CHAPTER 1

THE BEGINNING OF THE RESEARCH JOURNEY

1.1 The research as journey

The metaphor of the ‘journey’ was chosen to describe the research process and the knowledge that evolved from this study of ethical decision-making and gerontic nursing. The purpose of this metaphor is to broaden the view of the ethical decision-making of registered nurses in a nursing home. Journeying is about going to new places, learning new things and seeing the world through new eyes. The reader is invited to journey alongside me into the relatively uncharted waters of gerontic nurses’ ethical decision-making to deepen their understanding of the life-worlds of registered nurses employed in an Australian nursing home.

The metaphors used throughout this research journey are: planning and preparing for the journey; transportation for the journey; the journey’s discoveries and the journey’s end. In terms of the research process the metaphor, planning and preparing for the journey, refers to the initial review of relevant literature. Transportation for the journey relates to the research method used. The journey’s discoveries describe the findings of the research that contribute to the creation of an approach to ethical decision-making known as respectful relationships, and at the journey’s end an approach to ethical decision-making is articulated along with implications for future gerontic nursing practice, education and research.
1.2 The journey begins

This journey began in 1993, when I was employed as a nurse educator in a nursing home in New South Wales, Australia. During the time I was employed at the nursing home, my discussions with the registered nurses working there, and my observations of the clinical practice that took place, led me to the understanding that gerontic nursing abounded with problems that were of an ethical nature.

Prior to 1993, I had no knowledge of the ethical problems which concerned gerontic nurses working in nursing homes. During the 1980s and early 1990s, I worked in general hospitals and in a large international company as an occupational health nurse. Gerontic nursing did not feature in my career plan until, in 1993, I applied for and was appointed to the position of nurse educator in a nursing home.

Almost immediately, my assumption that aged care was a “sleepy back-water” was challenged. Far from being an environment where work was slow and mundane, in the nursing home I found myself in a dynamic environment where high quality care was delivered to older members of the community in an environment governed by constantly changing regulatory requirements.

Over time, I became enamoured of the living and working environment of the nursing home. The unique nursing home environment fascinated me. Here I found registered nurses delivering care to residents and their families, without the interference of high technology common to hospital settings. In the nursing home there were no intravenous infusions or cardiac monitors to
take up the nurses' time. Here in the nursing home, nurses had the opportunity to deliver direct
care to care recipients, in an environment where highly technical equipment could not 'get in the
way' of the relationship which developed between nurses, residents and their families.

As a registered nurse myself, I was fascinated by the experiences of others working in the
nursing home. This fascination led me to reflect deeply on some of the ethical problems that the
nurses experienced in their day-to-day clinical practice. Many of the nurses at the nursing home
spoke to me about the ethical problems they experienced and how they managed those problems.
For example, they spoke to me of how they attempted to manage ethical problems concerning the
use of chemical and physical restraints or whether or not to tube-feed elderly dying residents.
The impetus for this research journey came, however, during a conversation between myself and
a registered nurse, where the nurse, out of sheer exasperation, exclaimed that someone should
research the ethical dimension of gerontic nursing, in particular how registered nurses go about
making ethical decisions.

The research journey’s destination suddenly became very clear to me and I realised that I needed
to know more about registered nurses’ ethical decision-making. I believed that the best way I
could discover this information was through the use of a qualitative research design. I believed
that a qualitative research approach would enable me to understand nurses’ individual views
about ethical decision-making, from their emic, or own, perspective.
1.3 My assumptions at the beginning of the journey

Just as a traveller has certain expectations about what their journey will be like and what they expect to see along the way, so I brought to this research journey a number of assumptions. Lincoln and Guba (1985) argue that researchers should make explicit the assumptions they hold about the research phenomenon under investigation as researchers have “no choice about representing some ideology - one cannot be alive without one. The real issue is whether one consciously takes account of it or it is left to guide one’s judgement without awareness” (Lincoln & Guba, p. 185).

In keeping with the views of Lincoln and Guba (1985), I will make explicit the assumptions I held at the beginning of this journey. The purpose of this explication is so that both I and the reader can take account of these assumptions in our understanding of this study. “Such a course is infinitely to be preferred to continuing in the self-delusion that methodology can and does protect one from their unwelcome incursions!” (Lincoln & Guba, p. 186).

One of my assumptions, that aged care is a “sleepy back-water”, has already been explored. Other assumptions that I held at the beginning of this journey were that:

• Similar to the populations of other countries of the western world, Australia’s population is ageing and therefore research into all areas of aged care, including gerontic nursing, is a priority;
• Life and death ethical problems such as euthanasia would be a significant ethical problem that registered nurses encountered in aged care. At the time this research journey was unfolding, the legislative assembly of Australia’s Northern Territory government became the first in the world to pass a law legalising voluntary euthanasia. Much media attention was paid to euthanasia during this time and I expected that the gerontic nurses’ interest in the topic would be as strong as that of the general publics;

• Registered nurses working in nursing homes draw on the ethical principles of autonomy, beneficence, non-maleficence and justice to inform their ethical decision-making.

• Qualitative methods of inquiry offer nurse researchers the opportunity to come to a deep understanding of the lives of research participants. Qualitative research methods provide useful information that can be used to develop recommendations for future nursing practice, education and research. In support of the use of qualitative methods of inquiry in aged care Kendig (1994) wrote that “it would be especially valuable to have research which examines the complex interactions among older people, family members and professionals in health and aged care” (p.159).

• Gerontic nursing practice provides a useful starting point for an examination of the ethical decision-making of registered nurses in a nursing home. Research into gerontic nursing should begin with an exploration of clinical practice and move from there to a consideration of the theoretical issues involved, not the other way around.
Other assumptions were revealed during the planning and preparation phase of this research journey and emerged during the course of the literature review that appears in the following chapter.

1.4 A glossary of the journey’s terms

When travellers’ journeys take them to unfamiliar lands, they usually find it beneficial to refer to documents that will help them to make sense of the unfamiliar sights and sounds they encounter. The following glossary of terms will be a useful reference point for those readers who are unfamiliar with the world of gerontic nursing as it covers the most frequently-used terms that appear in the following report of this research journey. For this reason the following glossary of terms are specific to gerontic nursing in a nursing home setting.

**Care recipient:** Residents of a nursing home and their family.

**Ethics:** Gerontic nurses doing what is right in order to maximise good for residents of the nursing home and their family

**Ethical decision-making:** The means by which gerontic nurses make ethical decisions.

**Gerontic nurse:** A registered nurse who provides nursing care to residents in nursing homes.

**Gerontic nursing care:** Professional nurse caring of residents of a nursing home.

**High level care:** High level care is delivered in nursing homes where residents experience a complex array of physical and psychological disorders.
Low level care: Low level care is delivered in hostels where residents care needs are of a lower level than those in nursing homes.

Nursing home: A health care facility that offers high level care to members of the community who are no longer able to live in their own homes or in low care facilities. Nursing homes provide 24-hour per day nursing care to residents.

Older person: A person over the age of 60 years.

Registered nurse: A nurse registered by the New South Wales Nurses’ Registration Board and who holds a current practicing certificate.

Resident: An older person who resides in a nursing home. A resident may be a permanent nursing home resident or someone who has entered the nursing home so that their family or carer can have a short period of respite. These residents are referred to as receiving ‘respite care’.
CHAPTER 2

PLANNING AND PREPARING FOR THE RESEARCH JOURNEY

I planned and prepared for this research journey by exploring a range of literature pertinent to gerontic nursing and ethics. The purpose of this planning and preparatory stage was twofold. Firstly, it helped me to understand some of the knowledge that already existed on the topic of gerontic nursing and ethics. This knowledge later underpinned the research discoveries and thus can be said to be assumptions that influenced research outcomes. Secondly, planning and preparation enabled me to articulate a research question that guided and illuminated the remainder of the research journey. Planning and preparing for the journey consisted of exploring literature pertinent to gerontic nursing, ethics and ethical decision-making.

2.1 Literature on gerontic nursing

In order to understand the ethical dimensions of gerontic nursing it is necessary to explore contextual literature on Australian nursing homes. The first section, therefore, explores literature related to Australia’s ageing population, Australian nursing homes, nursing home residents and nursing staff.

2.1.1 Australia’s ageing population

Scholars and demographers agree that the number of older Australians in the population is increasing (Khoo, 1995; National Institute on Aging (NIA), 1996; Commonwealth Department of Health and Aged Care, 2000; Jones, 2001; Aged and Community Care Services in Australia (ACSA), 2001; Safe, 2001). Debate over what constitutes an ‘old’ person has lead scholars to
adopt definitions that vary slightly. Bryan (1981) refers to an old person as someone who is over
the age of 65, as does Covey (1992). The United States National Institute on Aging (NIA),
however, defines an older person as someone over the age of sixty (NIA, 1996). For the
purposes of this literature review, I have adopted the NIA’s definition as much of the available
demographic details about older people are based on the assumption that a person becomes old
when they turn 60.

Demographic data provided by the NIA (1996) indicates that the total number of Australian
people aged 60 years and over in 1996 was 2,931,000 which represented 16% of the total
population. This number was predicted to rise to 5,914,000 or 26.6% of the population in 2025.
Like other countries in the Western World, the numerical growth in the percentage of Australia’s
population over 60 has been attributed to reductions in infant and maternal mortality rates, a
decrease in fertility rates, decreases in the incidence of infectious and parasitic diseases and
improvement in the people’s education and nutritional status (NIA, 1996). McMurray (2001)
illustrated the magnitude of this rise in the number of people over the age of 60 when she
described how globally, 1,000,000 people reach the age of 60 each month.

2.1.2 Australian nursing homes

Gerontic nurses in Australia provide care to older people in a range of health care settings
including nursing homes. In 1997, nurses provided high level care to older residents of 1466
nursing homes throughout Australia. This translated to the provision of 74,233 nursing home
Nursing homes are owned and operated by a range of Australian government and non-
government organisations. In the late 1990s just under half, or 48%, of Australian nursing home
beds were in nursing homes run by private for-profit organisations. Thirty eight percent of the
beds were in nursing homes run by private not-for-profit organisations while the remaining 14%
were in nursing homes run by state and local government (AIHW,1998).

From July 1996 to June 1997 108,628 Australians spent some time living in an Australian
nursing home either as a permanent or respite resident (AIHW, 1998). This represents a very
small proportion of the total population of Australians over the age of 60. The vast majority of
older Australians remain in their own homes and only a relatively small percentage of older
people require nursing home care (Legge & Westbrook, 1993; Mackinlay, 1997; Safe, 2001).
Despite this, the minority of older Australians who do require care in a nursing home have
significant care needs which must be consistently and adequately addressed by appropriately
qualified and motivated staff (Stevens and Onley, 2000; ACSA, 2001).

2.1.3 Nursing home residents

High level care is delivered to residents of nursing homes whose care needs are significant.
Residents of nursing homes experience a range of illnesses and disability which prevent them
from remaining in their own homes or from living in low care residential care settings such as
hostels (Foldes, 1990). The majority of nursing home residents experience chronic illness and
disability such as cardiovascular, musculoskeletal disorders or cognitive impairment (Kane &
Caplan, 1990) due to dementia (Henderson & Jorm, 1998; ACSA, 2001; Flicker, 2001). Vision,
hearing and speech deficits are common in nursing home residents (Kane and Caplan, 1990).
The greater proportion of nursing home residents is female (Jacelon, 1995; ACSA, 2001). During 1996-1997, 71% of nursing home residents were female (AIHW, 1998). This trend is likely to continue (de Vaus & Qu, 1997) and can be attributed to the fact that in Western countries women tend to outlive men (Blair & White, 1998). Many of the women who move into nursing homes do not have a spouse or partner living with them at the time of their relocation. Lack of a partner to provide them care was considered by Stevens and Onley (2000) to be a major contributing factor in their relocation to a nursing home.

A large proportion of nursing home residents spend more than three months in a nursing home (ACSA, 2001). As at June 1997, nine percent of permanent nursing home residents had been in a nursing home for less than three months, 21% had been a resident for between three months and one year, 50% for one year to five years and 20% for five years or more (AIHW, 1998). According to the ACSA (2001), the average length of stay for residents of a nursing home is 32 months. Nurses in nursing homes care for residents and their families over long periods of time and this affords them the opportunity to establish close, interpersonal relationships with the care recipients (Hudson & Richmond, 1994).

2.1.4 Stresses associated with relocation to a nursing home

For older people and their families, moving into a nursing home can be a devastating experience. The stresses associated with the nursing home move have been the subject of a considerable amount of scholarly activity (Zweig & Csank, 1975; Schultz & Brenner, 1977; Chenitz, 1983; Thomasma, Yeaworth & McCabe, 1990; Young, 1990; Zarit & Whitlach, 1992; Dellasega &
Research has indicated that older people and their families can feel a sense of extreme urgency and crisis during relocation to a nursing home (Chenitz, 1983; Dellasega & Mastrian, 1995). They can feel unsupported (Hudson & Richmond, 1994; Nay, 1996; Nolan and Dellasega, 1999), guilty (Johnson & Werner, 1982), confused (Zarit & Whitlach, 1992; Dellasega & Mastrian, 1995) and angry (Ade-Ridder & Kaplan, 1993). Family members' guilt can be exacerbated when others accuse them of shirking their familial responsibilities (Moody, 1992; McGuinness, 2000). Guilt is found to be reduced in limited circumstances such as where the older person has experienced immobility or where they have failed to recognise others (Johnson & Werner, 1982) or where the older person has been involved in the decision to relocate into the nursing home (Schultz & Brenner, 1977; Chenitz, 1983).

Older people may feel frightened at the thought of moving into a nursing home. In a recent study of very old people’s experiences of feeling old in which Nilsson, Sarvimaki & Ekman (2000) interviewed fifteen research participants aged from 85 to 96 years of age, the findings indicate that many expressed misgivings about falling ill and becoming in need of residential care in a nursing home. The phrases they commonly use when they refer to a nursing home move include being ‘packed off somewhere’ or ‘ending up in one of those terrible institutions’.

The negative emotional effects of nursing home relocation on older people and their families mostly outweigh any positive effects (Hoefel, 1979; Mikhail, 1992; Drysdale, Nelson &
Wineman, 1993; Nay, 1995; Nay, 1996; Phoenix, Irvine & Kohr, 1997). Of the few authors who have reported positive emotional outcomes Ross, Rosenthal and Dawson (1993) have recorded how spouses sometimes felt relieved of time consuming and physically-demanding tasks after their husband or wife had moved into a nursing home. In a similar vein, family members have reported having increased time for relaxation, jobs around the house and seeing friends and relatives (Bidewell, Ledwidge, Blanch & Johnson, 1999) after the placement of their relative in a nursing home.

Despite the overwhelming amount of literature reporting that relocation to a nursing home is highly stressful for residents and their family, relocation does not end family involvement with their relative (Courts, Barba & Tesch, 2001). Many family members continue to be heavily involved in the care of the resident, including the provision of physical as well as psychological care (Bowers, 1988). Other family members provide care to their relative in the form of an advocacy role (Mallet, 1993). Gerontic nurses who work in nursing homes are well placed to support families through the stresses involved in relocation and to facilitate continuation of their relationship with the resident (Chenitz, 1983).

2.1.5 Gerontic nurses in Australian nursing homes

Registered nurses, enrolled nurses, and assistants-in-nursing provide nursing services to residents of nursing homes. Registered nurses supervise the care delivered by enrolled nurses and assistants-in-nursing as well as provide residents with clinical and personal care. Enrolled nurses undertake a 12-month enrolled nursing certificate course while assistants-in-nursing may have no formal qualifications or may have undertaken a short assistant-in-nursing course.
Registered nurses manage nursing homes and assess, plan, deliver and evaluate resident care. They liaise with medical and other health care professionals to coordinate the overall care required by the care recipient (Hudson & Richmond, 1994) they work alongside residents, their family and friends to provide care that meets the unique needs of the older person (Pearson & Walsh, 2000).

Ethics plays a central role in the professional lives of registered nurses' working in the environment of the nursing home (Paier & Miller, 1991; Nazarko, 1995; Goodhall, 1997). Indeed, ethical decision-making is an “unavoidable part of ... living” (Preston, 2001, p. 11) and can be expected to be an integral aspect of the care that gerontic nurses deliver to nursing home care recipients (Kane & Caplan, 1990).

2.2 Literature on ethics

In order for this research journey to continue, it is necessary to explore pertinent literature relating to ethics. For this reason literature relevant to ethics and gerontic nursing and ethical problems in aged care appear in the following section.

2.2.1 Ethics and gerontic nursing

Although important to gerontic nurses, ethics and gerontic nursing have not been the focus of attention of a large number of nurse scholars. Nurses have much to contribute to the debate on ethics and nursing (Thompson, Melia & Boyd, 1988; Rumbold, 1989; Berger, Seversen & Chvatal, 1991; Davis & Aroskar, 1991; Scott, 1995; Scott, 1998) and gerontic nurses are no exception (Lund & Wei, 1990; Watson, 1994; Nazarko, 1995). “It is probably true that bioethics
is singularly one of the most important issues facing the nursing profession at this time - and one which nurses both individually and collectively cannot ignore” (Johnstone, 1989, p.vii).

Gerontic nurses should be encouraged to reflect on the ethical aspects of the care they deliver (Paier & Miller, 1991; Jenkins & Emmett, 1997). However, uncertainty over the meaning of ‘ethics’ is not uncommon amongst health professionals (Johnstone, 1989). This uncertainty may stem from confusion about what constitutes ethical phenomena, the realm of ethics and the relation between ethical theory and practice (Allmark, 1995). Johnstone (1989) urges all nurses to exercise great care when using the term ‘ethics’. It is fraught with danger, she argues for nurses to assume that all health professionals use the term with the same meaning in mind. Clarification of its definition will enable nurses to engage in ethical dialogue with scholars and colleagues (Johnstone, 1989; Chambliss, 1996) and will deepen their understanding of its impact on the quality of care the care recipient receives (Paier & Miller, 1991).

2.2.2 The meaning of ethics

According to the Fontana Dictionary of Modern Thought (1977), ethics is:

“The branch of philosophy that investigates morality and, in particular, the varieties of thinking by which human conduct is guided and may be appraised. Its special concern is with meaning and justification of utterances about the rightness and wrongness of actions ... the praiseworthy or blameworthiness of the agents who perform them, and the goodness or badness of the consequences to which they give rise” (p. 215).

For Beauchamp and Childress (1994), ethics is a generic term used to refer to the “various ways of understanding and examining moral life” (p.4). Taken in the context of nursing practice, Aroskar (1982) maintains that nursing ethics refers to an examination of the moral dimension of
nurses' decision-making and involves nurses reflecting on their individual obligation to patients within the context of their membership to a professional organisation.

