inclusive rather than a reductionist model.

Thus, the sensitizing research questions for this present study have been drawn from the perspective that the interpersonal nature of psychiatric nursing calls for a research approach that allows for the illumination of experiential aspects of moral decision-making. This approach is congruent with a phenomenological view of ethics (3,19,20). The following questions initiated the research process:

- How do psychiatric nurses experience making decisions for the patient?
- Within the context of the nurse-patient relationship, how do psychiatric nurses perceive and respond to the needs of the patient?
- Can a naturalistic research approach increase knowledge of the experiential aspect of moral decision-making?

Procedure

Sample: In order to obtain rich verbal descriptions, participants were purposively selected, on the basis of two main criteria: more than five years' experience in the field of psychiatry, and willingness to share their experiences. The nurses who participated were suggested by nurses known to one of the authors (KL). The participants were described, by these nurses, as reflective and competent psychiatric nurses. Fourteen nurses, three men and eleven women, all with advanced education in psychiatric nursing and more than five years' experience in this area, comprised the sample. Four nurses were employed in community psychiatry and ten in hospital settings. Information about the study was given and confidentiality was assured. The study was approved by the hospital ethics committees in Gothenburg and Huddinge, Sweden.

Data collection: Data were obtained from the transcriptions of audiotaped interviews, which were most often conducted in the clinical setting and lasted one to two hours. Theoretical memos, containing the results of inductive and deductive thinking about potentially relevant categories and their dimensions were kept. Hypothetical questions were raised during the analysis of transcripts and memos. These were tested in each successive interview. This means that emerging concepts could

be verified by comparing the primary data, ie, the nurses' stories, and by seeking support in relevant literature.

Interview approach: Each interview began with one of us (KL) asking the respondent to describe a situation in which she had to make a decision about patient care but was unsure about the right action. In order not to bias the nurses, the main researcher (KL) avoided use of terminology connected to ethics and to moral concepts. As the nurses themselves began to describe their experiences in moral terms, more specific questions were posed, regarding their ways of experiencing the moral conflict. An example of this type of question is: 'When you weighed the different alternatives, what was your main concern?'

Concept development: The ethnograph, a computer programme designed for qualitative data-analysis, was used for the first and second level of analysis, commencing with the first transcript. The first level of analysis consisted of open coding, the process of identifying and comparing substantive codes. These codes were then subsumed into broader concepts (6). At the third level of analysis, 'modifying autonomy' was identified as a theoretical construct or core category. This category continued to be compared in each successive interview until saturation (completeness of all levels of codes when no new conceptual information is available), was achieved in the last interview (6). Some examples from the interviews will be given below to illuminate the concepts derived.

Findings

MODIFYING AUTONOMY

The emerging theme or theoretical construct, 'modifying autonomy' provided a conceptual framework for interpretation of the experiential aspect of model decision-making. Selective sampling of the literature supported this construct as well as identification of its dimensions, namely being aware of the patient's vulnerability, caring for and caring about the patient.

'Modifying autonomy' is defined as adjusting the meaning of self-choice to suit the perceived needs of a patient when there is a conflict. In practice, this could entail enhancing as well as limiting the patient's self-choice. In this study, however, the nurses' descriptions revealed actions which were interpreted as limiting self-choice, for example, making decisions without the patient's knowledge, persuading, manipulating the patient's choice and taking over personal hygiene. It should be pointed out, that in this study, modifying autonomy is defined according to the meaning of autonomy the nurses themselves implicitly and explicitly expressed, ie, self-choice. This definition is understood as distinct from coercing, by which we mean threatening the patient with undesirable

consequences if he or she does not go along with a decision. Further, 'modifying autonomy' is neither the same as informed consent, which implies shared decision-making (21), nor the same as self-sufficiency, defined as 'independence and separation from others' (22).

