Unravelling the Dilemmas Within Everyday Nursing Practice

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Each day, nurse practitioners are faced with clinical situations and dilemmas that have no obvious right answers. This article sets out the process of ethical mapping as a reflective device to enable practitioners to reflect on dilemmas of practice in order to learn through the experience and inform future practice. Ethical mapping is illustrated around a single experience that an intensive care practitioner shared in an ongoing guided reflection relationship. Within this process the practitioner draws on ethical principles to inform the particular situation, notably autonomy, doing harm, truth telling and advocacy. Through reflection, ethical principles are transcended and assimilated into knowing in practice, enabling the practitioner to become more ethically sensitive in responding to future situations.

Introduction

> The challenge and opportunity for ICU nurses is to make manifest, through their competence and engagement with the patient, the presence of care. This requires vigilant attention to the ordinary expressions of nursing care, to the patient's experience of illness, recovery, or dying; and to their own responses to their work with patients in ITU. It requires that nurses tell their stories of care to each other and to other health care providers. With each recounting of a caring experience by nurses, care becomes more visible and valued (Cooper, p. 31).[1]

This article tells a story that Michael shared in his guided reflection session; it concerned his caring for a young male patient and his family. Michael is a senior staff nurse working in a neurological intensive care unit (ICU). The story is grounded in Michael's dilemma of knowing *how best* to respond to a situation of potential suffering. The dilemma centred around whether to inform the parents of the full extent of their son's injuries resulting from his suicide attempt. Michael avoided informing them because he felt this would add to their distress at this time.

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Michael's experience is used to illustrate the complexity of decision making and the benefit of guided reflection in unravelling the interplay within the complexity of the whole. From a reflective perspective, this article offers a source of information for other practitioners to reflect on in the light of their own experiences. The value of a single case study is to retain the highly contextual and subjective essence of experience so that others can relate to it in terms of their own experience.

Within everyday practice, the nurse practitioner is faced with a constant stream of decisions to make and actions to take. Many of these decisions are unproblematic, grounded in technological understanding and response to the patient's medical status. ICUs are areas of clinical practice where the interface of technology and caring is most pronounced. Responding to suffering can never be a technological reaction. It can only be grounded in knowing the person(s) involved and interpreted within the unfolding clinical moment. Knowing what is best is essentially unpredictable within a complex unique human encounter, presenting the practitioner with uncertainty and dilemmas about the most appropriate way to proceed. Often, more than one practitioner is involved in the decision making, which may lead to a conflict of values over what is best and a conflict of power over who has the authority to make the decision. The decisions are concerned about the best interests of patients and families, often in situations of life and death, and are certainly associated with strong emotions of suffering: distress, pain, guilt and anger. As such, many decisions are imbued with a strong emotional presence that defies rationality or blurs perception.[2] Situations of dilemmas and conflict create anxiety for practitioners.[3] As such, practitioners are very conscious of these events, which are often the focus for disclosure within guided reflection or clinical supervision.

Guided reflection

Guided reflection is a co-developmental and collaborative research process whereby practitioners reflect on everyday experience with a guide, who leads them to expose, understand and work towards resolving contradictions between what they aimed to achieve within any particular situation and the way they actually practise.[4] Guided reflection can be used synonymously with the term 'clinical supervision', although guided reflection includes reflective activity between 'supervision' sessions. Guided reflection offers one way to structure what takes place within clinical supervision. Michael and his guide, Carol, meet with another practitioner for one-and-a-half hours every four weeks. Carol works as a university lecturer. Michael approached her because of her known expertise in guiding reflection. They meet at Michael's hospital in a room away from the clinical area. Carol had been approached to become their supervisor for a 12-month period. At the time that Michael shared this experience, he had been in guided reflection for five months.

Michael's story

Michael's story is reconstructed through using dialogue notes taken verbatim by Carol during the guided reflection session:

> This experience concerns a university student, Timothy, who had jumped off the roof of his college. He had also slit his wrists and left a suicide note. He landed on his head and suffered head injuries besides fractures down his left side. His parents live abroad. They came over and settled into the intensive therapy suite. Timothy's head injuries were initially quite stable, but became increasingly unstable, requiring two operations. Eventually, Timothy required a third operation to which his parents cautiously gave consent. They were told that this would definitely be the last one. The parents were inquisitive, questioning . . . normally all the things that we would encourage yet . . .