Common to the definitions that appear above, and to other definitions of ethics that appear in the literature, is that an understanding of ethics involves an understanding of the notion of morality (Fry, 1988; Moss, 1995). Kelly (1991) describes the discrete yet inter-related concepts, ethics and morality, when she says that morality involves a private set of values that an individual ascribes to, whereas ethics involves a formalised, universal and public group of values.

Conversely, Johnstone (1989) argues that no distinction should be drawn between ethics and morality and that such a distinction only serves to add to the confusion that nurses experience when they involve themselves in ethical debate. However, for the purposes of this literature review, I have adopted the approach taken by Kelly (1991) that ethics and morality are separate but related terms, as this approach reflects the common-use meanings by nurses and gerontic nurses. In the context of this study, ethics is considered to mean gerontic nurses doing what they feel is right in order to maximise good for residents of the nursing home and their family.

2.2.3 Ethical problems in aged care

Ethics is an important aspect of nursing care of older people and their families in a nursing home (Kane and Caplan, 1990). The literature indicates that it is not uncommon for gerontic nurses to encounter a range of challenging ethical problems in their day-to-day practice (Kane and Caplan, 1990; Beerman, 1997).
Gerontic nurses may experience ethical problems in a range of circumstances. Authors have identified how nurses in aged care may experience ethical problems when they believe they know what the right course of action is, but are faced with institutional constraints which prevent them from acting the way they wish (Thomasma, 1991; Redman & Hill, 1997) when they have to decide between upholding the care recipient’s wishes when they believe that by doing so they will cause the care recipient harm (Callahan, 1993) or when they have to balance the rights of some residents with the rights of others (Gorman, 1996). The literature review indicates that gerontic nurses also experience ethical problems when their view of what is right conflicts with the views of others involved in the resident’s care (van Hooft, Gillam & Byrnes, 1995).

The literature review reveals that many scholars of aged care have focused their attention on life and death ethical problems such as artificial feeding of residents at the end stages of their lives (Akerlund & Norberg, 1985; Bernat, Gert & Mogielnicki, 1993; Peck, Cohen & Mulvihill, 1990; Goodhall, 1997), euthanasia (Hunt, 1994; Watson, 1994; Tulloch, 1996) and advance directives (Diamond, Jernigan, Moseley, Messina & McKeown, 1989; Parkman & Calfee, 1997). While life and death ethical problems are described as significant and pressing problems for staff working in aged care, they represent only a proportion of the ethical problems that gerontic nurses encounter (Lund & Wei, 1990).

In their book *Everyday ethics resolving dilemmas in nursing home life*, Kane and Caplan (1990) draw attention to other ethical problems, which they refer to as “ordinary [or] small” (p. 38). The ordinary ethical problems to which Kane and Caplan (1990) refer, occur frequently, do not involve life and death decisions but nonetheless involve decisions that have the potential to impact
significantly on the older person’s quality of life. Ordinary ethical problems include problems like: who should share their nursing home room with whom and who should sit in a particular sitting room chair (Kane & Caplan, 1990). Ordinary ethical problems involve questions about everyday occurrences such as what the resident wishes to do, eat and wear (Mattiasson & Andersson, 1995).

A disproportionate number of references reviewed during this literature review indicate that generally authors emphasise life and death, or extraordinary, ethical problems at the expense of those that are ordinary in nature. This may be because life and death problems are seen by health professionals and scholars to be more ‘glamorous’ (Johnstone, 1989) than ordinary ethical problems and as such more pressing and worthy of attention.

Caplan (1990) and Kane and Caplan (1990) argue that ordinary and extra-ordinary ethical problems are equally deserving of the attention of gerontic health professionals and scholars. Both types of ethical problems constitute the world of living and working in a nursing home (Caplan, 1990), therefore, it is “simply wrong to think that [ordinary ethical problems] are less momentous or deserving of careful thought and deliberation” (Caplan, 1990, p. 39). The over-emphasis of extraordinary ethical problems at the expense of ordinary problems evident in the literature fails to portray aged care in all its complexity.

“An exclusive focus on the highly dramatic issue of the ethics of stopping or withdrawing medical care draws attention away from the many other equally wrenching ethical dilemmas that those who live or work in nursing homes experience” (Caplan, 1990, p.37).
2.3 Literature on ethical decision-making

The final section of this literature review relates to ethical decision-making. This section covers gerontic nurses’ experience of managing ethical problems, factors affecting gerontic nurses’ ethical decision-making, principle-centred ethics, virtue ethics, the ethic of care and integrating principle-centred ethics and the ethic of care.

2.3.1 Gerontic nurses’ experience of managing ethical problems

The literature indicates that health professionals generally find it difficult to make ethical decisions (Beerman, 1997; Riley & Fry, 2000)

“These are stressful and emotional times that call on our resources and training to help patients and their families. This is also the context within which most of our ethical problems emerge; these are the situations in which we find ourselves not knowing what to do, what to say, what to advise, or where to go for help” (Pierce, 1997, p1).

Gerontic nurses also find it difficult (Akerlund & Norberg, 1985) and commonly experience negative emotional responses when they seek to manage ethical problems, such as feeling upset and disturbed (Berger, Seversen & Chvatal, 1991), anxiety (Akerlund & Norberg, 1985), distress (Menzies, 1970) or uncertainty (Goodhall, 1997)

Factors such as nurses’ personal values (Palmore, 1999) and the contextual conditions of nursing homes have been identified as likely to impact on gerontic nurses’ ethical decision-making. This topic will be the subject of the next section of the literature review.
2.3.2 Factors affecting gerontic nurses' ethical decision-making

The literature indicates that nurses' personal values influence the ethical decisions they make (Murphy, 1986; Scott, 1995) and their personal values may reflect the values held by the society in which they live (Scalzi & Nazarey, 1989). Two values that have the potential to affect gerontic nurses' ethical decision-making are biomedicalism and ageism (Palmore, 1999). In addition to the influence of personal values, a number of contextual conditions may also impact on gerontic nurses' ethical decision-making such as tension between nurses and doctors, the physical environment of the nursing home and gerontic nursing's unflattering image.

2.3.2.1 The biomedical model

The influence of the biomedical model has been extensive throughout health care as a whole (Katz, 1992; Paier & Bowdish, 1995; Chambliss, 1996; Sidell, 1998) and in aged care (Bates & Lapsley, 1985). The biomedical model is one in which the "health professional assumes the rhetoric and popularly conceived image of the scientist [who] deals only with facts, divorcing himself (sic) from all questions of ethics and value considerations in the decision-making process" (Carper, 1979, p. 15). This model of care focuses on cure rather than care (Aroskar, 1982; Pellegrino, 1985; Colliere, 1986; Gething, 1999; Reed & Clarke, 1999) and is technologically driven (Bates & Lapsley, 1985; Gadow, 1985; Cheah & Moon, 1993).

Within this paradigm, patients who do not 'fit', because their conditions do not lend themselves to cure through technological means, are viewed as failures (Bates & Lapsley, 1985) and 'bed-blockers' (ACSA, 2001) because they require longer than usual periods of hospitalisation (Gething, 1999). The literature has indicated that many older people fall into this category and are viewed as poor candidates for medical interventions (Binstock & Post, 1991) because a
significant number of older people experience chronic, incurable illness (Nolan, 1994). The biomedical approach has come to view old age as a “problem to be solved by science and medicine” (Andrews, 1999, p.3). However, for many older people and their families, the curative orientation of the present-day health care system has little to offer them (Cheah & Moon, 1993; Nolan, 1994).

The dehumanising effects of the biomedical model on elderly care have been illustrated poignantly in the book *A very easy death* by the French author Simone de Beauvoir (1969). The book is an account of the death of the author’s mother from bowel cancer and includes Simone and her sister’s impressions of some of the health professionals who cared for their mother prior to her death. One doctor, Dr ‘N’, was not liked by the author because of his need to defy death and keep her mother alive at all costs. The paradigm that Dr ‘N’ worked in, the biomedical model, meant that he did not see de Beauvoir’s mother as a person but merely as a scientific experiment.

### 2.3.2.2 Ageism

Another societal value that may influence gerontic nurses’ ethical decision-making is ageism. Ageism, or the discrimination of people on the basis of their age (Levin & Levin, 1980; McMinn, 1996), is common in Western society which values youth over age (Friedan, 1993) and is consistently reinforced by the mass media (Gunter, 1971; Friedan, 1993; McMinn, 1996) which worship youth over age and where most older people are portrayed as being boring, silly and dull (McMurray, 2001). Ageism can result in nurses viewing older people according to commonly-held negative stereotypes. For example, they may view all old people as being a
burden to others (McMinn, 1996; Hall, 2000), selfish (Binstock & Post, 1991), sick, dodderly, senile, helpless and asexual (Jones, 1993).

Nurses' work practices may demonstrate ageist attitudes, for example, when they describe older people using demeaning language (McMinn, 1996) such as 'oldie' or 'geri' (Kneipfer, 1989), when they are cold and distant toward them (Flaskerud, Halloran, Janken, Lund & Zetterlund, 1979), ignore them (Brooker, 2001), use baby-talk when conversing with them (Caporael, 1986), focus on nursing tasks rather than interacting with the older person during care activities (Wagnild & Manning, 1985) or infantilising the relationship between the nurses and the residents by scolding them or sending them to their room (Storlie, 1982).

The apparent ambivalence of nurse educators to gerontic nursing has been evident in the past (Cheah & Moon, 1993) and has been a major contributing factor to the ageist attitudes expressed by student nurses when they say they would prefer not to care for the aged (Ellis, 1999). Nay, Garratt & Koch (1999) has described how there has been

"limited recognition of elderly care in undergraduate nursing curricula, inappropriate placements of student nurses in aged care facilities that lacked positive role approaches, insufficient positive role approaches among university faculty, and pitying responses to new graduates who have gained a placement in aged or extended care" (p. 15).

Factors such as those cited by Nay et al. (1999) have only served to add to student nurses' beliefs that gerontic nursing is a poor career choice.

Estes and Binney (1989) have argued that, as the care of the aged becomes increasingly biomedicalised, so health professionals working in gerontology increasingly adopt the ageist
values expressed by society at large. Ethical decisions made by gerontic nurses based on the influence of the biomedical approach and ageism, may result in recommendations for inappropriate treatment choices (Palmore, 1999) for older people and their families. For example, services for the aged may be recommended that are based on the assumption that all older people are relatively helpless and dependent and such services may be adopted “without adequate concern as to whether the outcome of these services contributes to reduction of freedom for the participants to make decisions controlling their lives” (Palmore, 1999, p.15).

2.3.2.3 Contextual factors

Chambliss (1996) argues that health care facilities are not only the setting for a vast array of ethical problems, but that their organisational context actively generates the emergence of ethical problems. While his arguments centre on the general hospital setting, much of Chambliss’ (1996) critique has relevance to nursing home settings.

Health care settings, including nursing homes, consist of contextual influences which may enhance the likelihood of the emergence of ethical problems. When nurses experience ethical problems because they believe they know what the correct course of action is, but are faced with institutional constraints which prevent them from pursuing what they think is right (Steinfels, 1997), they experience distress which Jameton (1984) refers to as “moral distress” (p. 6).

Gerontic nurses may experience moral distress that can be attributed to organisational influences occurring in nursing homes. Chambliss (1996) refers to longstanding tension between nurses and doctors as one source of moral distress for nurses. This can occur for gerontic nurses as it
does for nurses in other settings. Other contextual conditions common to nursing home settings which may contribute to gerontic nurses' moral distress relate to the physical context of care in nursing homes, gerontic nursing's unflattering image and the institutional culture of nursing homes.

2.3.2.4 Tension between gerontic nurses and doctors

According to Chambliss (1996), organisational influences which enhance the likelihood of nurses' moral distress largely spring from "well-articulated disputes between interest groups" (p.95). Most notable, says Chambliss (1996), is the conflict that occurs between doctors and nurses over ethical problems concerning whether to stop aggressive treatment for the terminally ill. The doctor's reluctance to stop aggressive treatment can conflict with the gerontic nurses' feelings of futility, especially when the patient requests to be left alone, thus resulting in an ethical problem for the nurse.

2.3.2.5 The physical context of the nursing home

The physical context of the nursing home where residents share their living and sleeping spaces with other residents creates ethical problems for gerontic nurses. Drawing on the work of Goffman (1968) on total institutions, Jilek (2000) describes how the social conditions or "normal circumstances, regimes, rules or rights that are generally enjoyed by individuals living in the community" (p. 16) can be significantly altered when an older person moves into a nursing home resulting in a life that is disempowered, because the physical context of the nursing home frequently prevents residents from undertaking the ordinary, day-to-day tasks they prefer. The outcome of this disempowerment may see nursing home residents experiencing loss of dignity,
personal identity and functional decline. Other negative effects that may result from the nursing home context are that the resident may become excessively passive and assume a ‘sick’ role.

Ethical problems stemming from the physical context of the nursing home are particularly difficult in circumstances where cognitively intact and cognitively impaired residents share the same residential spaces (Gorman, 1996). In these circumstances, gerontic nurses are faced with decisions about whose rights should predominate and whose should not. When cognitively impaired residents exhibit socially unacceptable behaviour, their behaviours often impinge on the privacy of other residents thus leaving the cognitively intact residents feeling disenfranchised and enervated (Gorman, 1996). Gerontic nurses in these situations are called on to balance the rights of one resident with the rights of others and manage the ethical problem in such a way that is satisfactory to the residents and the nurses themselves.

2.3.2.6 The unflattering image of gerontic nursing

Another contextual influence on the ethical decision-making of gerontic nurses relates to gerontic nursing’s unflattering image. Australian society’s negative image of gerontic nursing may stem from the community’s belief that gerontic nursing is depressingly tedious, mundane and of little value because gerontic nurses generally care for chronically ill older people who rarely have spectacular cures and go home (Kneipfer, 1989). This view is exacerbated by the belief amongst the nursing community that nurses who work in aged care have lost their nursing skills and are at the bottom of the nursing barrel (Davis, 1997; McMurray, 2001).
Gerontic nurses thus find themselves making important ethical decisions in an environment in which they feel undervalued by society in general and marginalised by their nursing colleagues. Speaking from the perspective of mental health nurses, Lutzen and Schreiber (1998) make the point that institutional culture and social context impact significantly on nurses’ ethical decision-making. Their argument that mental health nurses need to feel supported both personally and professionally in the workplace and that such support impacts directly on their ethical decision-making, would hold true for gerontic nurses.

2.3.2.7 Institutional culture

A limited number of authors have explored the impact of the institutional culture of nursing homes on nurses’ ethical decision-making. Institutional cultures that support an ‘assembly-line’ approach to care where nurses have “neither the incentive or inclination to become involved with patient care in a concerned, expressive and physically present way” (Flaskerud, Halloran, Janken, Lund & Zetterlund, 1997, p.160) have been found to adversely affect nurses’ ability to act ethically. For Levine (1977), a nurse who practices ethically is one who is willing to enter into a partnership with the patient where dramatic and trivial moments of life are shared. She says “The willingness to enter with a patient that predicament which he (sic) cannot face alone is an expression of moral responsibility [of the nurse]” (p. 845).

In nursing home cultures where care is delivered according to a routinised institutional model of care, nursing tasks are completed within predetermined time frames and nursing home residents are viewed, not as people, but as busy work to be completed within the course of a full day (Hoefel, 1979; Setterlund, 1998). In these situations, nurses are unable or unwilling to form
partnerships with care recipients. Lintern (2000) describes how this model of care resulted in care practices where nursing home toilet rounds and bath rota are undertaken at a time convenient to staff not residents. Meal times, visiting times and sleeping times (Childress, 1990) are all regulated to enable the smooth running of the nursing home.

Routinised models of care have as their focus the smooth operation of the nursing home organisation. The needs of the residents and their families are seen to be secondary to the organisation's goals. Routinised models of care result in staff having limited opportunities to develop meaningful relationships with residents (Setterlund, 1998) and little concern for residents' individual care needs or the concepts of choice, privacy and dignity (Nolan & Grant, 1993). Routinised institutional regimes have been found to have a detrimental effect on residents because they limit the amount of control the residents have over their own lives (Booth, 1986).

Nursing home residents who experience this style of nursing care feel "dominated by the demands of the work timetable, powerless to have any influence on their own care and unable to express their individual needs" (Koch & Webb, 1996, p. 955). Care structured on routines is also found to limit the amount of control residents exercised over their lives (Booth, 1986).

2.4 Principle-centred ethics

In order to overcome the influence personal values and contextual influences have on ethical decision-making, scholars have ascribed to the belief that the application of ethical principles will overcome any subjectivity involved in the ethical decision-making process (Botes, 2000b).
The literature indicates that the predominant focus of current bioethical debate has therefore centred on a traditional approach to ethics whereby ethical principles have been posited as the dominant mechanism for managing all ethical problems (Fry, 1989; Moody, 1992; Lutzen, 1997).

The principle-centred approach to ethical decision-making is based on the assumption that there exist universal principles upon which everyone agrees (Lutzen, 1997) and where “moral choice involves consideration of competing principles. Reason provides the means for adjudicating between these principles” (Cooper, 1991, p. 23). Based on this paradigm, people share the same rights, duties and moral obligations and are “governed by the same public norms, rules, and principles, in a construct that enhance[s] moral predictability and consistency” (Cooper, 1991, p.23). Consequently, when people apply ethical principles in the same way, they should all reach the same conclusion. “The moral agent … is impartial and objective. The idea is, in this way, to eliminate arbitrariness and subjectivity” (Botes, 2000b, p. 1077).

Four ethical principles have traditionally underpinned the principle-centred approach to ethics and have, in the past, been seen to be foundational to much bioethical debate (Beauchamp & Childress, 1994). These are the principles of autonomy, beneficence, non-maleficence and justice (Beauchamp & Childress, 1994; Clarke, 1995; Yeo, 1995; Beerman, 1997; Berglund, 1997) where autonomy refers to respect for the rights of others (Garfield, 1997; Orb, Eisenhauer & Wynaden, 2001), beneficence refers to doing good and non-malificience relates to the prevention of harm (Beauchamp & Childress, 1994). The fourth ethical principle, justice, relates to the notions of equal share and fairness for all people (Favor, 1997).
The literature indicates that nurses have embraced the principle-centred approach to ethics (Yeo, 1991). “The majority of studies have assumed that the operant moral framework in nursing practice is a principle-orientated framework” (de Casterle, Roelens & Gastmans, 1998). The predominant place given to principle-centred ethics has resulted in the development of ethical decision-making approaches for nurses which have as their foundation one or more of the four ethical principles. Ethical decision-making approaches such as those devised by Thompson, Melia and Boyd (1988) draw heavily on the assumption that ethical principles “can provide guidance and direction for any nursing staff member in any nursing situation” (Milner, 1993, p.23).