BEING AWARE OF THE PATIENT'S VULNERABILITY

To be vulnerable is to be exposed to the will and choice of others (3). The dimension, 'being aware of the patient's vulnerability' describes the interaction between the patient's vulnerability and the nurse's awareness of the implication of this. The nurse recognizes that being in a vulnerable position also restricts the patient's range of choices. The nurse places an importance on self-choice, in a moral, as well as a therapeutic, sense. At the same time she perceives that the patient is in need of protection. The nurse interprets the patient's behaviour, for example, as not being based on a rational choice. Therefore, in order to maintain the patient's self-esteem or to protect him or her from harm, the nurse takes over the patient's self-choice, in other words, modifies his or her autonomy.

Expressions such as 'not infringing on the patient's privacy', 'preventing loss of dignity', 'helping the patient to communicate his needs', 'the patient's life was in my hands' and 'not wanting to breach his trust' provided indications of the nurse's awareness that the patient's welfare could be altered by her actions. An example of being aware of the patient's vulnerable position is provided by the following statement:

'This experience made me think in new ways about the meaning of my work. I see myself more clearly now as being on the patient's side, against what is often a huge, insensitive health care system serving its own purpose in which the patients can really come to be badly treated'.

The relationship between anticipating the patient's needs and vulnerability is exemplified by the following account:

'A fifty-year-old man, of another nationality, came to the clinic in a crisis. His wife wanted a separation and this meant that he was forced to move from their apartment and to leave their two children. He was in a panic state and could not see clearly why his wife would do this. His dignity as a person was infringed. He was agitated, desperate and repeatedly said he was going to kill himself'.

As it was told by the nurse, the patient in the above example came to the nurse for help and advice, thus a dependent relationship was established. The patient asked not only for help to deal with his crisis, but also exhibited self-destructive and irrational behaviour. The nurse understood this and was aware

of the consequences of alternative actions. Her main concern was how best to respond to the patient's vulnerability: 'How can I protect the patient from harm without violating his trust in me and his dignity?'

The relationship between 'trust' and 'vulnerability' is described in another situation:

'A man who had recently been a patient turned up at the clinic. He was paranoid and I began to be concerned for his and his son's welfare. He had hit his son before, and I decided to make a home visit. When I got there, I saw how the place looked and understood that he needed to be admitted. My problem was, if I went behind his back and reported to the doctor, it would be a blow to his identity. On the other hand, if I didn't, there was a risk that his son would be harmed'.

In the above context the nurse senses the vulnerability of the patient through observing and thus understanding his circumstances. She is aware that her choice of action may breach the principle of trust and also reinforce the patient's loss of self-choice. The nurse was aware of the patient's vulnerability, even when she entered his home, a private sphere, but she felt motivated to do this because she felt she bore some responsibility for his and his son's safety.

A language problem

In another example, the nurse responds to a patient's being vulnerable by virtue of a language problem:

'A young patient from another country was admitted to our ward with the diagnosis manic psychosis. None of us staff believed she was psychotic. The only one who did was the new and inexperienced doctor, who wanted to follow the rule book and give her an injection of haloperidol, by force if necessary. His superior had diagnosed her after seeing her very upset in the emergency room where she had been accompanied by her husband. The woman had only lived in this country three years, she didn't know the language and was completely isolated. In my opinion she was in a crisis. I couldn't go through with giving her an injection against her will. It was morally wrong'.

An awareness that it may not always be possible for a patient's own wishes to be met was also made clear by another nurse:

'I know that in order for the ward to function there have to be limits, but if I were a patient I would be mad, scream and kick if I couldn't make a cup of tea when I wanted one'.

The nurse in the above situation, put herself in the patient's position and could in this way understand the patient's vulnerability. As with all the nurses in this study, sensitivity to the patient's needs seemed to be based more on human feelings and less on principled thinking.

CARING FOR – CARING ABOUT

When the nurses' ways of responding to the patients in each described situation was compared, two senses of 'care' emerged: caring about and caring for, which can be related to ways of modifying autonomy. For example, in what follows, caring about a patient is reflected by the nurse's spontaneous action. That is to say, she responds to the patient's vulnerability not out of a sense of duty, but out of a genuine, positive feeling towards the patient:

'We decided that we would bathe the patient. There were two of us and we began by holding her so that she couldn't scratch or hit us. We took off her clothes and she just stood there. I thought: "Is this right? How much is this harming her?" ... When we were finished I stroked her on the cheek and helped her with her hair'.