Michael paused. Carol completed the sentence: 'Relentless?' Michael continued:

> Yes. That's it . . . relentless. Yet in denial about what their son had done. The nurses found that difficult. One shift, Constance (a senior staff nurse) came to me. She wanted to tell the parents that their son had cut his wrists. They hadn't been told. His wrists were covered with a plaster cast. The college had not involved the police. When we discussed it I felt that Constance should not inform them. She felt better about me saying that because she was irritated with them . . . with their denial. Timothy made a good recovery and was transferred to the ward. And then the other lunchtime, Constance, coming into the hospital, bumped into the mother, who said, 'You didn't tell us that he had cut his wrists.' Constance was shocked by this. This incident made me reflect. Should we have told them? The mother said it in such a way that suggested she felt she should have been told.

Carol drew Michael's attention to the cue question within the model for structured reflection (Figure 1), 'Did I act for the best?', and then guided him to reflect again on the situation using ethical mapping.

The model of structured reflection was constructed empirically through reflection on the process of guidance within supervision while informed by the extant theory of reflection from various sources. It offers the practitioner and supervisor a way forward to explore the breadth and depth of reflection and focus on particular aspects of the reflective process. Over time, the practitioner internalizes and transcends the model within his or her personal knowing. However, as in Michael's story, this model is a useful framework to prompt challenge within supervision. The model has been tested continuously for its adequacy, leading to its reflexive development into the current version.

Ethical mapping

Ethical mapping (Figure 2) guides the practitioner to view the various perspectives and contextual factors within any ethical decision. At each point within this 'map', the supervisor challenges the practitioner to understand and balance the dynamics towards making the 'right' decision in the particular circumstance. The map helps the practitioner to 'see' the different and often contradictory perspectives within any situation, and to examine the factors that determine which perspective prevails. The grid acts as a focus for the practitioner to examine the

conflict of values and power relationships that exist within the unit and which largely determine who makes the decision.

From a reflective perspective, ethical principles, like all extant sources of knowl-

Write a description of the experience.
Consider – what are the significant issues to which I need to pay attention?

Reflective cues

Aesthetics
- What was I trying to achieve?
- Why did I respond as I did?
- What were the consequences of that for:
  - the patient?/others?/myself?
- How was this person(s) feeling?
- How did I know this?

Personal
- How did I feel in this situation?
- What factors embodied within me or embedded within the environment were influencing me?

Ethics
- Did I act in accordance with my beliefs and for the best?
- If not – what factors made me act in incongruent ways?

Empirics
- What knowledge did or should have informed me?

Reflexivity
- How does this connect with my previous experiences?
- Could I handle this situation better in similar situations?
- What would the consequences be of alternative actions:
  - the patient?/others?/myself?
- How do I NOW feel about this experience?
- Can I support myself and others better as a consequence?
- Am I now more 'available' to work with patients and families to help them to meet their health needs?

Figure 1 Model for structured reflection (version 11; developed from Johns[4])

Patient's/family's position	Who has authority to act?	The doctor's position
Is there any conflict of values?	The situation/dilemma	What ethical principles inform this situation?
The nurse's position	How was the decision actually made in terms of power?	The organization's position

Figure 2 Ethical mapping (developed from Johns[4])

edge, exist only to inform the practitioner. They cannot prescribe what is best, at least not without defying the particular circumstance. Ethical principles are often contradictory. Truth telling may be harmful. Respecting autonomy may lead to conflict over what is best. The issue of power guides the practitioner to explore who had the authority to make the decision and act within that particular situation, and to understand the way in which the actual decisions were made in terms of power relationships between the different parties involved. The intention is to help practitioners to understand and expand their own boundaries for making decisions *vis-à-vis* others in terms of achieving caring.

The application of the ethical map is set out in Figure 3. The decision not to inform the parents was made by Michael. His rationale was to protect the family from further avoidable grief. Was this decision appropriate?

Carol challenged Michael over whether his action not to inform the parents could be justified against the criteria to judge whether parentalism is therapeutic (Table 1[5]).