Thompson et al. (1988) have developed an ethical decision-making approach for nurses that is based on ethical principles and the nursing process. Ethical problems, the authors argue, should be managed according to the four steps of the nursing process, namely, assessment, planning, implementation and evaluation. The authors argue that the utilisation of ethical principles occurs during the assessment phase of the nursing process and is an integral aspect of nurses’ assessment of the ethical problem at hand.

Darzins, Molloy and Strang’s (2000), capacity assessment approach is based heavily on the ethical principle of autonomy. In their approach, Darzins et al. (2000) draw on autonomy to present health care workers with an approach that enables them to determine the decision-making capabilities of their elderly clients. Darzins’ et al. (2000) six-step capacity assessment process involves: determination that a valid trigger for the assessment is present; involvement of the older person in the capacity assessment process; gathering information that will assist in the
capacity assessment; education of the older person regarding health care issues important to their lives; undertaking assessment and acting on the results of the capacity assessment.

The difficulties associated with the utilisation of ethical decision-making approaches based on ethical principles is highlighted by Hayne, Moore and Osbourne (1990), who take the position that one decision-making approach is unlikely to be able to address the variety of ethical problems nurses experience in a range of clinical settings. In addition, some authors have begun to question the hegemony of principle-centred ethics (Jecker, 1997). “Principle-centered ethics has come under fire for its almost formulaic approach to ethics” (Pellegrino & Thomasma, 1993, p. xi) because ethical principles fail to take into consideration the nuances of real-life situations in health care practice which define ethical problems (Scott, 1995). “Obeying them [ethical principles] to the letter does not provide a failsafe mechanism for achieving moral goodness, because context and perception are also important influences on moral decision-making and behaviour” (Scott, 1995, p. 281).

Remedies to the perceived difficulties associated with principle-centred ethics have been sought in a variety of alternative ethical decision-making approaches (Pellegrino & Thomasma, 1993). Two of these alternative paradigms, virtue ethics and the ethic of care, have been the subject of a great deal of interest in the ethics literature and will thus be the subject of the next two sections. Both of these approaches have a great deal to contribute to the debate on nursing and ethics, however their strength lies in the complementary nature of the alternatives with principle-centred ethics. The alternative paradigms enrich and supplement principle-centred ethics because, as
Pellegrino and Thomasma (1993) argue, the limitations of one approach are balanced by the strengths of the other.

2.5 Virtue ethics

The origins of virtue ethics lie in ancient Greek philosophy (Pellegrino & Thomasma, 1993), particularly in the works of Aristotle (Allmark, 1998). It has been claimed that virtue ethics is the oldest ethical perspective in western philosophy (Putman, 1991; Botes, 2000,b). Virtue ethics defines goodness,

"in terms of the kind of person one is ... instead of examining the consequences of health professional’s choices or actions themselves, virtue ethics regards choices and actions as reflections of the character internal to a person" (Fry, 1988 p. 98).

Thus, virtue ethics challenges people to reflect on the kind of person they are, or intend to be, in any given situation (Hofmeyer & Cecchin, 2000). "Virtue ethics focuses on what the moral agent is to be, rather than on what one is to do" (Fowler, 1986, p. 528), so virtuous nurses ask themselves the question ‘who ought I be?’ (Tuckett, 1998; Tuckett, 2000). Virtue ethics focuses on the character of the person rather on their ability to follow ethical principles to the letter (Scott, 1995).

Virtue ethics recognises the positive benefits of a range of qualities in individual people. "Virtues are qualities which are necessary in order to reason well about living a good, flourishing life. These virtues are potentially present in most human beings ... a virtuous person is one who cares about the right things in the right way" (Allmark, 1998, p. 468). For Johnstone (1989) the qualities essential to a virtuous nurse are respect, care, compassion, kindness, genuineness, warmth,
trust and empathy. Other virtues that have been identified as being important to health professionals are fidelity, compassion, phronesis (practical wisdom), justice, fortitude, temperance, integrity and self-effacement (Pellegrino and Thomasma, 1993). For Moss (1995) ethical nursing practice requires nurses to have two virtues, humility and courage.

A number of objections to virtue ethics have been explored by Veatch (1985) who argues that virtue ethics may be dangerous because “naked virtue together with the wrong virtues may well lead to wrong acts even though the intentions of the actor may be well-meaning” (p.337). Thus, training in virtue ethics does not guarantee that moral agents will do the right thing by their fellow human beings.

Sound ethical decision-making is thus dependent on more than people merely exhibiting the qualities of a virtuous person (Beauchamp & Childress, 1994). Pellegrino and Thomasma (1993) argue that ethical decision-making based on virtue ethics should be complemented with principle-centred ethics. They state “No matter what theory of ethics one espouses … the moral agent is a constant factor in the implementation of the moral act … Virtue, the virtues, and the virtuous person are unavoidable conceptions” (p. xiv) and later they write “ … a proper balance must be struck between rule-based and virtue-based ethics” (p. 19).

2.6 The ethic of care

Along with virtue ethics, the ethic of care has been posited either as an alternative to principle-centred ethics (Noddings, 1984) or as complimentory to it (Pellegrino, 1985; Olsen, 1993). Before proceeding with an exploration of the notion of the ‘ethic of care’ it is useful for the
reader to increase their understanding of caring and nursing. Such a course of action is beneficial because scholars have argued that caring is central to nursing (Peplau, 1952; Gaut, 1983; Watson, 1985; Fry, 1988; Crane, 1991; Lawler, 1991; Lumby, 1991; McMillan, 1997; Arthur, Pang and Wong, 1998; Nay, 1998) and that it is compatible with the philosophical foundations of nursing (de Casterle, Roelens & Gastmans, 1998).

2.6.1 Caring and nursing

Despite numerous scholars agreeing that caring plays a central role in nursing, consensus amongst them over its definition is yet to be reached (Arthur, et al. 1998). According to Benzein and Saveman (1998), it is not unusual for concepts critical to nursing to lack clear definition. In the past caring has not been seen as worthy of scholarly interest (Gray & Pratt, 1991) as it has been associated with women’s natural maternal characteristics (Dean & Bolton, 1980) and therefore undervalued (Lumby, 1991). The current lack of definition for caring is of concern to van Hooft (1987) who claims that, unless it is carefully defined, caring may be in danger of becoming an unattainable goal for nurses.

An alternative to seeking a definition for caring is proposed by Gaut (1983) who posits instead that caring should be understood in terms of a ‘family of meanings’ (Kaplan, 1964). “When one speaks of a family of meanings, resemblance is not a matter of some definite features common to all members of the family, but the sharing of some features or other, enough to show the resemblance by any two members of the family” (Kaplan, 1964, p. 48). The family of meanings appropriate to caring is “attention to or concern for; responsibility for or providing for, regard, fondness or attachment” (Gaut, 1983, p. 315). In the context of this study, gerontic nurse caring
involves gerontic nurses providing for, having regard for, and feeling fondness and attachment for residents of nursing homes and their families.

Such a family of meanings for gerontic nurse caring is supported by the writings of numerous authors. The literature indicates that caring gerontic nurses take the time to look in on residents’ families to see if they need anything, stay with them during stressful times but also know when to provide them with privacy (Wilson & Daley, 1999). Family members identify gerontic nurses as caring nurses when they listen to them (Pincombe, O’Brien, Cheek & Ballantyne, 1996), answer their questions (Kellet, 1996), support them in their expressions of grief (Wilson & Daley, 1999) and when they advocate on their behalf and take the time to get to know them as individuals (Pincombe et al. 1996). Smith and Sullivan’s (1997) findings show that nursing home residents believe that gerontic nurses are caring when they put them first, speak to them in understandable ways and take into consideration the best time to speak with them about issues surrounding their care. In this way the residents can obtain honesty from the nurses and participate in informed dialogue.

In an Australian study, Nay (1993) finds that residents perceive caring gerontic nurses to be those who are cheerful, interested and who enjoy their work. Nay (1993) also finds that caring nurses are those who are seen to minimise residents’ embarrassment and feelings of being a burden. In research conducted by McMillan (1997), residents of four nursing homes in New Zealand describe how caring nurses sought to meet their physical, spiritual, psycho-social and cultural needs. Residents of the nursing homes also identify how they appreciate gerontic nurses who seek to meet their need for love and belonging. It was found that residents’ needs are more
likely to be met in nursing home environments which foster the development of close interpersonal relationships between care recipients and care givers. Bowers (1988) finds that family members appreciate gerontic nurses who demonstrate a broad focus of care that includes the psychological aspects of their care and feel frustrated with nurses whose focus is so narrow that they only concern themselves with the technical aspects of care delivery.

It has been argued that caring flourishes in situations in which carers and care recipients develop a close interpersonal relationship (Davies, 1998). As nursing has long been recognised as an activity based on the establishment and maintenance of interpersonal relationships that support the physical and emotional needs of care recipients (Kitson, 1987; May, 1990; Williams & Irurita, 1998), caring has been found to underpin the work undertaken by nurses in a range of settings including nursing homes and can be viewed in terms of being a personal and professional value (Pellegrino, 1985). In the context of nursing practice, the ethic of care is a philosophical perspective that highlights caring as foundational to all nursing activities. In other words, it is a moral guide for the conduct of all nursing practice (Fry, 1989; Young-Mason, 2001).

2.6.2 The origins of the ethic of care

Much of the work on the ethic of care can be attributed to the writings of Carol Gilligan (1977, 1982, 1987). Her work is centred on the notion that women and men approach moral reasoning in different ways and was originally developed in response to research conducted by Lawrence Kohlberg (de Casterle et al. 1998) which postulates that individuals at their most advanced stage of moral development utilise the ethical principle of justice to guide their moral decisions (Fry,
1989). As an alternative to Kohlberg's thesis, Gilligan (1982) proposes a level of moral reasoning for women that is a 'different voice' to that of men. For Gilligan (1982) the feminine perspective of moral reasoning involves an ethic of care that demonstrates women's interdependence with others, in contrast to the masculine perspective of moral reasoning that is based on an ethic of justice.

According to Gilligan (1977) women use an approach to moral reasoning whereby they pass through three levels of development with transitions between each level. Their moral development evolves through the levels beginning with an "early focus on 'no hurt', when the concern of the young female is not to cause any, or at least not much, hurt, to a later more mature concern and responsibility for self and others" (Huggins & Scalzi, 1988, p. 45). Following on from the work of Gilligan (1982), Noddings (1984) delineates a 'feminine' approach to moral reasoning which has at its foundation receptivity, or being open to the experiences of others, reciprocity, or being able to give and take in caring, and relatedness, referring to women's relationship with others. Within an ethic of care women's moral responses are individualised within interpersonal relationships and guided by notions such as friendship, love and care (Cooper, 1989).

2.6.3 Nursing and the ethic of care

Many nurse scholars have embraced the notion of the ethic of care and have argued that its potential for the nursing profession is great (Huggins & Scalzi, 1988). One reason for this is that it seems to "offer a different way of doing things from mainstream ethics [and] partly because it is linked to feminism (and nursing is a female dominated profession)" (Allmark, 1998, p. 466).
Another reason that nurses have embraced the ethic of care is that there appears to be a natural link between it and nursing as “the ethic of care would seem, intuitively, to fit the reality of nursing well” (Huggins & Scalzi, 1988, p. 46).

Much of the literature on the ethic of care appears to focus on the notion that female nurses are more likely to be caring compared to their male counterparts. Kuhse (1997) criticises the ethic of care from the point of view that it seems to be supporting the notion that men cannot be caring, or have feelings of care for others. Chinn (1989) argues that all nurses, regardless of their gender can incorporate the feminist ethic of care into their everyday praxis or practice.

Some scholars have questioned whether the ethic of care can adequately form a foundation for nursing practice. For example, Olsen (1993) identifies factors that may affect nurses’ ability to care for others and which may be problematic, “factors that have been known to affect caring, but ought not to are race, religion and economic status ... the patient’s demeanor, the patient’s dependence on the nurse ... and the patient’s culpability for the painful condition he/she is in” (p. 1697). For the ethicist, Kuhse (1993), the ethic of care falls short in its attempt to evolve as a framework for nurses’ ethical decision-making.

“An adequate ethics needs to be able to guide and justify actions and recently articulated nursing ethics of care fail in this regard. While these approaches typically exhort nurses to develop caring attitudes or dispositions, they are silent when it comes to the grounding and justification of morally significant actions” (p.32)

Loewey (1996) continues in a similar vein when she argues that merely caring for someone does not provide nurses with a framework for making sound ethical decisions.
2.7 Integrating the ethic of care and principle-centered ethics

The literature has indicated that one way that scholars can overcome weaknesses associated with principle-centred ethics and the ethic of care is to formulate an approach to ethical decision-making that is based on an integration of both paradigms (Sherblom, Shipps & Sherblom, 1993; Olsen, 1993; Botes, 2000a; Botes, 2000b). For Flanagan and Jackson (1987) there is no logical reason why the coupling of ethical principles and the ethic of care cannot be undertaken. The advantages of this synthesis to nurses would be that they would see patients as

"equally worthy, equally dignified human being[s] ... such an outlook of others is simultaneously a universal principle equally applicable to any and all individuals irregardless of any factor other than their humanity, and contextually specific in that caring is induced by a specific person based only on their being human" (Olsen, 1993, p. 1699).

Like Olsen (1993) and Flanagan and Jackson (1987), Botes (2000b) also calls on health professionals to use an integrated approach to ethical decision-making. To operationalise such an approach health care professionals need to extend their rationality and discourse (Botes, 2000b) about the ethical problems they encounter.

For Botes (2000b) the notion of extended rationality is dependent upon health professionals participating in a "communicative version of rationality" (p. 1078) whereby consensus over ethical problems is achieved through discourse between health professionals, care recipients and their families. Such a discourse includes the application of ethical principles from a "holistic and contextual perspective to understand and interpret the ethical problem" (p. 1078).
A limited number of authors have described how an integrated approach to ethical decision-making can be operationalised by nurses. Cooper (1991) has approached this issue from the point of view of critical care nurses and Austin (2001) from the perspective of forensic psychiatric nurses. No scholars were found to have addressed this issue from the point of view of gerontic nurses.

In a study conducted by Cooper (1991) of eight critical care nurses, the author describes how the ethical principles of autonomy and beneficence provide the beginning frame of reference for critical care nurses’ ethical decision making. Within this framework the nurses incorporate an ethic of care by engaging with the patient as “the particularities of the patient’s experience became a part of the nurses’ moral considerations” (p. 25). A creative tension thus ensues which sees the nurses’ ethical decision-making broadened from sole reliance on ethical principles to encompassing the complexities, uncertainties and emotionally-laden aspects of the particular patient’s unique experiences.

Speaking from the perspective of forensic psychiatric nurses, Austin (2001) describes the operationalisation of an integrated approach to ethical decision-making, known as relational ethics, which is based “on the assumption that ethical practice is located in relationship” (p. 14). This approach has its foundation in the understanding that the ethical principles of non-malificence, beneficence, autonomy and justice form a guide to ethical practice when they are placed in the context of the “intricate, close-up relationships” (Austin, 2001, p. 14) that exist between psychiatric patients and nurses.
The three core elements of a relational ethic, mutual respect, engagement and attention to environment, are enacted in order that a relationship is developed between nurses and patients whereby nurses respect the patient's interdependence on others, engage with patients by deepening their understanding of the patient's situation, perspective and vulnerability and respond to the patient's uniqueness. An understanding of the environment in which ethical decisions are made is important to the relational ethic. Questions such as "Does the environment allow us to act as we think best? Does it encourage us to question? Does it crush us into silence?" (Austin, 2001, p. 15) are the types of issues that need to be considered by nurses practising within this approach to ethical decision-making. The integrated approach to ethical decision-making, relational ethics, provides psychiatric nurses with the framework to make sound ethical decisions that are based on sensitivity to the particular care situations they encounter in the highly challenging environment of the forensic psychiatric setting.

2.8 Reflecting on the planning and preparation for the research journey

While undertaking planning and preparation for this research journey, I had the opportunity to reflect deeply on the nature of the literature that related to gerontic nursing, ethics and ethical decision-making. In summary, the literature review revealed that similar to other countries in the western world Australia’s population is aging. Despite the fact that only a small proportion of Australia’s older people live in a nursing home, the nurses who care for nursing home residents and their families are likely to be called on to make ethical decisions. Factors that affect gerontic nurses’ ethical decision-making are, the biomedical model and ageism and a range of contextual factors relating to the nursing home environment such as tension between gerontic nurses and doctors, the physical context of the nursing home, the unflattering image of gerontic nurses and
institutional culture. The literature revealed that nurses in general draw on principle-centered ethics, virtue ethics and the ethic of care when making ethical decisions or they may utilize a combination of these approaches.

It became apparent to me during this aspect of the journey that there existed a dearth of literature that related to the specific way in which gerontic nurses made ethical decisions in nursing homes. This strengthened my earlier understanding (see chapter 1) that I needed to know more about the ethical dimension of gerontic nursing practice in particular how the nurses make ethical decisions.

2.9 The research question

In order to overcome the dearth of literature that existed about how gerontic nurses make ethical decisions, and to satisfy my desire to know more about the topic, the following research question was posed.

**How do registered nurses in a nursing home make ethical decisions?**
CHAPTER 3
TRANSPORTATION FOR THE RESEARCH JOURNEY

This section outlines the means of transportation, the research methodology, used during this research journey, and covers the following aspects of transportation: the research method; research context; ethical considerations; nurse selection criteria; sampling; data collection; data analysis and research rigour.

3.1 The research method

The research method, naturalistic inquiry (Lincoln & Guba, 1985), was chosen for this research journey. This qualitative approach, which has its foundations in interpretivism, was chosen for three reasons. Firstly, naturalistic inquiry offered me methods of inquiry that helped me to understand the nurses’ experiences from their own, unique perspective. Secondly, the data generated from this method was in narrative form. This was important because I expected to use excerpts of the narratives to support my understanding about nurses’ ethical decision-making, and thirdly, the outcomes of the research were authentic representations of the nurses’ experiences.

3.1.1 Interpretivism

The epistemological stance of interpretivism forms the foundation for this research journey. Interpretivism is based on the notion that human action relies on concepts of human freedom, choice and responsibility (Schwandt, 2000) and that the meanings people place on their own experiences (van Manen, 1990) create the knowledge base utilised by advocates of this post-
positivist approach. Interpretivism does not aim to predict or control the phenomenon under investigation, nor does it aim to generate theory.