By asking 'how much is this harming her', the nurse indicated an understanding of how the patient may have experienced being forced to bathe. This also indicates that the nurse's question is based more on feelings and less on principles or rules. By 'stroking her cheek', the nurse expressed in action these feelings.

Moral decisions that seemed to emerge from a sense of professional duty and obligation emerged as caring for. An example of maintaining the professional duty to care for was expressed by the following nurse, in response to a patient who did not want to take her medication:

'When the patient came to me and said she didn't want any injections I told her that was not my area, it was the responsibility of the psychiatrist to answer questions concerning medication, ... and that my responsibility as a nurse was only to evaluate the need for additional medication'.

The moral commitment to care 'for' and 'about' patients, seems to lead to a dual and conflicting loyalty towards the patient on the one hand and the physician on the other. This problem is made clear in the following:

'It is the physician who restricts the patient's self-choice, not only in terms of injections, but also in terms of orders, such as those which restrict outside privileges. The problem is, I'm the one responsible for carrying out these orders, even if I don't agree with them'.

Discussion

The aim of this study was to describe the lived experiences of moral decision-making in psychiatric nursing. As the examples make plain, even patients who seek psychiatric help on a voluntary basis, are primarily dependent on the nurse for their daily personal care and preservation of dignity. Within this framework, moral decision-making can be viewed as an interpersonal phenomenon.

The experiences described by the nurses in this study focus on situations in which they are compelled to act on behalf of the patient. 'Modifying autonomy', conceptualizes the nurses' struggles to adjust the principle of self-choice to fit the situation on hand. In all of the described situations, the nurses perceived a threat to the patient's safety or well-being and took measures to prevent harm from coming to him or her. This meant that the patient's self-choice was restricted.

Catalyst for caring

The obligations of nurses as well as physicians have traditionally been understood in terms of a professional commitment to the principle of beneficence as well as to the principle of autonomy. The principle of beneficence provides justification for actions which decrease the patient's autonomy (21). In psychiatry, the infringement of a patient's freedom of action may be justified if it will benefit the patient and is consistent with existing medical knowledge and prevailing norms and values (23). Compared to justifying making decisions for a certified patient, who lacks the mental capacity for rational self-choice, it may be more difficult ethically to justify taking over a non-certified patient's self-choice. The nurses in this study seemed sensitive to this problem.

The dimension of being aware of the patient's vulnerable position, may have to do with the nurses' sense of connection, involving transpersonal experiences and feelings, which may act as a catalyst for caring (24). Psychiatric nursing staff have to deal with the need to be aware of patients' loss of privacy, helplessness, and at times dignity, and their total dependency on others for basic needs. An understanding of the connection between patients' vulnerability and their limited self-choice may be learned through experience. All of the nurses in this study had long experience in psychiatry, which may have sharpened their awareness of the consequences of limiting or enhancing the patients' autonomy.

However, it is not always clear what conditions, with the exception of conditions stipulated by the Declaration of Hawaii, must be met before self-choice can be overridden by the principle of beneficence. Moreover, it cannot be presumed that all nursing actions based on 'good' intentions are 'right' ethically.

The nurses in this study did not seem to begin their point of moral reflection by referring to

professional codes of ethics or to autonomy as an ethical principle. Rather, it was the context of the nurse-patient relationship, involving response and responsibility, rather than principles, that determined the nurses' definition of self-choice. In this study, the nurses' actions were motivated by 'not wanting harm to come to the patient' and 'doing good'. This indicates that psychiatric nurses' interpretation of the psychiatric patient's 'right' and their knowledge of formal codes of ethics needs to be further investigated.

The findings of this study suggest there is a need for further thought about the meaning of moral categories such as vulnerability, self-choice and care, and about how these relate to concrete experiences in psychiatry as well as in other settings. The inter-relating of concepts such as 'safety', 'well-being', 'best-interest' and 'autonomy' needs to be further explored in other contexts, especially, how these concepts and the way they inter-relate are related to the two senses of care.