Causing harm

Michael could not justify his decision, in terms of the criteria set out in Table 1, to protect Timothy's parents from the distress he had assumed they would suffer if they were informed that their son had also slit his wrists. Knowing the meaning of harm within this situation was a question of judgement based on knowing Timothy's parents. It would be psychological rather than physical harm. Would knowing this have a detrimental effect on the parents? How do we know that this was likely? What evidence might support that?

Respecting and creating opportunity to exercise autonomy

Seedhouse[6] claims that respecting and creating opportunity to exercise autonomy are the highest ethical principles. The question of whether the parents would be harmed by such news was a secondary consideration to which Michael could have responded with appropriate support. As Michael noted, if he had felt out of his depth in supporting the family he could have referred to the psychological counsellor. Indeed, Michael felt that he might perhaps debrief with this

Table 1 Criteria for justifying parentalism (developed from Benjamin and Curtis[5])

Factor	Criterion
Harm	That the patient (relative) may come to some harm if no action is taken
Autonomy	That the patient (relative) was unable to make the decision for himself or herself
Ratification	That, at a later date, the patient (relative) would ratify the action taken

person. How would knowing that their son had cut his wrists have influenced the course of events? Did they have the right to know? Yet the parents had not asked; does this make a difference? We do not know how the parents would have responded if they had been told. They were not distressed by not knowing. The ethical problem hinges on the issue of whether the parents had the right to know the full facts and whether Timothy would have wanted them to know. Not having a voice of his own, he was dependent on the health care team to act on his behalf.

Patient's/family's perspective: – Did you think they would want to know? – What evidence do you have to support this view?	Who has authority to act? – Did you have authority to break this news?	The doctor's perspective – Would he or she have been sympathetic for you to tell?
Is there any conflict of values? – Medical values versus your nursing values	The situation/dilemma: – Should 'we' have informed the parents that their son had also cut his wrists?	What ethical principles inform this situation? Would telling the parents: *Cause them harm*: Did not telling cause more harm? Would telling them have helped them? How do you know? *Affect their autonomy:* Did the parents have the right to know? Could you have been indirect to create the opportunity for them to exercise autonomy? *Be telling the truth*: Is omission a lie? Should you consider Kant's moral imperative: do as you would be done to? If it was you, what would you want?
The nurses' perspective – Nurses feel we should inform them	How was the decision actually made in terms of power?	The organization's perspective: – To avoid conflict with the college where the patient was a student

Figure 3 Applying the ethical map

Truth telling

Does truth telling apply only to direct questions, or is not disclosing information tantamount to a lie? Using Kant's moral imperative, would Michael and Constance want to know if they were in the parents' shoes? Deep inside, did Michael or Constance sense that the parents should be told? Empathy is the sense of connecting with the experience of the other.[7] Empathy is the primary essence of caring: what must it be like for this family? It stems from a concern and knowing for the other person. It is informed by theory and previous experience and yet it requires the practitioner to clear away any personal concerns that may distort the perception of how the other was feeling and thinking. As such, was Constance's concern that the parents should be told acting out her angst toward this family?

Advocacy?

Michael claimed that being the patient's advocate prompted his nondisclosure. Would Timothy have wanted his parents to know he had also slit his wrists? Parentalism can be viewed as a continuum with advocacy.[8] Parentalism is concerned with taking action on behalf of another, while advocacy is enabling others to take appropriate action about their health care.[9]

Michael claimed a holistic perspective towards his practice, whereby his and his colleagues' intention was always to enable the other to make decisions about his or her care. In other words, Michael aspired to Gadow's understanding of advocacy as intrinsic to the helping relationship. For many reasons this may not be possible, particularly within an ICU setting, where many patients are clearly unable to be involved in making good decisions about their health, and families are often distraught and feel they lack the technical know-how to enable them to make good decisions. In the unfolding drama of the ICU, relatives may often feel side-lined.[10] However, as Michael's previous experiences had illustrated, he was very sensitive to the feelings and needs of relatives and endeavoured to include them fully within his caring focus.

Ratification factor

Carol further challenged Michael to consider the meaning of creating and respecting autonomy for this family. By asking the parents what they knew of the incident, Michael and Constance might have been able to gauge their response, and direct the parents to ask those who might have authority for disclosing the news. The mother's response to Constance suggested they would have wanted to know, but meeting her in the corridor was different; the time, the place and the circumstances had changed.