According to Schwandt (2000), the goal of interpretivism is interpretive understanding or verstehen, which is possible where researchers empathetically identify with research participants, when they seek to understand the life-world (lebenswelt) of others and when they engage in analysis of the language the participants use. In order to empathetically identify with research participants, researchers seek to understand the research phenomenon from the 'inside' (Webb, 1992). Verstehen is facilitated where knowledge is derived interactively between the researcher and research participant (Lincoln & Guba, 1985) through dynamic relationships that are based on trust, honesty, genuineness and unconditional positive regard, and where values held by the researcher inherent to the research process are made explicit (Lincoln, 1970; Lincoln & Guba, 1985). In these circumstances, the researcher’s values are not a source of bias, but are considered to be a source of data, to be reflected on in order to enhance interpretation and understanding (Webb, 1992).

Post-positivist researchers who seek to deepen their knowledge of the lebenswelt of others, focus on the inter-subjectivity of the research participants with other people in their lives (Schwandt, 2000). The notion of inter-subjectivity relies on the premise that people are non-reducible, non-divisible beings who are interconnected with others and nature (Watson, 1985). Inter-subjectivity is constituted in everyday conversations and interactions (Gubrium & Holstein, 2000) and revealed through qualitative research methods which exhort researchers to remain close to research participants and research phenomenon in order to “objectively report the
perceptions of each of the participants in the setting” (Morse & Field, 1996, p. 117). Closeness to research participants and phenomenon can be demonstrated when researchers report research discoveries by writing in the first person (Webb, 1992), as I have done in this thesis.

Researchers can increase their understanding of the lebenswelt of research participants by engaging them in dialogue (Gubrium & Holstein, 2000). Life-worlds are best revealed by going directly to the research participants themselves (van Manen, 1990) and this approach is likely to reveal insightful discoveries on topics about which little may be known (Morse & Field, 1996).

3.1.2 Qualitative methods of inquiry

Qualitative methods of inquiry are well suited to the goal of interpretivism chiefly because they provide researchers with research methods that aim to produce data which describe the world of researcher participants from the participant’s own perspective (Denzin & Lincoln, 2000; Orb, Eisenhauer & Wynaden, 2001). Qualitative methods are data-gathering techniques which are utilised by post-positivist researchers, and which generate narrative as opposed to numerical data (Knafl & Howard, 1984; Berg, 1989; Crabtree & Miller, 1992). They are essential for nurse researchers who seek to understand the subjective nature of people’s reality, which is dynamic rather than static (Packard & Polifroni, 1991).

As human experience provides the most useful data for nursing science (van Manen, 1990; Beck, 1992; Walters, 1994) nurse researchers can use qualitative research methods to transport them on their journeys into complex human experience. This is because qualitative research methods are:

“more adaptable to dealing with multiple realities ... such methods expose more directly the nature of the transaction between [the researcher and
research participant] ... and qualitative methods are more sensitive to and adaptable to the many mutually shaping influences and value patterns that may be encountered” (Lincoln & Guba, 1985, p. 41).

3.1.3 Naturalistic Inquiry

Numerous methods of qualitative research are available to nurse researchers (Morse & Field, 1996). However, naturalistic inquiry was chosen as the method of transportation for this journey as it enabled me to collect data from research participants in such a way that the data were not altered or changed, thus providing faithful representations of the phenomenon under investigation from an emic or insider’s viewpoint. Additionally, when research is conducted in the natural setting, the context of the study comes to be considered part of the phenomenon itself (Hinds, Chaves and Cypess, 1992). As I considered the research context to be an integral aspect of this research journey, naturalistic inquiry was the research method of choice.

This journey into the ethical decision-making of gerontic nurses was made possible through the application of the methods of naturalistic inquiry (Lincoln & Guba, 1985). Throughout the entire research journey, naturalistic inquiry influenced the way I thought about the study design, collected and analysed data and presented the study’s discoveries.

The aspects of naturalistic inquiry that I used in this research journey are described in the following pages. They are described using a step-wise format for ease of presentation here. The problem with such a format is that it may give the reader the impression that the entire research journey was one-directional and undertaken in an entirely linear manner. This, however was not the case. A number of aspects of the research journey were highly interdependent and their application occurred in a circular manner where I moved backwards and forwards between each
of the aspects rather than completing one in its entirety before moving onto the next. Lincoln and Guba (1985) identified this non-linear approach as an important aspect of naturalistic inquiry and have identified how the flow of naturalistic inquiry is often circular in parts, particularly during data collection, analysis and writing of the research outcomes. My experience during this research journey supported Lincoln and Guba’s (1985) beliefs.

3.2 The research context

A description of the research context is provided here to enable the reader to understand something of the contextual aspects of the nursing home where the research journey was undertaken. Lincoln and Guba (1985) recommended that naturalistic inquirers provide ‘thick description’ to their readers of all aspects of the research design, including the research setting. This enables the reader to decide whether the study’s discoveries can be transferred to similar settings (Lincoln & Guba, 1985, p.360).

The research context is a 100-bed nursing home situated in New South Wales, Australia. It had originally been constructed in the early part of the last century and during the time the research journey was unfolding, care delivery was still occurring in some of the original portions of the building.

Of the 100 residents living at the nursing home approximately 95 were permanent residents. The remainder entered the nursing home for short periods to enable their relatives or carers to have a period of respite. A large proportion of the residents had diagnosed medical conditions such as cerebro-vascular accidents (CVAs), cardiac disease and musculoskeletal diseases. Some residents
had psychiatric illnesses and others suffered from dementia. Many of the residents were diagnosed with multiple system disorders and experienced a complex array of physical and psychological disabilities.

The nursing home was divided into four distinct areas known as wards. Two wards were designated for residents with high care needs, for example, those who had had extensive CVAs or were diagnosed with late stage dementia. The other two wards admitted residents with moderate to low care needs, for example those with early stage dementia.

Registered nurses (RNs), enrolled nurses (ENs) and assistants-in-nursing (AINs) delivered nursing care to care recipients of the nursing home. The registered nurses’ role involved supervising the care provided by other nursing staff and they were responsible to the deputy director of nursing and ultimately the director of nursing. The vast majority of the RNs, ENs and AINs employed at the research site were female. Only one male RN, three male ENs and three male AINs were employed on the staff during the data collection phase of the research journey.

All RNs, ENs and AINs worked a variety of shifts including morning, evening and night shifts. The largest proportion of the nursing staff were AINs, followed by RNs. ENs made up the smallest proportion of the nursing staff. Approximately 65% of the nurses were full-time employees while the remainder of the staff worked either on a part-time or a casual basis.
3.2.1 The choice of research context

Before the commencement of the journey, I decided to conduct the research at the nursing home where I was employed. This setting was chosen for a number of reasons. I was familiar with the nursing home and its staff, and I had developed a professional rapport with the registered nurses employed there. Also, the nursing home was sufficiently large enough to employ a large pool of registered nurses from which I could sample a variety of research participants.

An issue of concern for researchers who conduct research in settings with which they are very familiar is that they may bring to their research biases and presuppositions which may influence the research methods and its outcomes (van Manen, 1990). This can lead researchers to premature closure where they can assume too much understanding and not unpack the research participant’s meaning. To minimise the impact of researchers’ own assumptions and pre-understandings, Lincoln and Guba (1985) recommend that they make them explicit at the outset. In keeping with the views of Lincoln and Guba (1985) assumptions I held at the beginning of this research journey have been recorded in chapter one. Preconceptions about the research topic gleaned from a review of the literature appear in chapter two.

The problem of power imbalance between researchers and research participants has been identified as another area of which qualitative researchers should be aware (Orb, Eisenhauer & Wynaden, 2001). In order to minimise the effects of this problem I took care to ensure that my position in the nursing home’s management team did not lead the nurses to feel compelled to participate in the study. I was aware that some registered nurses might feel pressured into
participating in the study in order to maintain their personal and professional relationship with me. To overcome any feelings of obligation on the part of the research participants, I built trust with each nurse by assuring them that they should not feel pressured into taking part if they did not want to, and that their decision not to participate would not jeopardise their relationship with me nor would their decision jeopardise their employment at the research site. I emphasised their voluntary participation in the research and their right to withdraw from it at any time. I also described for them how I intended to ensure their confidentiality and maintain their anonymity (refer to section 3.3). All the nurses who I invited to participate decided to do so, and no nurses withdrew their consent to participate once they were involved.

3.3 Ethical considerations

In order to gain access to the research participants, it was a requirement that I first obtain ethics approval from the area health service of which the nursing home was part. This essential, preliminary step in the research journey was necessary to ensure that I could demonstrate to the ethics committee that the research participants would not be harmed in any way by their participation in the study. Accordingly, I was required to provide evidence to the committee that the nurses would not be coerced to participate and that if they chose not to participate their employment at the research site would not be affected in any way. Evidence also had to be provided that described my actions should a nurse become emotionally upset as a result of their participation in the study. If that did occur I would cease the interview, spend time with the nurse myself and provide the nurse with the details of a trained counsellor.
Once ethics approval was obtained from the area health service, I was required to present a verbal explanation of the proposed study to a meeting of the governing board of the society that managed the nursing home at the time. After satisfying the governing body of the nature, relevance and ethical soundness of the study, I was in a position to proceed to the next stage of the research journey and approached the nursing home’s Director of Nursing to seek permission to commence the research.

An integral aspect of the ethical considerations for this study involved me providing the nurses with adequate information prior to their involvement in the study so they could decide whether or not they wished to become research participants. All the nurses who expressed an interest in being involved in the research were provided with a research information sheet which contained details about the study, including a description of the research, the possible risks and benefits of involvement in the research and details of research consent (see appendix A). Each nurse was asked to provide written consent to take part by signing a research consent form (see appendix B) which I witnessed. I kept a copy of the signed consent form and the nurses retained the original for their own information.

It was imperative that the participating nurses maintained their anonymity throughout the entire research journey and that anything they shared with me remained strictly confidential. As a result, I urged each nurse to choose a pseudonym so that any comments they made could not be traced back to them. All the nurses agreed, and chose their own pseudonym prior to their first interview with me. I referred to the nurses by their pseudonym in all their interviews, transcribed data and in my discussions of the work in progress with my research supervisor.
Confidentiality of the research data was assured by keeping all data in a locked cabinet. I was the only person who had access to the cabinet. Data would be kept in locked storage for the duration of the research journey and for a period of five years after its completion. No information that could be used to trace the nurses’ identities would be stored with the research data. In this way the nurses’ anonymity would be maintained.

3.4 Sampling methods

Sampling methods employed in qualitative studies aim to provide a diverse range of research participants who can provide details of the phenomenon under investigation from a range of individual view-points (Lincoln & Guba, 1985). The sampling method used in this research journey was purposeful (Lincoln & Guba, 1985) because the purpose was to reveal a sample of gerontic nurses who could provide thick description of their experiences of making ethical decisions in aged care. Purposeful sampling was facilitated through four processes: the selection of research participants according to a pre-determined criteria; the utilisation of a ‘key informant’; ‘snowball sampling’ and by nurses ‘inviting themselves’ into the study. Inviting themselves was an unexpected outcome of the sampling process and resulted in the inclusion of three nurses who were neither the key informant nor included through snowball sampling. These nurses approached me themselves and asked to be included in the research sample; they had invited themselves along on the research journey.
3.4.1 Nurse selection criteria

A prerequisite for all participating nurses, regardless whether they were the key informant, selected according to snowball sampling or had invited themselves, was that they met a selection criteria that was predetermined before the commencement of the study. Qualitative research aims to collect data that are rich in detail (Denzin & Lincoln, 2000) and so careful consideration was given to the selection criteria.

A purposive convenience sample of registered nurses at the nursing home evolved by applying the following selection criteria. The criteria stated that only registered nurses who had worked in aged care for at least two years could participate. Registered nurses with two years aged care experience were deemed to have sufficient knowledge and experience of gerontic nursing to be able to provide valuable insights into the ethical problems they encountered. The second criterion related to the nurses’ availability for interview. As interviewing commenced within one week of the nurse signing the consent form, the nurses had to be available for their first interview within that time frame. All the nurses who expressed an interest in participating met the selection criteria and subsequently were included as study participants.

3.4.2 Utilising a ‘key informant’

The first nurse involved in this study was selected because I identified her as a ‘key informant’. Gilchrist (1992) says that key informants “differ from other informants by the nature of their position in a culture and by their relationship with the researcher, which is generally one of longer duration, occurs in varied settings, and is more intimate” (p. 71). The first research participant was in a management role in the nursing home and had worked with me for almost
the entire time I had been employed at the research site. I had a strong professional relationship with the nurse by virtue of our close working relationship. Gilchrist’s (1992) criteria, which state that key informants should be involved with researchers in varied settings, was not the case here as I had been a colleague of the nurse at the research site only. Failure to meet this criterion, did not preclude the nurse from being a key informant as she easily met the other three criteria.

3.4.3 ‘Snowball sampling’ and ‘inviting themselves’

The other nurses were recruited to the study using two methods. Either they were recruited by me using snowball sampling techniques, or they invited themselves and approached me personally to inquire if they could be included in the research. The snowball sampling technique had been planned prior to the commencement of the study while ‘inviting themselves’ was an unexpected outcome of the research process.

Snowball sampling is a useful means by which researchers can avail themselves of a sample of research participants once a convenience sample has already been identified (Wilson, 1987). Snowball sampling involves research participants providing the researcher with the names of others from the convenience sample who they believe would provide useful data for the study. In this way the depth of data collected is extended and gaps in the data can be filled (Lincoln & Guba, 1985).

When I used this method of sampling, I asked each nurse to provide me with the names of one or two other nurses from the research site who they thought would be interested in participating. I
followed up their suggestions and approached the nominated nurse to seek their permission to participate. In total, six nurses were recruited using snowball sampling.

In three cases, registered nurses approached me personally and asked to be included in the study. They had found out about the study through a highly effective 'grapevine' that existed in the nursing home and each had independently decided to invite themselves into the study. All the nurses who invited themselves were included in the study as they met the selection criteria.

All of the nurses who became involved in the study expressed a high degree of interest in the research topic. They gave me the impression that they felt proud and complimented that I had chosen to do the research at 'their' nursing home. I felt extremely grateful to the nurses for their involvement in the study and was humbled by their enthusiasm.

3.5 Study design

The study's design was allowed to unfold and emerge during concurrent collection and analysis of the data according to the tenets of naturalistic inquiry espoused by Lincoln & Guba (1985). Concurrent collection and analysis became an integral aspect of the research journey. This was a circular process that commenced the moment I first immersed myself in conducting and recording the interviews. Thus I found myself constantly moving backwards and forwards between collecting, analysing, reflecting and writing about the emergent data.

In keeping with the notion of an emergent design, a specific number of interviews was not predetermined. Instead, interviewing continued until I realised that I was no longer hearing
anything new and had reached ‘information redundancy’ (Kuzel, 1992). Information redundancy was recognised after the 21st interview had been conducted. The design emerged to include the unexpected occurrence of nurse-initiated interviews, and was responsive to the nurses’ needs enabling them to determine the number, duration and location of the interviews.

3.6 Means of data collection

Data were generated for this study using a questionnaire, in-depth semi-structured interviews and excerpts from my reflective journal.

3.6.1 Data generated from the questionnaire

A short questionnaire (see appendix C) was used to gather demographic details about the nurses. It was completed by me during the first interview with each nurse. These data were used as background information and helped me to interpret the nurses’ comments within the context of their current work-related circumstances at the nursing home. A short summary of each nurse’s demographic details appears in the table 3.1 below. The reader can refer to a more detailed table of biographical information of the nurses in appendix D. The inclusion of these tables enables the reader to gain deeper insight into the nurses’ comments by understanding something of their individual circumstances.

A striking feature of the demographic data obtained from the nurses related to the length of time they had been involved in gerontic nursing. This group of nurses were very experienced gerontic nurses. They had worked in aged care between five and 18 years with an average duration of
just over nine years. The data generated from a group of experienced nurses such as these nurses could be expected to be highly valuable and insightful.

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Work role</th>
<th>Work status</th>
<th>Number of years employed in aged care</th>
<th>Number of years employed at the research site</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sandra</td>
<td>49</td>
<td>Clinical nurse</td>
<td>Full-time</td>
<td>15</td>
<td>3</td>
</tr>
<tr>
<td>Mary</td>
<td>45</td>
<td>Nurse manager</td>
<td>Full-time</td>
<td>10.5</td>
<td>10</td>
</tr>
<tr>
<td>Kirstie</td>
<td>61</td>
<td>Clinical nurse</td>
<td>Part-time</td>
<td>18</td>
<td>3</td>
</tr>
<tr>
<td>Emma</td>
<td>63</td>
<td>Clinical nurse</td>
<td>Part-time</td>
<td>10</td>
<td>3</td>
</tr>
<tr>
<td>Pamela</td>
<td>53</td>
<td>Clinical nurse</td>
<td>Part-time</td>
<td>9</td>
<td>9</td>
</tr>
<tr>
<td>Daisey</td>
<td>37</td>
<td>Clinical nurse</td>
<td>Full-time</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Clarissa</td>
<td>49</td>
<td>Clinical nurse</td>
<td>Full-time</td>
<td>10</td>
<td>7</td>
</tr>
<tr>
<td>Maggie</td>
<td>43</td>
<td>Nurse manager</td>
<td>Full-time</td>
<td>14</td>
<td>4.5</td>
</tr>
<tr>
<td>Anne</td>
<td>44</td>
<td>Clinical nurse</td>
<td>Casual</td>
<td>5</td>
<td>2</td>
</tr>
</tbody>
</table>

Another feature of this demographic data is that all the research participants are female. The choice of only female research participants was not a deliberate action on my part. Instead it occurred because the vast majority of the nurses employed at the research site at the time of data collection were female. As has been stated previously, only one male registered nurse was employed at the research site during data collection, and since he was not nominated by his colleagues during snowball sampling and did not invite himself to participate in the study, he did
not become part of the convenience sample. Consequently, the final sample of nurses selected for this study was all female.

3.6.2 Data generated from interviews

The predominant means of data collection for this research journey was through individual interviews between myself and the nurses. See appendix E for examples of interview data from two nurses involved in this study. The literature provides evidence that there has been considerable discussion amongst scholars over the use of the word ‘interview’ in qualitative research (van Manen, 1990; Walters, 1994). It has been suggested that ‘conversation’ is a more appropriate term to use as it describes more realistically the collegial, non-hierarchical nature of the interaction that occurs between researcher and research participant in qualitative research (Walters, 1994). In this study I chose the term ‘interview’ to describe my interaction with the nurses, as this is a commonly used word in the nomenclature of naturalistic inquiry (Lincoln & Guba, 1985).