One of the limitations of this research was that the participants were selected on the basis of their competency. This raises questions about the generalizability of the findings. However, future research could, for example, study how the concepts identified in this study work in a hypothesis-testing design, using a larger sample. It would be interesting to explore moral decision-making in psychiatry, using for example, different staff categories with various educational backgrounds and in different clinical settings.

Naturalistic research has its advantages in that it can explore in depth lived experiences, especially ethical issues, not readily penetrated by other methods. Yet, a problem with using interviews in research is that the expressed moral thoughts and feelings may not reflect 'true' experiences, since time, reflection and awareness of prevailing norms may have served as a filter. There may be a natural reservation about exposing 'true' personal feelings and values to researchers. Triangulation of data (25), ie the use of a variety of methods to collect data on the same concept, may confirm the accuracy of concepts derived in this present study. It may also be of interest to focus on specific situations involving the balance between self-choice and beneficence in order to determine whether both concepts can be retained, rather than one giving way totally to the other.

Institutional restraints

In psychiatry, autonomy is an important concept, however, its application in research is complicated by the various definitions that abound in the literature. For example, autonomy defined as personal freedom of choice, without coercion or manipulation, is central to Kantian ethics (26). This somewhat restricted interpretation, if applied in the

psychiatric setting, could have different undertones if we take autonomy to mean independence and self-sufficiency. Furthermore, defining autonomy from the perspective of self-sufficiency seems to contradict the interpersonal and caring nature of nursing.

The concept of autonomy, understood as 'self-choice', when applied in health care ethics, raises additional questions about whether nurses perceive themselves as autonomous in moral decision-making. Worth considering is Pellegrino's comment: 'the moral obligations of a health professional to his patient care are complicated by the superimposition of the moral agency of the team as a team' (14). For example, nurses may be caught in between the physician's authority and the patient's demands, and thus may not experience themselves as morally autonomous team members. It could be that institutional restraints and medical authority prevent the nurse having freedom of action, i.e. prevent her from making unforced choices (27).

Although it was beyond the scope of this study, a future study aimed at examining nurses' autonomy in moral decision-making in relationship to other professional groups within the psychiatric team may uncover other dimensions of psychiatric nursing ethics.

The two senses of caring that emerged in this study reflect the broad spectrum of professional nursing, which includes response and receptivity, and interdependency, as well as commitment to rules and regulations. The sense of care that is based on deeper feelings has been defined by Montgomery (24) as spiritual transcendence; a definition which emphasizes connection and the aesthetic form of caring. The two senses of care identified in this study can be compared to Shogan's (28) distinction between caring for and caring about: caring for describes the person's conscientious reflection and professional obligation to do that which is morally right. Caring about, is defined as a genuine motivation to do that which is right, independent of rules and regulations.

However, it is important that a theoretical distinction between caring for and caring about is viewed with caution. Everchanging contexts place different demands on the nurse in the execution of care. While caring for can be interpreted as reflecting instrumental care, based on professional obligations, and caring about, genuineness, based on a natural motivation to care, these two senses of care may be equally morally right, depending on the particular context.

The nurse's focus on finding ways to respond to the patient's vulnerability was also expressed as the main moral question for the women that Gilligan interviewed (11). Specifically: 'How shall I respond to the needs of the other' is a main moral concern for women in an ethics of care (11,12,15). However, the three men included in this study showed similar

concerns, which implies that responding to the needs of another in professional caring is more a matter of personal commitment to nursing and not so much a gender issue.

Many questions can be raised as to the consequences of caring about a patient too much, since the argument: 'I acted in the best interest of the patient', obviously, cannot always be sustained. What are the moral consequences of the extreme of caring about? Is there not a risk for professional incompetency when heroic actions take over?

In conclusion, the ability to weigh the principle of self-choice against beneficence by perceiving, i.e. seeing, feeling and understanding the needs and wishes of the person being cared for, should be viewed as a fundamental moral responsibility in health care ethics.

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News and notes

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News and notes

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