Influencing factors

Michael was then guided to reflect on the factors that influenced his decision. The 'what factors influenced my action?' grid (Figure 4) acknowledges factors that have been identified as influential within nurses' decision making.[4]

Expectations from self about how I should act? Conforming to normal practice?	Negative attitude towards the patient/family?	Expectations from others to act in certain ways?
Emotional entanglement?	What factors influenced my actions?	Misplaced concern? Loyalty to staff versus loyalty to patient/family?
Limited skills/discomfort to act in other ways	Time/priorities?	Anxious about ensuing conflict? Fear of sanctions?

Figure 4 Grid for considering 'what factors influenced my action?' (developed from Johns[4])

Michael could see that his decision had caused him to avoid his own anticipated discomfort of the family's reaction to this news. When challenged with this idea, he acknowledged that the prospect of breaking this news would have been uncomfortable. In other words, Michael's act may have been primarily in his own best interests rather than the family's, although justified in terms of protecting the family from unnecessary harm at this vulnerable time. He could also see that perhaps he had been influenced by other nurses' attitudes towards the parents' denial.

Because of the parents' insistence, the nurses felt they had to create a distance. Do relatives have to learn the right amount of acceptable insistence? There is a fine line for relatives to learn to tread. Do they become unpopular if they overstep a mark of asking too many questions or are too interfering in caring issues? Robinson and Thorne[11] noted that relatives had a naive anticipation that nursing staff would share their expectations. When this understanding proved to be misplaced, it led to a sense of disenchantment and breakdown of communication, what Mclaughlin and Carey[12] referred to as adversarial relationships. Within a therapeutic relationship it is fundamental to be open and honest rather than defensive. Identifying any person with a negative label such as 'insistent' may lead to uncaring consequences. Relatives may then be viewed with less concern and nurses will perhaps tend to see them in terms of their presenting *difficult* behaviour rather than the underlying reasons why they behave in this way. Nurses respond by avoiding the relatives at a time when they need most support. Indeed, the avoidance may be perceived as noncaring and actually contribute to anxiety and suffering.

Authority to act?

Carol challenged Michael with his authority to make the decision. In particular, she challenged him to consider the doctors' perspective. Michael did not involve the doctors in his decision. He believed they would have informed the family

themselves if they had thought it was necessary to do so. However, this raised a question of whether Michael believed he had the autonomy to disclose this information even if he had wanted to.

In exploring other ways of responding, Michael felt that perhaps a better option might have been to discuss the issue with the doctors and seek collaboration, in the wider belief that collaborative relationships between nurses and doctors were desirable. However, he knew from experience that this was not the case in practice. He felt that doctors viewed decision making about clinical issues as their prerogative. The scope of this authority claim included giving relatives information; Michael could not judge what the doctors' response might have been. There is evidence to suggest that personal relationships and proven experience are significant factors when doctors listen to nurses in ICUs.[13,14]

Support

Michael had been burdened by this issue but had not felt able to share it with his colleagues. Carol helped Michael not to judge himself as having failed in some way, offsetting any tendency to judge himself with hindsight, or to feel frustrated that he is unable to change himself or organizational structures quickly. The world of practice has been compared with a messy swampland where there are no easy answers.[15] As Michael's experience has illustrated, interpreting meaning and responding appropriately can never be predicted with any certainty. However, Michael did feel cared for by Carol. He was able to harness his anxiety as positive energy through which to learn. The metaphor of a water-butt illuminates this point. Michael is like a water-butt, constantly filling up with stress. Through guided reflection, Michael was helped to manage his stress levels, using the drain tap to draw off the stress and use it positively to 'water' his growth. Failure to monitor and drain the 'water-butt' of stress leads to overflow, which creates an emotional mess that is uncomfortable for others to deal with, and which ironically reinforces the need to keep the lid on stress within a culture where dampening feelings and avoiding conflict is the norm.[16] When beliefs are continually frustrated, then nurses are likely to become morally outraged,[17] distressed[18] and damaged.[19] As Pike[17] noted:

> moral outrage ensues when the nurse's attempts to operationalize a choice are thwarted by constraints. The outrage intensifies when these constraints not only block actions, but also force a course of action that violates the nurse's moral tenets (p. 351).