Four premises underpinned and guided the interviewing for this research journey. They were that:

1. The interviews were conducted in a manner where the nurses felt relaxed and comfortable

2. The nurses were given every opportunity to lead the interview to topics they felt were most important

3. The interviews provided thick description of the nurses’ ethical decision-making from an insider’s perspective of the nurses themselves, and
4. The interviews were tape-recorded because I expected to use verbatim sections of the transcribed data to illustrate the journey's discoveries.

3.6.2.1 Pacing the interviews

Interviewing was conducted over a 12-month period. This lengthy period of time enabled me to 'pace' the interviewing process. In the past, I had been involved in research where the interviewing of researcher participants had been completed within the relatively short period of three to four months. The intensity of my previous interviewing experience had left me feeling drained, overwhelmed and experiencing a deep sense of disappointment that I hadn't had the time to enable the research participants to deeply explore their experiences of the phenomenon under investigation. In the current research journey I endeavoured to exclude this problem and chose to pace the interviews at approximately one interview every two weeks.

3.6.2.2 Interview location

In keeping with Premise 1, the location of the interviews was determined by each nurse to suit their individual needs (see table 3.2). The nurses chose to be interviewed either in their own homes, in my home or at the research site. By far the most popular interview location for interview was the nurse's own home. The popularity of this location was probably due to the fact that the nurses felt most comfortable in their own home environment. Privacy could be easily maintained and interruptions managed and kept to a minimum in their own home. In order to minimise interruptions some nurses took their telephones off the hook and made arrangements with family members and friends so that we could have lengthy periods of uninterrupted time together.
Some interruptions were unavoidable. On two occasions, tradespeople arrived to complete repairs for one of the nurses and the interviews were stopped. The threads of the interview were quickly picked up again when the interview was resumed after I briefly gave the nurse an overview of the points she had already covered in the interview.

I was very conscious that I was invited into the nurse's home as a guest so I always took to each interview a small contribution of food. In most cases the nurses provided food and beverages for both of us. In one case the nurse cooked dinner for me and the interview was conducted while we enjoyed our meal.

Where the interviews were conducted in my home and at the research site, issues of privacy were managed by ensuring that we were not interrupted during the interview. The interview that occurred in my home took place while my family were not at home. Interviewing at the research site was done in my office with the door closed and the telephone taken off the hook.

3.6.2.3 Number and duration of the interviews

As can be seen in Table 3.2 (below), some nurses were interviewed more than once and each interview varied in duration. Both the nurse and myself determined the number of times the nurse was interviewed. Interviewing continued until the nurse indicated that she no longer wished to arrange another interview or until I reached information redundancy. Information redundancy occurred when I recognised that I was no longer hearing any new information from the nurses (Lincoln & Guba, 1985; Kuzel, 1992) and it occurred after I had conducted 21 interviews. No more interviews were arranged after I had completed the 21st interview.
Table 3.2 The number, duration and location of each interview

<table>
<thead>
<tr>
<th>Nurse</th>
<th>Total number of interviews</th>
<th>Duration of each interview in minutes</th>
<th>Interview location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sandra</td>
<td>2</td>
<td>1. 45</td>
<td>1. Nurse’s home</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. 45</td>
<td>2. Research site</td>
</tr>
<tr>
<td>Mary</td>
<td>4</td>
<td>1. 60</td>
<td>1. Nurse’s home</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. 60</td>
<td>2. Nurse’s home</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3. 30</td>
<td>3. My home</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4. 60</td>
<td>4. Nurse’s home</td>
</tr>
<tr>
<td>Kirstie</td>
<td>3</td>
<td>1. 60</td>
<td>1. Nurse’s home</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. 60</td>
<td>2. Nurse’s home</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3. 85</td>
<td>3. Nurse’s home</td>
</tr>
<tr>
<td>Emma</td>
<td>4</td>
<td>1. 60</td>
<td>1. Nurse’s home</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. 60</td>
<td>2. Nurse’s home</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3. 60</td>
<td>3. Nurse’s home</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4. 90</td>
<td>4. Nurse’s home</td>
</tr>
<tr>
<td>Pamela</td>
<td>3</td>
<td>1. 30</td>
<td>1. Nurse’s home</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. 30</td>
<td>2. Research site</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3. 30</td>
<td>3. Nurse’s home</td>
</tr>
<tr>
<td>Daisey</td>
<td>1</td>
<td>30</td>
<td>Research site</td>
</tr>
<tr>
<td>Clarissa</td>
<td>1</td>
<td>30</td>
<td>Research site</td>
</tr>
<tr>
<td>Maggie</td>
<td>2</td>
<td>1. 60</td>
<td>1. Research site</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. 90</td>
<td>2. Nurse’s home</td>
</tr>
<tr>
<td>Anne</td>
<td>1</td>
<td>30</td>
<td>Research site</td>
</tr>
<tr>
<td>Total</td>
<td>21</td>
<td>16 hours and 45 minutes</td>
<td></td>
</tr>
</tbody>
</table>
Each interview lasted for between 30 and 90 minutes each. The length of each interview was dependent on the needs of each nurse. Where the nurses indicated that they wanted to finish the interview, by making comments like “I think I’ve said all I want to . . .” or where the silences between sentences increased in duration, the interview was terminated. The interviews that were conducted at the research site were done so within strict time constraints as they were conducted during the nurse’s meal break. Both myself and the nurse were obliged to keep to the time limits so the nurse could return to her work in the nursing home.

3.6.2.4 The interview questions

To support the intent of Premise 2, I had a broad outline of what I wanted to discuss in the interviews through the use of three focal questions. In keeping with this flexible approach to interviewing I used the following questions to act as a guide for the interviews, “what does ethics mean to you?,” “what ethical problems have you encountered in aged care?” and “how did you manage these problems?”.

These questions were used as a guide only and were deliberately structured as open-ended in nature to encourage the nurses to reflect on their answers (Ivey, 1988) and to illustrate their perspective through examples from their own gerontic nursing experience. The structure of the questions encouraged the nurses to begin to discuss issues surrounding ethics and gerontic nursing in the general sense, then move to a more detailed discussion of specific examples from their own clinical practice. Often this occurred as a natural consequence of the interview process and was facilitated by my improving skill and patience at interviewing. In these circumstances the focal questions became redundant and the interview took on the form of a free-flowing
naturally-occurring conversation between colleagues. One of the exciting aspects of open-ended interviewing was that I was never quite sure where each interview would take us. The interviews were guided by the nurses’ comments. It was they, not me, who ‘led’ the interview (Morse & Field, 1996).

Bogdan and Biklen (1982) situate interviews conducted for qualitative studies along a continuum which at one end includes interviews that are structured tightly on the phenomenon under investigation and at the other end includes interviews in which research participants define the entire content of the exchange. The interviews used in this study fell midway along the continuum and can be described as semi-structured. During these semi-structured interviews I focused the nurses’ attention on the research topic through the use of the research questions but, at the same time, gave the nurses the latitude to tell me what they thought was most important to them. I took a flexible approach to interviewing and did not try to re-direct or constrain the nurses’ comments to areas of concern that I believed were most important.

This approach to interviewing meant that I collected data which were rich in detail thus supporting Premise 3. It also meant that some of the collected data which at first glance appeared not to be entirely relevant, were later found to be highly valuable. A good example of this came from the nurses’ comments about their own self-respect. As the research journey unfolded I slowly began to realise the importance of this data and these insights became a central aspect of one of the discoveries, “respect for self”. However, at the time of their recording, their significance was not apparent and I viewed them merely as a fascinating insight into the nurses’ regard for their own selves.
The focal questions were trialled initially during the first interview to ascertain if they were clear and answerable. The first nurse involved in the study agreed that they were and the questions were subsequently adopted for future interviews. Information collected during the first interview was then included as part of the study data.

3.6.2.5 Recording the interviews

All the interviews, 21 in total, were tape-recorded. Weiss (1994) canvassed some of the difficulties researchers can experience with the use of tape-recording equipment. He described how in some instances research participants can regard the recorder as an unwelcome intruder in the interview and feel constrained by its presence.

The nurses in this study gave no indication to me that the presence of the tape recorder interfered with the interview process. I found that by placing the recorder on a table between the nurse and myself, turning it on, then relaxing into the interview, the nurse and I very quickly forgot about its presence. When my verbal and non-verbal communication indicated to the nurse that I was listening intently to her and that the workings of the tape recorder were a secondary concern, the nurses’ attention remained focused on the interview at hand. An integral aspect of this process was the use of recording tapes that were of one hour’s duration long. The use of long tapes meant that I could begin the tape recording then leave the recorder alone, thus avoiding any disruption that can occur when recording tapes have to be turned over part way through an interview.
Permission for taping had been sought prior to the nurses’ participation in the study and again prior to the commencement of each interview. No nurses objected to the use of the tape recorder, although on two occasions nurses requested that the recorder be turned off while they discussed issues that they requested not become part of the study data. On both occasions I did as the nurse requested and did not turn the recorder on again until the nurse gave permission for this to happen.

3.7 The human research instrument

In qualitative research in general (Janesick, 2000), and in naturalistic inquiry in particular, the researcher is the research instrument of choice (Lincoln and Guba, 1985). This means that the researcher collects and collates data themselves. Lincoln and Guba (1985) claim that the human instrument is well suited to data collection because they are capable of being responsive and adaptable to the phenomenon under investigation, they can process data immediately and take an holistic view of the emerging data.

A problem for nurses conducting research where they are the main instrument of research, is that they may have difficulty defining their role. They may experience “duality and dichotomy of roles when ... carrying out research in the clinical arena” (Beale & Wilkes, 2001, p.34). Duality of role has been identified when nurses find themselves in the quandary of having to decide between acting as a nurse or acting as a researcher (Borbasi, 1994; Carr, 1994).

In this research journey I adopted the stance that I was a “researcher who is solely a researcher [as opposed to being] a researcher who is sometimes a nurse [educator]” (Borbasi, 1994, p.37).
By adopting this stance I believed that I was placing myself in the best position to understand the life-world of the nurses. To understand their life-world, as they experienced it, I believed that the nurses needed to trust that I would not report what they told me to the nursing home’s administration.

This position of trust resulted in me experiencing my own ethical problem. For example, when the nurses told me their experiences of ethical decision-making, on a number of occasions they related to me instances where a colleague or themselves had acted unethically. Consequently I found myself experiencing a ‘grey problem area’ (Martin, 1995) where I had to decide what to do with information concerning care recipients that was not life threatening but nonetheless was an important issue.

The solution to my ethical problem came when I re-focused my attention on my role as researcher. As I believed that it was imperative that I collect data that were faithful representations of the nurses’ life-worlds, I needed to be sure that the data I collected had not been contaminated by my interventions (Beale & Wilkes, 2001). Therefore I reminded the nurses of the confidential nature of the research data and reassured them that I would not pass anything they said to me to the nursing home’s Director of Nursing.

3.8  Processing the interview data

The human research instrument is well suited to clarify and summarise any data gathered using the methods of naturalistic inquiry (Lincoln & Guba, 1985). The semi-structured format of the exchange which took place between the nurses and myself enabled me to process data, come to
understandings about it and communicate these back to the nurse through the processes of clarification and summarisation.

Clarifying statements such as “as I see it, you are saying that …” were used so that the nurse could agree or disagree with my understandings and offered the opportunity for the nurse to clarify any misconceptions I held. By summarising what the nurse had said, I provided feedback to her to ensure that interview details were correct. Summarising was conducted at the end of each interview and provided me with the opportunity to give an overall account of what I had gained from the interview. Again, the nurse could clarify any misunderstandings the researcher held.

I did however find that processing interview data was a physically and emotionally exhausting experience. A common reflection recorded in my journal related to the effort involved in concentrating for lengthy periods of time on the interviews, assimilating the information and feeding it back to the nurses. A useful means of counteracting the physical and emotional tiredness was to undertake some physical activity as soon as I could after the interview was conducted. This enabled me to ‘distance’ myself from the interview for a short time, begin to reflect on it and relax before returning to begin transcription.

3.9 Data collected from my reflective journal

Data from my reflective journal also became part of the data for the study. I had kept a personal journal for a number of years prior to the commencement of the study and many of the journal entries focused on my observations and reflections on gerontic nursing. Later, after the research
journey had begun, the focus of the entries changed to document and explore my personal experience of the research journey, along with my reflections on the research process and findings.

Holly (1995) describes how reflective journals are a useful means for nurses to record their observations, thoughts and feelings about their nursing experiences. When used as a data collection tool for a research project, the journal is also an ideal means of recording the evolutionary nature of the research process. A striking feature of entries recorded in my journal over a period of years is the frequency of recurrent thoughts and ideas and how these thoughts evolved as time passed. For example, the consistency of my reflections about how gerontic nurses make ethical decisions helped me to formulate my thoughts on this aspect of the research and later they became incorporated as a discovery of the study. Interestingly, their importance only became evident to me after I had re-read a number of entries recorded in my journal (see appendix F) and after the research journey was well underway. Thus, with hindsight, I came to recognise how the notion of interpersonal relationships had influenced my work at an unconscious level.

3.10 Data analysis

Data analysis for interpretive qualitative research aims to reveal faithful representations of the life-worlds of others (Schwandt, 2000). In order to achieve this goal, data analysis conducted for this research journey used the data analysis processes of transcribing and coding the data and the evolution of themes. These processes occurred within a framework of research rigour whereby I
ensured that at each step of the research journey, issues of the study's credibility, transferability, dependability and confirmability were addressed.

3.10.1 Transcribing the data

The first step in data analysis involved transcribing the spoken word of the interviews into the written word of a transcript. I made the decision to transcribe each tape-recorded interview myself. While the use of a typist would have considerably reduced the time taken in transcribing each interview, I found that the transcription process, while laborious, enabled me to immerse myself deeply in the interviews again. As I transcribed, I heard again the nurses’ voices, I relived the interview experience and in some cases noticed things that I had missed when I had initially been involved in conducting the interview.

During this aspect of the research journey I standardized the method I used for the transcription of the interview data. As I expected that all the interviews would be audio-taped and that they would be transcribed soon afterwards, it was my intent that the reader should be able to grasp the meaning of transcribed excerpts and to understand the nurses’ experience of ethical decision-making from their unique perspective. However, I was aware that spoken English can differ from written English, and so I needed to utilize a method of transcription for editing that would enable the reader to make sense of each excerpt in its original context. Appendix G illustrates the standard transcript editing methods used throughout each interview.

After transcription had been completed, copies of the transcripts were returned to each nurse for authentication. The nurses brought any errors in the transcript to my attention and I made
alterations to the transcript based on their comments. The next stage of data analysis, coding of the data, did not proceed until the corrections had been incorporated into an authenticated transcript. In this way only data that were a faithful representation of the interviews were used for data analysis.

3.10.2 Coding the data

Coding is conducted in an effort to “capture the interview material ... as I go through the material I do ask myself what I am seeing instances of, what I am learning about, and what questions the material raises” (Weiss, 1994, p.155). Coding began when I undertook a careful analysis of each of the interview transcripts. Coding was facilitated when I proceeded according to a three-phase coding procedure that evolved during the research journey. I conceptualised the coding as being a macro-micro-macro procedure where by a line-by-line (micro) analysis of the interview data was sandwiched between two overall (macro) analyses of the whole interview text.

The coding procedure comprised of the following steps. Firstly, the interview data were individually read in their entirety so that I could gain an overall ‘feel’ for what the nurses had said. This first macro-analysis was usually completed within seven to ten days after the interview had been transcribed.

The next step in the procedure involved a micro-analysis of the transcribed data. An in-depth line-by-line analysis took place whereby I asked myself the questions “What is going on here?” and “What point is the nurse making?” As I reflected on these questions I made notes in blue
pen in the page margins adjacent to the interview data transcript. Codes, or shorthand-like signifiers, which captured the content of my reflections of the data, were also recorded in the page margins, this time in red pen. In most cases, the codes were made up of words taken verbatim from the interview data. For example, my reflection that “sometimes nurses encountered ethical problems when they had to decide whether or not to tell the truth to family members” was recorded as the code, “being truthful with family members”. The words of this code originated from the interview with Kirstie.

Each individual code was recorded on cards, known as ‘coding cards’, along with information, which identified the code’s source. For example, the code identifier “K.3.2.1-7” appeared next to the code “being truthful with family members”. The code identifier indicated that the code originated from the transcribed data from Kirstie’s third interview, page two, lines one to seven.

The final stage of the coding process involved another macro-analysis of the data where the interview data were read again in their entirety. The second complete reading was done with the hindsight of the preceding micro and macro-analysis. The aim of the final macro-analysis was to ensure that no data had been overlooked and to check that the selected codes did in fact faithfully capture the intent of the nurses’ words.

3.11 Theme evolution

Once the coding process had revealed approximately 25 codes, I began to search the coding cards for common threads. This was facilitated by spreading the coding cards on a floor and categorising common cards together. For example, one coding card read “nurses need to take
the time to communicate with residents while undertaking other activities” and another read “nurses can undertake resident assessment while they are doing personal care activities”. These were sorted together under the category referred to as “having time”. Once a number of categories had emerged from the data they in turn were examined for common threads and sorted into themes. For example, the category referred to above, became an aspect of the theme, establishing closeness. In this way, over a period of months, out of an array of seeming chaos emerged a growing number of categories and themes. The themes, and some of their associated categories and codes, along with their source appear in appendix H. In total three themes emerged from 11 categories, which in turn had evolved from 76 codes.

In the initial stages my efforts at coding, categorisation and theme development were slow and laborious. However, as I became more skilled and as my familiarity with the data increased over time, the procedure became smoother and easier.

The themes were listed on a large sheet of paper and I asked myself the question “What are these themes telling me about nurses’ ethical decision making in aged care?” At that point I found it helpful to construct a diagram that encompassed all the themes, categories and their associated codes. The beginning diagram looked like a strange underwater creature and was the first of many attempts to make pictorial sense of gerontic nurses’ ethical decision-making.

Unexpectedly, a flash of insight occurred. Suddenly, in a moment of clarity, I saw that respectful relationships were pivotal to ethical decision-making and that the themes that were discovered
during data analysis were really elements of the approach to ethical decision-making utilized by the gerontic nurses in this study. Easily the other themes, now viewed as elements of an approach to ethical decision-making, seemed to fall into place around the central organizing theme of respectful relationships.

This insight led me to re-analyse the transcripts, codes, categories and diagrams. The re-analysis served to strengthen my belief in the centrality of ‘respectful relationships’ and my understanding of the nurses’ approach to ethical decision-making was consequently deepened significantly.

3.12 The personal experience of theme evolution

Lincoln and Guba (1985) optimistically claim that the human research instrument is well equipped to grasp all the "buzzing confusion" (p.194) of the coding and theme evolution processes. I experienced this aspect of the research journey as particularly challenging and many times did not feel at all well equipped to manage the seemingly overwhelming volume of data that was continually emerging from the interviews. The task of making sense of the data seemed at times to be impossible. The following extract from my reflective journal is representative of other entries that recorded the frustration I experienced during this time.

To say that I feel overwhelmed by the sheer volume of data is understating how I really feel. Most of the time I feel desperate, I feel like, no matter how hard I try, I will never come to an holistic view of the data as Lincoln and Guba (1985) say I will! This part of my journey is very lonely, I am acutely aware that I am the only person who can do this. [Melissa]
Evolving a central organizing theme from the complex array of themes, categories and codes necessitated me immersing myself in the interview data and involving myself in many hours of deeply reflective thinking. I found that two modes of thinking, process and free-flowing, as described by Carlson and Bailey (1999), helpful with this difficult task. The advantages of these two forms of thinking were recorded in my journal:

*I've found that, in order to make sense of all the buzzing confusion, in order to bring it all together, to create an overall picture, it has been helpful to use Carlson and Bailey's (1999) principles of process and free flowing thinking. When I'm in process thinking mode I "churn, process, reprocess, mull over and relive" (p.32). Well, I certainly do that! However, I enter into free-flowing thinking when I move out of process mode. Free-flowing thinking is easier thinking; it operates "like a river. It is always flowing, bringing us new information and thoughts" (p.16). An interesting insight for me is that I can switch from one thinking mode to the other. Over the last few months I've felt that I must process and re-process all the data coming at me from the coding and categorising that I'm immersed in. In other words I've felt that I must stay in the process thinking mode. But now I see that there is another way. I can stop my process thinking and accept that my free-flowing thinking has its part to play. Only then, will I open myself up to insights about my work. [Melissa]*

3.13 Data management

An unexpectedly time-consuming aspect of this research journey related to the development of a system of data management to assist in the efficient management of the huge volume of data that emerged during this research journey. An essential data management tool devised for use in this research journey was the ‘data collection master list’. The master list enabled me to obtain a visual representation of my progression in data collection and analysis. Consequently, it became a very important map on which I could track data collection and analysis details beginning with initial contact with the nurse, through 13 other steps, and ending with theme evolution.
I drew the data collection master list on a large piece of paper. On the left-hand side of the paper I listed the nurses names. Along the top of the paper I wrote the 14 steps of data collection and analysis I had identified as imperative to this study. By ruling lines on the paper I turned it into a grid. In this way I could record the steps of data collection and analysis as they were completed for each nurse. This enabled me to see at a glance what I had done, and what still needed to be done for each nurse for this aspect of the research journey.

An unexpected outcome of the use of this master list was that it became a psychological boost for me when I was feeling overwhelmed with the workload involved in data collection and analysis. As the list was a visual representation of my progress to date, by referring to it I could quickly gain a sense of how much work I had already completed and what still lay ahead. When feelings of tiredness overtook me I found that I could renew my energy source by ‘seeing’ how far I had come and to gain a sense that I was progressing through this aspect of the research journey. A list of all the aspects of the research journey included on the data collection master sheet appear in appendix I.

3.14 Establishing rigour

The challenge of rigour in qualitative research has been addressed by Lincoln and Guba (1985), Sandelowski (1986); Burns (1989); Beck (1993), Koch (1994), Munhall (1994) and Mays and Pope (1995). While it is clear that issues of rigour are very important to post-positivists, qualitative researchers the premises on which they base their understandings are very different from those of researchers who work within a positivist paradigm and use quantitative research methods.
Standards of rigour for research conducted within a positivist paradigm are centred on questions of internal and external validity, reliability and objectivity (Lincoln & Guba, 1985). Validity in quantitative research is achieved when the instrument used for measurement measures accurately what it sets out to do. Internal validity is maintained throughout a study when there is compatibility between the research question, method and conclusions (Sandelowski, 1986). External validity refers to the representativeness or generalizability of the study's findings. External validity is achieved when researchers use rigorous methods of sampling in order to gain a research sample that is representative of the population under investigation (Wilson, 1987). Reliability refers to a research instrument that produces consistent results on repeated use and objectivity involves researchers distancing themselves from the research subjects in order to overcome any biases or prejudices the researcher may hold (Shelley, 1984; Wilson, 1989).

3.14.1 Establishing trustworthiness

"Just as conventional investigators must attend to the question of how internal and external validity, reliability, and objectivity will be provided for in the design, so must the naturalistic inquirer arrange for credibility, transferability, dependability, and confirmability" (Lincoln & Guba, 1985, p. 247).

Credibility, transferability, dependability and confirmability provide the framework for establishing the trustworthiness of naturalistic inquiry (Lincoln & Guba, 1985). Trustworthiness refers to the criterion of rigour that is appropriate to naturalistic inquiry. "The basic issue in relation to trustworthiness is simple: How can an inquirer persuade his or her audiences (including self) that the findings of an inquiry are worth paying attention to, worth taking account of" (Lincoln & Guba, 1985, p. 290). According to the authors, trustworthiness must be an integral aspect of every phase of the endeavours of naturalistic inquirers and can be
demonstrated by establishing that the research is credible, transferable, dependable and confirmable.

When a study is credible, the findings are considered to be plausible and believable. The credibility of this study was strengthened by my prolonged engagement with the research site. Engagement with the site began prior to the commencement of the study through my employment at the site. Credibility was also strengthened by procedures undertaken which enabled the nurses to authenticate the interview content. I summarised the interviews at the end of each interview, asked two nurses to authenticate the data and had each nurse review the transcripts of their tape-recorded interviews. Only interviews that had been authenticated by the nurses were included as data for the study.

According to Lincoln and Guba (1985) transferability of study findings to other settings is the responsibility of the reader. The researcher’s responsibilities lay in the provision of thick description to enable readers to form an opinion about whether transferability is a possibility. In complying with the notion of transferability I provided descriptions of the research context, the participating nurses, my relationship to the nurses, the presuppositions I held and the decisions I made during the research journey.

The dependability of a naturalistic study focused on its level of believability. The dependability of this study was established through the consistent use of an audit trail (Lincoln & Guba, 1985; Burns, 1989). The audit trail demonstrates to the reader how I arrived at my conclusions and why they have found their way into the study findings. With this aim in mind I described the
data gathering process in detail and have supported the findings with excerpts from the interview transcripts and my reflective journal. This was done to assist the reader to follow the logical course of data analysis, coding, categorisation and theme development process.

In order to meet the criterion of confirmability I incorporated excerpts from the transcripts to assist the reader to follow the logical course of data analysis and theme evolution. I illustrated how codes were appropriately assigned to text and how they are clustered into categories and themes (see appendix H).

3.14.2 Seeking confirmation of the discoveries

Once the central organising theme ‘respectful relationships’ was elicited from the data, I sought confirmation of its validity from two of the nurses who had participated in the study and from my research supervisor. Of the nine nurses involved in the study, four had indicated earlier in the research journey that they would like to be involved in confirmation of findings when the time arose. As one of these nurses had recently retired, and the other was on an extended overseas holiday, the remaining two nurses were asked to confirm the journey’s discoveries.

Both the nurses confirmed that the notion of respectful relationships, faithfully captured their experience of ethical decision-making. One re-emphasised the important role played by nurses’ self-respect in gerontic nursing. She claimed that it was impossible for nurses to respect others unless they had self-respect. Her comment reinforced to me the importance of this theme to the approach to ethical decision-making, respectful relationships.
Since I worked alone and was not part of a research team, I met on a monthly basis with my research supervisor. At these meetings I presented an ongoing account of my progress and a synopsis of my discoveries to date. After the central organizing theme emerged, I discussed this with my supervisor and supported my discovery with codes, categories, themes, diagrams and confirmation from interview transcripts. My supervisor’s thoughtful reflections on the research discoveries helped me to deepen my understanding of the evolving themes.
CHAPTER 4

THE JOURNEY’S DISCOVERIES

This chapter, which is devoted to an elucidation of the research journey’s discoveries, and the creation of the ethical decision-making approach, respectful relationships, will explore the outcomes of data collection and analysis using the interpretive qualitative approach, naturalistic inquiry. It will illuminate the approach to ethical decision-making adopted by a group of gerontic nurses, along with this approach’s elements and sub-elements.

An interruption occurred in the research journey when I found that it was imperative that I deepen my understanding of certain aspects of the nursing literature in order to comprehend fully the emerging research discoveries.

4.1 Interrupting the journey

In order to create this approach to ethical decision-making, I realised I had to interrupt the discovery phase of the research journey to give myself the opportunity to immerse myself in literature on topics that had only become significant to me after I had commenced understanding the journey’s discoveries. Interrupting the journey involved increasing my understanding of the relevant literature pertaining to two areas of scholarly pursuit: literature on respect and interpersonal relationships.

The importance of the literature on respect and interpersonal relationships only became apparent to me after the research discoveries had revealed the pivotal role played by respectful
relationships in gerontic nurses’ ethical decision-making. At this time I realised that I did not have a comprehensive understanding of the literature on respect and interpersonal relationships. Also at this time I came to the understanding that the only course of action open to me was to interrupt the journey in order to undertake a review of literature not already explored in the planning and preparation that took place at the beginning of the research journey.

While the journey’s interruption is recorded here before the discoveries are elucidated, this sequence has been chosen merely to assist the reader to understand the nature and outcomes of the journey’s interruption. This format does not reflect the interdependent nature of the discoveries’ elucidation and the journey’s interruption. In reality, the emergence of discoveries and the interruption occurred in an iterative, rather than a linear fashion; however for ease of presentation here the review of the supplementary literature is provided before the illumination of the ethical decision-making approach, respectful relationships. The supplementary literature reviewed begins with a review of literature on respect, then moves to the literature on interpersonal relationships and gerontic nursing.

4.1.1 Respect

The Macquarie dictionary defines the noun ‘respect’ in this context as feeling or showing esteem or deferential regard for someone. As a verb, respect means to consider another worthy, to refrain from interfering, to show deference and concern for another.

The term respect appears in ethics literature and has been linked with the ethical principle of justice. Beauchamp and Childress (1994) describes how all people have the right to be respected
equally. Similarly, Erlen, Lebede and Tamenne (1993) claim that “nursing care is to be given in a non-discriminatory manner, patients are to be treated with respect regardless of their situation” (p.7). For Downie and Telfer (1970) respect is a central moral attitude which forms the basis of all moral principles and Rokeach (1979) sees respect as a human value that underpins justice, honour and human dignity.

The Australian Nursing Council’s *Code of ethics for nurses in Australia* includes value statements that refer to nurses having respect for other people by respecting the “person’s individual needs, values and culture in the provision of nursing care [and respecting] the right of persons to make informed choices in relation to their care” (p.3). The code of ethics also calls on nurses to respect the “accountability and responsibility inherent in their roles” (p.1). Clearly, respect is of central importance to what nurses do. Surprisingly however, respect has not been adequately defined in the nursing literature (Browne, 1993). One reason for this lack of definition is that it is an abstract concept and therefore defies easy definition (McGee, 1994).

For Forrest (1989) respect is an aspect of nurses’ involvement with patients. Behaviours that indicate respect for patients include “acknowledging the patient’s presence, use of preferred names and use of your own name, recognizing individuality and respecting individual need” (p. 819). According to Austin (2001), nurses respect patients when they “open themselves up [to] aspects of [the patient’s] situation that were not initially acknowledged - its sorrow, pain and hope” (p. 15). Respect for others is based on the understanding that each person is fundamentally dependent on others and that nurses’ attitudes towards others shape the environment in which they practise. In other words, respect for patients demands that nurses
really ‘see’ the patient before them and engage with them in a meaningful way (Austin, 2001). Respect is demonstrated to residents of nursing homes when nurses enter into reciprocally meaningful relationships with residents by working to maintain residents’ privacy, acknowledging residents’ feelings and viewing the resident in a positive way (Brechin, Walmsley, Katz & Pearce, 1998).

The relationship between respect and care has been the subject of inquiry for a small number of scholars. For Gaut (1983) respect is crucial to any discussion of caring and for Browne (1993) and McGee (1994) respect is the antecedent of caring. Browne (1993) describes respect as a “fundamental and essential aspect of nursing practice ... a nursing ethic that acknowledges the dignity, inherent worth, and uniqueness of humans, and their potential for self-determination” (p. 213).

There is a dearth of scholars who have explored the relationship between nurses’ respect for others and their own self-respect. Gaut (1983) argues that self-respect is important from the point of view that it is the antecedent to respect for others and foundational to caring. Gaut (1983) states, “The notion of “respect for persons” is crucial to the discussion of caring, for it entails an attitude necessary in the carer. Respect for other persons begins with respect for oneself” (p.320).

Given the central role played by caring in nursing, and the link Gaut (1983) makes between self-respect and caring, the need for scholars to understand the role of nurses’ self-respect is indeed great.
4.1.2 Interpersonal relationships

The significance of interpersonal relationships in nurse caring has been highlighted by numerous scholars (Peplau, 1952; Watson, 1985; Gastmans, 1998) but few have described the relationship between caring and interpersonal relationships so eloquently as Gilligan (1982) when she wrote that “the activity of care is an activity of relationship, of seeing and responding to need, taking care of the world by sustaining the web of connections so that no one is left out” (p. 62). Watson (1985) also emphasises the deeply personal nature of the relationship that emerges during caring when she describes how the caring nurse “is able to form a union with the other person on a level that transcends the physical ... [where] there is freeing of both persons from their separation and isolation” (p. 66).

That interpersonal relationships are important to gerontic nurses is evidenced by the number of papers published on the topic. Broadly speaking, gerontic nursing literature on interpersonal relationships falls into two major areas: literature related to resident-nurse relationships and literature related to family-nurse relationships. On the whole, the literature focuses on an examination of the advantages of close interpersonal relationships with care recipients. However Nolan and Grant (1993) explore the reciprocal nature of nurse-resident relationships and the advantages that may flow on to staff as a result. Sometimes interpersonal relationships between nurses and care recipients may be less than ideal and the reasons for the conflict that occurs in these circumstances is the subject of interest for a number of scholars.
4.1.3 Resident-nurse relationships

Resident-nurse relationships refers to the relationships that develop between gerontic nurses and nursing home residents. The advantage of a close connection between residents and nurses is explored by Olsen (1993) who argues that both parties can gain emotional satisfaction when their relationship is close. Close resident-nurse relationships impact positively on the quality of residents’ lives (Kitwood, 1990; Kitwood, 1993; Setturlund, 1998; Nunley, Hall & Rowles, 2000) and are enhanced when nurses seek to “reach out, listen and respond to the feelings and ideas experienced by the [older] person” (Coulson & Ronaldson, 1997, p. 123). Such an approach helps the resident to feel that they are cared for, unique and important to the nurse. The growth of close relationships is also facilitated by nurses who appreciate residents as unique individuals and who maintain an open and sharing demeanour toward them (Hudson & Richmond, 1994).

A potent factor in the development of interpersonal relationships in nursing homes is found to be the use of non-verbal communication such as touch (Caris-Verhallen, de Gruijter, Kerkstra & Bensing, 1999). In seeking to deepen their understanding of this aspect of resident-nurse relationships McCann and McKenna (1993) conducted interviews with elderly people to elicit their perspective on the use of nurses’ touch. The findings reveal that instrumental touch, touch that is initiated by the nurse and which enables the nurse to perform clinical care, is the type of touch that all research participants feel most comfortable with. The authors call on gerontic nurses to increase their awareness and sensitivity towards older people’s need for tactile communication.
According to Nolan and Grant (1993), therapeutic reciprocity is an essential component of the resident-nurse relationship. “Therapeutic reciprocity is possible in any situation where two people can interact to share either thoughts, feelings or behaviour” (p.1312). Therapeutic reciprocity occurs in situations where nurses and care recipients share personal information about themselves with positive benefits to both parties (Marck, 1990), give each other gifts (Morse, 1989), respect each other’s personal space (Meisenhelder, 1982) or share a joke (Marck, 1990). It can occur in the briefest encounters (Gilbert, 1993) and has been associated with increased work satisfaction for nurses (Nolan & Grant, 1993).

The aim of the model of therapeutic reciprocity proposed by Nolan and Grant (1993) is to overcome unequal power relationships that may exist between gerontic nurses and care recipients. Ultimately the authors expect that this will improve the relationship that develops between residents and nurses. Through the application of therapeutic reciprocity residents and nursing home staff work to equalise their relationship through, for example, opportunities for residents to do something for the staff or participate in decisions about their care.

4.1.4 Family-nurse relationships

A number of scholars have explored the relationships that develop between residents’ families and gerontic nurses (Hatton, 1977; York & Calsyn, 1977; Looman, Noelker, Schur, Whitlach & Ejaz, 1997; Duncan & Morgan, 1994; Fleming, 1998; Kelley, Specht & Maas, 2000; Kotai-Ewers, 2001). Authors have reported that an important outcome of strong family-nurse relationships is that families feel involved in resident care (Hudson & Richmond, 1994). Ultimately, high levels of family involvement in resident care positively influence residents’
wellbeing (Setterlund, 1998).

Bowers (1988) finds that family members feel that it is imperative to be involved in the care of their relative. The author describes the process whereby relatives maintain close relationships with their relative in a nursing home as maintaining ‘family connectedness’. Maintenance of family connectedness is a major focus of the care giving activities of relatives and is achieved when family take their relative away from the nursing home on trips, visit their relative and place memorabilia in their relative’s nursing home room. Family members also manage to maintain their connection with their relative by anticipating their care needs, preventing their relative from becoming more ill or disabled, supervising the care delivered by staff and protecting them from “the consequences of that which was not or could not be prevented” (Bowers, 1988, p. 26).

4.1.5 Adversarial relationships

Good relationships do not always occur for all nurses with whom the care recipient interacts (Williams & Irurita, 1998). While it is possible that residents, their family and nurses benefit from good relationships (Pillemer, Hegerman, Albright & Henderson, 1998), from time to time they may find themselves in adversarial positions (Bowers, 1988). Conflict may arise when nurses believe that families have unrealistic expectations of them (Hudson & Richmond, 1994), when families are under the impression that nurses are unable or unwilling to help them (Bowers, 1988), where families believe that resident care is undertaken in an inflexible, routine manner (Litwak, 1985), or where care is reduced to “perfunctory performance of set tasks” (Setterlund, 1998, p.136). Conflict may also occur when family members feel that the information they have
about the resident is disregarded by staff or when family members feel in competition and displaced by staff who appear to cope well with the resident’s condition (Setterlund, 1998).