Pike believed that the 'solution' to moral outrage is the development of collaborative relationships between nurses and doctors, based on a realization of mutual trust. However, this requires a mutual vision grounded in patients' and families' best interests, and also a sense of nurse empowerment, itself based on a strong commitment to the value nursing has to offer within intensive care. It also requires a supportive environment whereby feelings of self-doubt or inadequacy can be openly expressed. Michael espoused such collaborative intent, yet in practice it seemed difficult to achieve. He did eventually share his experience with his team, enabling them to become more open with each other and share their own feelings about sensitive and emotional issues of caring. In doing so he began to transform the practice environment, which became more caring. Within

a healthy therapeutic environment, staff should be mutually available to support each other and yet this environment seems to be singularly absent at a meaningful level. Street[20] has highlighted the way in which nurses protect themselves from exposure to anxiety by acting as if they are partially invisible to each other, literally keeping their heads down. While partial visibility may be protective, it also detracts from nurses mutually supporting each other. Guided reflection or clinical supervision may be perceived as supportive but it may also be considered as propping up a fundamentally uncaring organization.

Learning

In order to focus the learning that had taken place within the guided reflection session, Carol asked Michael to summarize what had been significant in sharing the experience and what actions Michael needed to take as a consequence. These issues would be picked up in subsequent guided reflection, both in following up this particular situation and in relating to new situations, enabling Michael to feed back to himself that new insights had been assimilated into his practice. This is not to say that he would act differently when faced with a new situation, yet he should be more sensitive to self, and more aware of the dynamics unfolding, possibilities and barriers. Each guided reflection session leads to a recognition of what was significant within the shared experience and what actions can now be taken.

Being available

To structure learning, Carol guided Michael to view himself within a 'being available' template. Being available to work with the patient and the family, to help them to meet their health needs, has been construed as the core therapeutic of nursing.[21] The extent to which the practitioner can be available is determined by six interrelated factors against which Michael could know himself as an effective practitioner:

- Knowing what is desirable;
- Concern for the other;
- Knowing the other;
- Interpreting the situation and responding with appropriate action;
- Knowing and managing self;
- Creating the conditions where being available is possible.

Michael was helped to find meaning in his holistic beliefs within the ICU environment. Just because he espoused holistic beliefs did not mean that he could practice in congruent ways. Reflection helped him to expose contradiction and work towards resolving it, making it more likely that he would act more congruently in future situations. Carol helped Michael to explore the meaning of ethical principles and ways in which these might inform the situation. As a consequence, the ethical principles should take on personal meaning and become assimilated within Michael's personal knowing. Perhaps it is only through guided reflection that any theory can be meaningfully assimilated within practice.

Michael's concern for nursing practice is evident in the passion with which he

talked about his own practice. Concern can be likened to a fragile flower being blown by the winds of reality. Concern needs to be nourished, but also the winds of reality have to be understood, otherwise they may diminish concern in the need for personal survival. Indeed, creating the conditions whereby practitioners such as Michael can practice from a caring perspective is itself an ethical issue.

Conclusion

Michael's experience illustrates the complexity of ethical decision making. Knowing how best to respond to situations of uncertainty and suffering within the unfolding moment are not easy. Difficult decisions may be set aside for a later time or avoided because the practitioner feels uncomfortable. However, from a therapeutic perspective this may not be the best decision. The nurses felt uncomfortable with the parents' insistence and with knowing that the parents were not fully informed of the extent of their son's injuries. We do know the mother felt let down by the nurses when she eventually found out. If nurses wish to work in holistic ways with the whole family, then such issues are very significant in forging working relationships with relatives in ICUs. If the news is distressing, then the nurse's role is to support. Deconstructing the experience within guided reflection enabled Michael to make sense of his guilt about the situation in ways that he might use to gain new insights into future situations. The process of reflecting-on-experience enabled Michael to become increasingly reflective and sensitive to himself and others in his practice. The situations that Michael shared in guided reflection shifted, over time, from being problems in which he had judged himself harshly as failing in some way, to situations that affirmed his increasing expertise to respond according to his beliefs and values about ICU nursing.

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