Conflicting role expectations between relatives and nursing home staff may result in tension (Schmidt, 1987). Conflict may stem from families experiencing difficulties in the perception of their new role in relation to their relative (Ade-Ridder & Kaplan, 1993). By necessity, after their relative has relocated to a nursing home, families are required to develop new ways of caring for their family member in the unfamiliar environment of the nursing home (Kellett, 1996). Family members are called on to redefine the role they played in the life of their relative (Dellasega & Mastrian, 1995) and to seek ways to maintain their relationship within the parameters of the new role (Kellett, 1996). This can be facilitated when gerontic nurses encourage family involvement through visiting their relative, continuing involvement in task performance and sharing care through collaboration between staff and family in an atmosphere of friendliness, understanding and patience (Ross, Rosenthal & Dawson, 1993).

Gerontic nurses play a pivotal role in developing relationships with family members to ease their transition from their ‘old’ to their ‘new’ roles in relation to their relative, and in assisting residents of nursing homes to adjust to their new life. Much of the work that has been undertaken to date on the interpersonal relationships that develop between residents, family and gerontic nurses has focused on the advantages of these relationships to residents, their family and staff, as well as looking at the reasons why the relationships sometimes are less than ideal. While this work on interpersonal relationships and gerontic nursing is a sound beginning for scholars of aged care much more work in this area needs to be undertaken. In particular, it
would be useful for scholars to focus their attention on the ethical dimension of gerontic nursing from the point of view of the role played by interpersonal relationships in the ethical decision-making process.

As has been stated previously, this interruption in the research journey afforded me the opportunity to increase my understanding of areas of literature about which I knew very little. This interruption proved to be essential to my understanding of the approach to ethical decision-making, respectful relationships, that was adopted by a group of gerontic nurses working in a nursing home.

4.2 *Illuminating the approach to ethical decision-making, respectful relationships*

An illumination of respectful relationships, its elements and sub-elements appears in the following section. After interrupting their journey to explore previously unexamined literature on respect and interpersonal relationships, the reader is invited to resume their travels and walk alongside me to deepen their understanding of the journey’s discoveries as they relate to respectful relationships, an approach to ethical decision-making for gerontic nurses.

Illumination of this approach is facilitated through the utilisation of data excerpts obtained from my in-depth interviews with nine registered nurses and from my personal reflective journal. Selected excerpts from these data sources provide the reader with the opportunity to deepen their knowledge of the concept of respectful relationships and the elements and sub-elements that constitute it. In order that the reader can identify the source of each excerpt, all interview data contained in this chapter have been identified by the nurses’ pseudonyms. Excerpts from my
reflective journal also appear in this chapter. Where this occurs the excerpts are identified as coming from ‘Melissa’.

From time to time, data excerpts have included the name of the research site or other nursing homes. Where this has happened, I have removed the nursing home’s name from the excerpt and replaced it with brackets enclosing three ellipses (...). In this way the anonymity of the research site and other nursing homes is protected. In all the excerpts, the names of residents, health care professionals and family members have been changed to protect their identity.

4.3 Respectful relationships

Respectful relationships was discovered to be an approach to ethical decision-making utilised by the group of gerontic nurses who participated in this study. The themes and categories that emerged from this research journey’s data analysis came to be seen by me to be the elements and sub-elements of the approach to ethical decision-making, respectful relationships. A number of elements and sub-elements emerged from the research discoveries as constituents of respectful relationships. In total three elements and eleven sub-elements together made up this approach to ethical decision-making (see table 4.1). Each element and sub-element explicated in the following section will be described in a particulate fashion, even though, as part of this approach to ethical decision-making, they are interrelated. The interrelationships that exist between the elements will be described in chapter 5.
Table 4.1 Research discoveries: Elements and sub-elements of respectful relationships

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<th>Elements</th>
<th>Sub-elements</th>
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<td>Having self-respect</td>
<td>• Making personally-fulfilling ethical decisions</td>
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<td>• Being courageous</td>
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<td>Doing the right thing</td>
<td>• Practising gerontic nursing ethically</td>
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The nurses built respectful relationships with care recipients when they enacted the three elements of respectful relationships by having self-respect, establishing closeness with nursing home residents and their families and by doing the right thing. The element, having self-respect means that the nurses had high self-esteem and were proud of the ethical decisions that they had made. It comprises three sub-elements; making personally-fulfilling ethical decisions, being courageous and being reflective.

The second element, establishing closeness, refers to the close interpersonal relationship that the nurses sought to develop with care recipients. Sound ethical decision-making was facilitated when nurses formed a close relationship with nursing home residents and their family because this afforded the nurses the opportunity to deepen their understanding of the complexities of the ethical problem from the unique perspective of the resident involved. Establishing closeness
occurred when the nurses connected and focused on care recipients and when they had time to be with the resident and their family.

The final element, doing the right thing, refers to the nurses making sound ethical decisions. Doing the right thing was facilitated when the nurses acted ethically as gerontic nurses, managed ordinary ethical problems, balanced care recipient’s rights with the rights of others involved in resident care, used ethical principles and worked with colleagues to manage the ethical problems they encountered in the nursing home.

The nurses in this study described how their ethical decision-making was informed by the notion of respect for the care recipients of the nursing home. Respect for care recipients played a central role in nurses’ ethical decision-making and was referred to often during the interviews. When the nurses respected other people they had a genuine concern for the integrity of that person, and when they made ethical decisions based on respect, they believed that they were acting in an ethical manner.

*You respect the residents, their families... you really want to know that they are OK in all aspects of their lives, this is what we have to do as nurses, this is what nursing ethically means, so respect becomes the basis for the way we go about making ethical decisions* [Clarissa]

*You have to respect other people, that means residents and their family. Even when you don’t agree with them, when their views are different to yours, you have to respect them and their wishes* [Daisey]

It was of great importance to the nurses that the residents of the nursing home were treated with respect. There was general consensus amongst the nurses that older residents of the nursing
home were deserving of nurses’ respect. While some nurses acknowledged that all care recipients, regardless of their age, were deserving of the nurses’ respect, older people were believed to be especially deserving as they had lived through a considerable degree of social upheaval during their lives and, as they had ‘given’ to society they deserved to be respected in return.

*They have been through the most that anyone could possibly go through. They have been through wars and depression ... they have had the hardest life that anyone can have, we haven’t lived through that kind of thing, we don’t know what it would be like, they deserve to be respected, they have done a lot [Mary]*

The concept of justice was evident in the nurses’ comments when they said that they believed that all older people deserved to be respected equally. They maintained that sound ethical decision-making was possible in circumstances where all older people were respected irrespective of their diagnosis or level of disability.

*Nurses must respect the person in that particular time of their lives ... regardless of their medical conditions, you just treat them all the same ... that is the right thing to do [Emma]*

Respect was demonstrated to residents when nurses held them in high regard, listened to them and where possible acted according to their views and preferences. In the following excerpt, Daisey described how she believed that she had made a sound ethical decision by demonstrating respect for a demented resident by including the resident in decisions about her own care.

*You respect demented residents too and this can be hard ... you listen to their opinions even when they are different to your own, you accept other people’s ideas, this can be hard when the resident is demented. But it is the ethical thing to do. I remember a situation where the doctor wanted a resident to go on a reducing diet. She needed it because she had cardiac problems ... she was also*
dementing, she was in the early stages. I said to her “what do you think?”, she said that she didn’t want to. So I had to compromise about the details of the diet ... it made it easier for her ... you have to allow people their choices ... but when they have conditions like dementia, when they lack insight into their own health, it can be very difficult [Daisey]

The nurses believed that each resident’s family was deserving of the nurses’ respect and that respecting the family was the ethical thing to do. As in the case of residents, sound ethical decisions were possible in circumstances where the nurses respected the resident’s family, listened to them, acted according to their views and preferences and included them in decisions pertaining to the resident’s care.

You can never say “too bad, I’m not looking after the relatives, the resident is my responsibility”, it is unethical to say that ... no, not at all, you can’t say that. You have to respect the family too. You have a responsibility to include the family, because you need to get the relatives to understand that you understand their predicament. Then they are more willing to become involved and that helps a lot, it helps the nurses which in the long run helps the resident. So you have to take account of the relatives’ needs as well and listen to their ideas about the care of the resident ... they often have a lot of ideas that can help us [Kirstie]

Respectful relationships were the means by which the nurses demonstrated respect to residents and their family. A relationship based on respect was one in which the nurses sought to achieve a close interpersonal connection with the other person. This connection could be facilitated when nurses opened themselves to the possibility of empathising with the resident’s situation. In the following excerpt, Emma described how early in her nursing career, she discovered that showing empathy for a patient’s situation helped her to develop a close relationship with a patient and thus be in position to understand and show respect to the patient.

Years ago, doctors and senior nurses would talk over their patients as if they were not there. The student nurses were the ones who had to go back to the patient later to explain everything to them. I learnt a lot about the human side of nursing
from those experiences ... I remember when I was a student nurse and how offended I felt when I was talked over. I began to realise how the patients felt. You learn from those experiences, you remember what it was like and you realise that it is important to build a relationship with the patient ... because then you can understand why someone does what they do or says what they say, you are in a position to understand, then respect them as individuals and then they are not just the 'appendix in bed four' [Emma]

An important aspect of establishing a respectful relationship with nursing home care recipients involved the nurses understanding that each resident and their family reacted differently to the stresses involved in relocation to a nursing home.

I suppose it is because you are working with the human factor, it is very labile, humans are not machines that do the same thing every day. You never know what emotions you will come up against ... it can be very, very hard for relatives to put their loved one in a nursing home. Every time you come on duty ... we work with human beings and work with different people and the way they react to the nursing home move is different, each person reacts to staff, relatives and their illnesses differently ... it's an on-going thing [Kirstie]

The nurses in this study actively sought to build respectful relationships with care recipients. This aspect of the care they delivered appeared to be embedded within the everyday practice of the nine experienced nurses in this study. The embedded nature of the development of respectful relationships meant that it appeared to occur without the nurses' awareness.

It was only after I had been immersed in the data for quite some time that it occurred to me that respectful relationships were a central notion in the ethical decision-making process of the nurses in this study. However respectful relationships seemed to be embedded in the very fabric of the ethical decision-making that the nurses undertook. There was a sense among a number of the interviews that the nurses just got on with building respectful relationships and didn't give the process much thought at all ... it was 'business as usual', as experienced geriatric nurses this was just what they did. It was the right thing to do [Melissa]
4.4 Types of respectful relationships

Four types of respectful relationships emerged from this journey's discoveries and were identified by the nurses as being professional, familial, collegial and reciprocal. Each type of respectful relationship was not mutually exclusive, indeed elements of a number of types could be identified from the same data excerpts. However, for the convenience of the reader the four types of respectful relationship have been dealt with here as discrete entities.

4.4.1 Professional respectful relationships

When the nurses spoke of the first type of respectful relationship, professional, they drew largely on examples from their experience that focused on the professional duty of care they felt for residents and their families. The notion of duty of care was described in a number of examples the nurses gave when they recalled their experiences of ethical decision-making. For all the nurses in this study, sound ethical decision-making and upholding their duty of care to the resident and their family went hand-in-hand. They generally expressed the belief that it was not possible to have one without the other. Kirstie expressed this belief when she said:

_We have a professional responsibility to do what is right, this means that we have to understand our duty of care to the residents. It is there all the time in your mind, and if you use that as a guide, then you will make good ethical decisions_ [Kirstie]

An experience common to a number of the nurses was that in attempting to uphold their duty of care to a care recipient they found themselves in conflict with their medical colleagues. The
following excerpt is included here because it captures well the difficulties this nurse experienced in ensuring that she upheld her professional duty of care to a resident. Other nurses in this study reported experiencing similar situations to this one, described by Emma.

We had a man who was developing a urinary tract infection, and so I felt that I should ring the doctor and inform her of what was going on. The doctor said 'Oh, I saw him on Tuesday, and he was quite well then'. But it was Saturday now! ... she asked to be informed of the results of the ward urinalysis which we were about to collect. She said she would telephone us again in an hour. I said that I wanted her to see him sooner and she then gave me the spiel about how she was at home alone with two little children and she couldn’t leave them and couldn’t bring them in with her. Well, that didn’t make me feel any better! By this stage it was the end of my shift and I had to hand it over to the evening nurse. The doctor didn’t come that evening. The evening RN had to ring her again to get an order for antibiotics because by this stage the urinalysis results were indicating the urinary tract infection... the doctor told the evening RN that she’d be in to see the resident tomorrow. But still she didn’t come in. So the next day I had to ring her AGAIN for another order of antibiotics. We ended up having three emergency orders for antibiotics that weekend. The regular doctor came in on Monday to tidy up all the paperwork ... the point is, and this makes me angry, that if we’d left it up to the doctor, nothing would have been done for this man. He would have become very ill, very quickly as a result [Emma]

4.4.2 Familial respectful relationships

The nurses described how respectful relationships could be familial in nature. Like members of the same family, some of the nurses reported how they had come to know care recipients on a very personal level. This was facilitated by the fact that many of the nursing home residents had lived at the nursing home for extended periods of time. This afforded the nurses the opportunity to develop relationships with residents which the nurses described as being similar to familial relationships.
When you have known someone for quite some time, you know their background, you know their relatives, their history, you can become close... they can become like family, in the back of your mind you think that they could be your family. [Pamela]

Years ago residents came in when they were relatively well. A resident died just recently who had been at (...) for twenty-two years. That was a very long time to call a nursing home your home ... they used to come in when their husband or wife needed nursing home care, they would both be admitted even if only one needed nursing care. So we became like members of their own family [Mary]

However, Pamela described how she sometimes experienced difficulties from relationships with care recipients that were familial in nature. In the following excerpt she articulated how she experienced some negative emotional effects from such a relationship.

When I stayed working in one ward I became too involved, I got too close to the residents and their problems and I took too much on board. Now that I am moving around to different wards it is so much easier for me because I don't get so involved, their problems don't worry me so much now, I don't take them home with me [Pamela]

Kirstie acknowledged the emotional toll that a close familial-like relationship with care recipients could have on gerontic nurses. That was due, she claimed, to the strong emotional bond that developed between the nurses, nursing home residents and their families over lengthy periods of time.

We have a much longer commitment to the residents compared to nurses in acute settings. We have a long commitment that is an emotional commitment. It's a short term relationship in acute care, with us it's long term, and it's emotionally tiring [Kirstie]
4.4.3 Collegial respectful relationships

The third type of respectful relationships was referred to as collegial. These relationships were seen as similar to the relationship that developed between close friends. Collegial respectful relationships emerged as the nurses got to know residents and their families and came to understand some of the circumstances of their lives. Collegial relationships could become stronger when nurses and residents both understood that the resident’s death was imminent.

*There’s the issue of dying. The residents are frightened and they ask you about it. When they are frightened, they ask you about things. They sort of cling onto you … they ask you about all sorts of things from their lives … they cling on to you particularly when they have known you for some time, particularly in aged care, they look upon you as a friend, somebody to lean on, to cling to … and knowing that they are going to die they confide in you deep and personal things and you have to help them feel relieved and relaxed… I remember two residents in particular who I’d known for quite some time, they both knew that they were dying and it used to come up in conversation quite a bit. They’d call me over and I’d have to make time to talk with them. Obviously they felt comfortable with me otherwise they wouldn’t have asked me.* [Pamela]

Collegial relationships between nurses, residents and their family, were facilitated when the nurses were a similar age to the care recipients. One of the older nurses in this study expressed the belief that family members sought them out because older nurses were seen to have greater insight into the resident’s problems compared to younger nurses. They were believed by family members to have more insight into the problems of the older residents and their families because the nurse may have been in a similar situation with her own family.

*Older nurses have family members who are ageing themselves, they can see their own parents following in the resident’s footsteps. The registered nurse is ageing as well and they can see themselves becoming just like the*
resident's family. The whole process becomes much more personalised because you are much closer to those sorts of changes in your life compared to younger nurses ... The experiences we have had help us to empathise with the residents and their families better. The families feel that because we are a little older we understand better, because we are in their age group forty to sixties, their age group, immediately there is that rapport. We get told a lot more than a nurse who is in their twenties. It's a bit like being a member of the families' extended group of friends [Kirstie]

4.4.4 Reciprocal respectful relationships

The fourth type of respectful relationships, reciprocal relationships, refers to the give and take that often occurs in these relationships. They often began with the nurses sharing something of themselves with the care recipient.

I think that it is good for the resident's family to understand that you do have the capacity to understand their predicament. If you can let them know that you too have ageing parents, that you too are worried and concerned about the things that are worrying and concerning them, then it really helps when it comes to building up a relationship with them [Kirstie]

Reciprocity was evident in respectful relationships through the use of humour,

Every morning I arrived at work in the winter Annette would be sitting in the smoking room having her cigarettes. I'd often complain to her about how cold my feet were. Most mornings I'd get no verbal response from her. One morning she laughed at me when I told her and from then on every time she saw me she'd demand to know "are your feet cold?". When I said they were she'd chuckle and walk away, winter or summer she would demand to know about the state of my feet. I discovered very quickly that she loved it when I said they were cold. Then one day she
informed me that I should buy some sheepskin inserts for my shoes. She didn’t ask me about my feet ever again [Melissa]

and through the sharing of activities that the resident would probably undertake with family or friends outside the nursing home environment.

One resident was usually very gruff, every morning she would snap at me ... so I would put my arms around her and gave her a cuddle and she would just melt, and she would laugh and we could have a talk ... they just want you to sit and have a talk. I’ve done that many times, just sat on their bed and had a cuppa with the resident and a chat [Mary]

The four types of respectful relationships elucidated here provide the reader with a sound understanding of the nature of these relationships as described by the nurses who participated in this study. As has been stated previously, the nurses’ descriptions of respectful relationships could contain examples of more than one type of respectful relationship. For example, Pamela described how they could be both familial and collegial at the same time when she said that:

The residents can become like family members to you, you become very close to them, they become your mates [Pamela]

The next section in this chapter will move from an emphasis on the types of respectful relationships to focus instead on the elements and sub-elements that constitute the approach to ethical decision-making, respectful relationships.

4.5 Elements and sub-elements associated with respectful relationships

As has been stated previously, the knowledge that emerged from the discoveries of this research journey indicated that respectful relationships were made up of three elements: having self-
respect, establishing closeness and doing the right thing. Each of these elements was made up of sub-elements, in total, 11 sub-elements constituted the three elements. Each element and sub-element will be explored in the following sections

4.6 Having self-respect

Part of the development of this approach to ethical decision-making involved me travelling along research journey roads that were completely unexpected. Unexpected roads can sometimes lead to the discovery of new things that fascinate and astound the traveler. The following element, having self-respect, was one such example.

I was surprised to discover during the research journey that the element, self-respect, was a common thread that wove its way through many of my interviews with the nurses. Initially it took some time for my awareness of this element to be raised, as it wasn’t until I had conducted five interviews with the nurses that it first gained my attention. However, once my attention was caught I looked for and found evidence of nurses having self-respect and its relationship to the approach to ethical decision-making in much of the interview data. By diverting along this unexpected path I made a significant research discovery about gerontic nurses’ ethical decision-making. If I had chosen not to travel the unexpected path and continued with my journey, I might have left the element undiscovered.

The following short comment from Mary was instrumental in alerting me to this element.

*When you respect yourself, you give out respect to residents, self-respect has to come first* [Mary].
Emma also spoke of having self-respect. In some of her earlier interviews Emma spoke of how nurses' self-respect was a determinant of quality nursing care. She argued that when gerontic nurses' self-respect was high they delivered optimal nursing care; conversely, when gerontic nurses experienced low self-respect the quality of the nursing care they delivered was likely to be poor.

*If you are unhappy ... if you feel that the reward isn't there ... then your quality of nursing care might deteriorate, it all boils down to self-respect for the nurse ... on the other hand if you are happy and have good self-respect, you give good nursing care* [Emma]

Having self-respect emerged as important to nurses' ability to build respectful relationships with care recipients. This was highlighted in the following example where Emma described an ethical problem she encountered where a demented resident was moved to another ward without the knowledge or consent of the resident's wife. In this example Emma demonstrated how she drew on her own self-respect to build a respectful relationship with the resident's wife, Mrs Jones, in an attempt to manage this ethical problem.

*When we have to accommodate a very sick resident, then we have to shift other residents around, to move the sick resident onto a more appropriate ward. That's what I found with Mr Jones, he had been moved to another ward and his wife and family had had no say in it. His family were told after the decision had been made, and that really was the crux of the matter. If they had been involved before hand, things would not have become so bad with his wife ... the family had a point and the wife took great offence. I had to move him in the morning and after it was all done I had to apologise to Mrs Jones and try to explain why it had happened the way it did. It was hard but I still tried to get our relationship back on an even keel ... but because I was confident, because I was OK in myself, I could put the problem on the table and then deal with it. I acknowledged Mrs Jones' feelings, they were legitimate. I could see it from her point of view ... I agreed with her, she was right and we were wrong* [Emma]
In a later interview, when Emma referred to this ethical problem again, she described how her self-respect gave her the self-confidence that assisted her to understand what the right course of action was and ultimately how to manage the ethical problem. The confidence that she felt in her own nursing knowledge enabled her to acknowledge to Mrs Jones that the wrong thing had happened with her husband, which placed Emma in a better position to build a respectful relationship again with her.

**Emma:** I’m pretty outspoken about things. If I have a point to make I just steam roller in. Probably because I feel equal to others. I have high self-respect. Look, I’ve been a Director of Nursing myself. OK? I know how things should be done, I know how to do things properly. The Director of Nursing at (...) thought that this situation had been handled properly. From her point of view everything correct had been done. I disputed that. I didn’t think that it was done properly. That’s where the controversy came in.

**Melissa:** So when you approach an ethical problem from an equal point of view you can be fairly confident about ...

**Emma:** Definitely! Definitely! I know what I’m talking about too! OK? So I made my peace with the resident’s wife and tried to move on from there.

The nurses demonstrated their self-respect by proudly recounting narratives of their past gerontic nursing experience to me. Their pride was evident by the ease with which they volunteered their narratives about the ethical problems they encountered and through the body language they used during the interviews.

*As I spoke with Kirstie today I couldn’t help but get a sense that she really wanted me to understand what it was like for her when she experienced the ethical problems she had. I think that she enjoyed telling me, maybe she hasn’t had the opportunity to tell many people, and now that she is coming to the end of her working life she may feel that it is good to have her experiences recorded in this way. What struck me most about our interview was the pride in her voice and in*
her demeanor as she recalled her experiences. She was has such self-respect, but
what is slowly becoming clear to me is that there is an inter-relationship between
nurses' self-respect and the establishment of respectful relationships with
residents and their families, little by little I am coming to understand that the two
are very closely linked [Melissa]

The nurses sought to maintain their self-respect in an environment where they frequently felt
devalued and marginalised by their nursing colleagues. Many of the nurses spoke of this in their
interviews. There was general consensus amongst the nurses that the wider nursing community
did not acknowledge the skills the gerontic nurses developed in aged care. This lack of
recognition occurred, they believed, because of the higher status placed on other nurses,
predominantly those who worked with complex machinery common in acute hospital settings.
As a consequence, the nurses who participated in this study felt that gerontic nursing was rarely
recognised as a specialty in its own right.

Gerontic nursing has never been fully acknowledged like other nursing
specialties. It has been “Oh well, I’ll just work in a nursing home because I can’t
get any other job”. People don’t realise how difficult it can be, not everyone can
work in aged care [Emma]

We don’t care for people with drips and drains and tubes coming out of every
orifice. We don’t have all the flashing lights and doing observations every five
minutes in nursing homes. If you want that kind of work you have to work in a
hospital. But what we do is immensely important [Kirstie]

According to the nurses, the assumption that de-skilled or ‘bad nurses’ worked in nursing homes
and that ‘good (highly skilled) nurses’ found employment elsewhere was prevalent among their
nursing colleagues. ‘Good nurses’ in aged care were considered to be wasting their talents on
undeserving older people who usually experienced chronic, incurable illness and disability.
A lot of people say ‘aged care is the bottom of the heap, you mustn’t be a very good nurse if you work in aged care’ but I think that it is a great career path... they say ‘why is she working in aged care? What a waste, she could work anywhere’... this has got to change. [Mary]

The effect of a constant stream of media attention that highlighted sub-optimal care practices in some Australian nursing homes had a demoralising effect on a number of the nurses. They expressed their frustration that all nursing homes were portrayed as places to be avoided at all costs when they believed that at ‘their’ nursing home, the residents received a very high standard of care.

The nurses were very annoyed and said that they were sick of hearing all the bad news stories about nursing homes in the media. They wondered why the media consistently chose to ignore all the great nursing homes that were providing excellent care and services to residents and chose instead to continually portray nursing homes in a very poor light. While they acknowledged that there were a minority of nursing homes who were less than ideal, they firmly believed that ‘their’ nursing home was not one of them. They were proud of the care they delivered but also acknowledged that it was hard for them to tell other people that they worked in a nursing home. One nurse recalled how her mother had said to her “you won’t be working in the nursing home for long will you? It’s just a stepping stone to somewhere else, isn’t it?” [Melissa]

Nurses who had self-respect were characterised by the nurses in this study as those who made personally-fulfilling ethical decisions, were courageous in their ethical decision-making and were reflective about the ethical problems they encountered, see table 4.2 below. The three sub-elements of the element ‘having self-respect’ each constituted the way in which the nurses demonstrated their own self-respect as it related to their ethical decision-making in the context of the nursing home.
Table 4.2 Sub-elements associated with the element ‘having self-respect’

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<td>Having self-respect</td>
<td>□ Making personally-fulfilling ethical decisions</td>
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4.6.1 Making personally-fulfilling ethical decisions

It was important to the nurses that they made personally-fulfilling ethical decisions. This fulfilment could then potentially impact on their feelings of self-respect which in turn impacted on their ethical decision-making.

> When you feel fulfilled by your ethical decision-making, by what you are doing, then you feel better about yourself as a person and a professional, I think it is because you feel comfortable with yourself as a professional, then that flows back into your ethical decision-making [Clarissa]

The nurses reported how they needed to gain personal fulfillment from the knowledge that they were caring for older people to the best of their ability by making sound ethical decisions concerning their care.

> I need to get job satisfaction I need to know that I am doing the best I can for the residents. I need to get job satisfaction, not just money in the bank [Emma]

Personal fulfilment came from the nurses’ knowledge that they could and had made a positive contribution to the life of others through sound ethical decision-making. Gerontic nursing offered them this opportunity particularly when they cared for residents through the end stages of their
lives to their death. It was during this time that the nurses believed that their work had its greatest impact on the resident and their family. It was at this time that the nurses gained the deepest sense of fulfilment from the ethical decision-making they undertook.

*When you think about it, we have to make really good ethical decisions about the quality of care people receive at the end of their lives, it doesn't get any more important than that* [Mary]

In the following example, Mary described how she gained personal fulfilment from her ethical decision-making only after a nursing home’s Director of Nursing took her concerns over the ethical problem seriously. She required the support of the Director of Nursing to ensure that the resident received the care that she believed the resident deserved.

*I did complain to the Director of Nursing at (...) during my first year there. I felt very strongly about an ethical problem that I saw with the care of a resident here. The resident didn’t want to have a shower every morning, the Nurse Unit Manager expected that all the residents would come to breakfast showered and dressed for the day. I tried to discuss it with the Nurse Unit Manager but she had her set ideas and she wouldn’t discuss it with me. She told me that there was no way that she would deviate from her set views on the care of this particular resident ... in the end the Director of Nursing discussed it with her. It was a very lengthy discussion but in the end the Nurse Unit Manager had to change the way care was being delivered to that resident, I was glad that I did what I did for that resident, because if I hadn’t he would not have had anyone to speak up for him. He was developmentally delayed, there was no family and it was doing him no good at all to be forced to shower every single morning* [Mary].

In the above quote Mary is alluding to the relationship that exists between the gerontic nurses’ advocacy role and the personal fulfilment they experience when they make sound ethical decisions. Advocating on behalf of the resident, where it was required, was seen by the nurses to equate to making sound ethical decisions which in turn helped the nurses to feel fulfilled.
Advocating for the resident also required the nurses to be courageous in their ethical decision-making.

4.6.2 Being courageous

Being courageous in their ethical decision-making by acting on what they believed was right was deemed to be an important characteristic of a self-respecting gerontic nurse. The examples of courage described by the nurses frequently involved situations in which they were required to advocate on the resident’s behalf in order to do what was right for residents and their families. Having an understanding of what the residents and their families’ wishes and preferences were, was identified as the precursor for effective advocacy. Once the nurses had identified the care recipient’s needs they could courageously go about trying to ensure that those needs were met.

*It’s not the case that the nurses courageously stand up to others to fight for what THEY think is the right thing for the resident, time and time again, the nurses have made the point that they try to determine, as best they can, what the resident’s individual needs are. Once this has happened they can feel well prepared to pursue that goal, even if it means coming into conflict with doctors, and from what they have told me, that is often the case [Melissa].*

Sandra described how she drew on her personal courage in her interactions with her medical colleagues over ethical problems when she said:

*Professionally, as a nurse if I take a certain position and then a doctor comes along and says “hey, hang on a minute”, it does start raising questions for me ... but from my point of view, if something is an ethical problem, then no bugger, just because they are a doctor, are going to change my mind about it [Sandra].*
She did however temper her seemingly unyielding position later in the interview when she said:

*We can talk about the ethical problems, but if I disagreed with the doctor they would have to really convince me that they were making the right ethical decision* [Sandra]

Like Sandra, Kirstie also related how she listened to doctors’ opinions about ethical problems. However she added another dimension to the notion of being courageous when she alluded to her belief that being courageous also meant admitting your mistakes.

*I know that I am a dogmatic type of person but I do hope that no matter what, if I made a mistake, I can admit it. You have to be able to realise that you can make mistakes and to justify it even if it was the wrong decision* [Kirstie]

An important aspect of being courageous was, for Kirstie, the belief that nurses should see themselves as equal to their medical colleagues.

*I remember an ethical problem where I had to get my point across to a doctor ... sometimes I think that doctors know what they want to do, but don’t realise that there are alternative ways of getting there. I wasn’t subservient, there’s no way I would be subservient, I’m just as good as they are, we are all professionals ... The whole point of our relationship with other health professionals is that we should be able to nut things out, we should be able to say I think ‘this and this’ and others could say ‘yes but can’t we try it this way?’: If we all work it out we will come up with a totally different answer because there are four or five heads together. That’s not detracting from anyone’s professional capabilities ... because the most important thing is that we are doing the right thing for the resident, and together, with our colleagues, as a team, we can do that. [Kirstie]*

Being courageous sometimes brought the nurses into conflict with their nursing colleagues. In the following example, one of the nurses in this study described how her refusal to use chemical or physical restraints on a resident, on the grounds that it was unethical, brought her into direct conflict with other nurses at the nursing home.
In aged care where everyone is so busy and the workload is so heavy, the easiest way out for the nurse is to restrict the movement of the resident so the nurses can get on with their work. I get pressure from other nurses to sedate residents, especially at night time, or to restrict their movement in some way ... put them in a chair that you know they can't get out of ... whereas I think that the nurses should be doing something with the resident, take them for a walk, make them a cuppa ... some demented residents don't know night from day, how are they to know they should be asleep? [Mary]

4.6.3 Being reflective

When the nurses were reflective, they thought deeply about the ethical problems they had encountered and also about the way the problems had been managed. By critically reflecting on their past ethical decision-making and by having the self-confidence to use this information to change and improve their future ethical decision-making, the nurses demonstrated self-respect.

Personally I look at myself and I say “Well you could have done that better”. That's the way I am. Things can always be done better [Emma]

Self-reflection could be triggered when the nurses were uncertain about an ethical decision they had made. At such times the nurses questioned their actions and wondered if they had made the right decision. In the following excerpt, Maggie questioned whether she had hastened a resident’s death by acting on his request to be transferred to a hospital that was a considerable distance from the nursing home. Had Maggie over-ridden his decision and kept the resident at the nursing home then he would not have died in the ambulance en route.

The resident was adamant that he would not go to the local hospital, as far as he was concerned ... nobody was going to send him to that hospital. He had made his decision very, very clear, he wanted to go to the other hospital, the problem was it was at least an hour’s drive away, so we did what he wanted we transferred him ... but we found out later that he died
in the back of the ambulance on the way there and I did wonder whether the transfer itself had made everything worse, you know, sped up his death [Maggie]

Self-reflection was enhanced when the nurses had the opportunity to discuss ethical problems with their nursing colleagues. However this opportunity rarely occurred.

Having access to others to talk things over with would be helpful ... It would be nice to have an avenue where you could discuss an ethical problem. Your ideas may change if you listened to other people who have experienced a similar thing and shared what they have been through. Maybe there is stuff that you are dealing with at the time that they have dealt with in a different way ... just being able to share problems and get different ideas and feedback would be ideal ... there could be things you haven’t thought about but you could pick them up by listening to other people’s experiences [Mary]

Having self-respect was discovered to be an unexpected, yet essential, element of the ethical decision-making approach, respectful relationships. The geronic nurses who participated in this research identified how sound ethical decision-making was facilitated when they had self-respect. There were three sub-elements of the element, self-respect: making personally-fulfilling ethical decisions, being courageous in their ethical decision-making and being reflective about the ethical decisions they had made.

When nurses made personally-fulfilling ethical decisions they felt satisfied personally and professionally and maintained their self-respect. This in turn impacted positively on other ethical decisions they made. This occurred despite working in an environment in which they felt devalued by their nursing colleagues. Self-respecting nurses were also described by the nurses as those who were courageous in their ethical decision-making. This meant having the courage
to advocate on behalf of the resident and their family regardless of whether this brought them into conflict with other people involved in the resident’s care. The third sub-element, being reflective, involved the nurses reflecting on the ethical decisions they had made in the past and using this reflective thought to improve practice in the future.

4.7 Establishing closeness

The second element of the ethical decision-making approach, respectful relationships, will now be explored. The element ‘establishing closeness’, which relates to the nurses’ feelings of warmth and affection felt for residents of the nursing home and their families, was an aspect of their ethical decision-making that appeared again and again in the transcripts of their interviews with me.

*The residents become special to you. They all have their own little ways, you remember them fondly, when you think about them later on, maybe after they have died, you miss them* [Pamela]

Sound ethical decision-making was enhanced, Clarissa argued, in circumstances where nurses established closeness with care recipients. By establishing closeness, the nurses were well placed to understand the subtleties and complexities of the ethical problem at hand.

*When you make an effort to get close to the resident, to understand the ethical problem from their point of view, then you start to think about it from different angles, ways you may not have thought about before, you sort of have your eyes opened up to their point of view, and that helps you to understand their problem, and then that impacts on the way you manage the problem* [Clarissa].
Emma believed that ethical gerontic nurses consciously chose to establish closeness with residents and their family on a deep level. Anything less than this, she believed, resulted in nursing care that was sub-optimal because it was task, rather than resident focused.

*I guess that you could choose to practise on a superficial level where you go to work, give out the pills, write the reports and go home. Or you could choose to practise on a much deeper level, on a level where you really get close to the residents* [Emma]

Mary admired nurses who she believed actively strove to develop closeness with care recipients and expressed frustration with those gerontic nurses who did not.

*Some nurses are excellent, the work and time and effort they put into getting to know the resident and their family is so much more than I could, but others float in and float out and really don’t make any impact on any shift* [Mary]

The nurses believed that they developed levels of closeness with care recipients that were not possible between nurses and patients in hospital settings. This was because of the long-term relationship that they built with residents and their family.

*We have a much longer commitment to the residents compared to nurses in acute settings. We have a long commitment that is an emotional commitment. It’s a short-term relationship in acute care, with us it’s long-term* [Kirstie]

The nurses also maintained that they and their colleagues working in nursing homes had the opportunity to establish closeness with care recipients because collectively nurses spent larger amounts of time with care recipients than did other health care professionals.
Because they see the nurses more often, they see that nurses care for them, and they know that the nurses care for their relatives as well because they can see it happening around them. Nurses are like mentors for relatives. Doctors see residents and their families once a week, once a month. Nurses are there with them all the time [Kirstie]

However, sometimes the nurses found it difficult to establish closeness with residents and found it almost impossible to deliver anything other than ‘nursing care’ to them. The reason for this was unclear to Clarissa who spoke of the need for nurses to bracket or put to one side any negative feelings they felt toward the resident and concentrate instead on the ‘job at hand’.

*I must admit that I can’t stand some residents, I don’t know what it is, I just can’t warm to them, I try but sometimes I fail ... when it happens I have to try to put it out of my mind and just get on with the job at hand* [Clarissa]

Kirstie also described how she bracketed any negative personal feelings she had toward the care recipients and as well as any of her personal worries. Such an approach enabled her to establish closeness with residents and their family.

*There are some people who drive you to drink and you think ... “how am I going to get around these people?”. But you never, ever let them know that you feel like that; you never let them know that that is what you are thinking. You may think that they are the biggest fools out but you cannot let your personal feelings come into it, because your main focus has to be about someone else, not yourself, your main focus has to be the person at the receiving end of the care, in other words, the resident ... you have to make sure that your mind is devoid of all your problems ... you have to learn that whatever happens to you personally has nothing to do with the people you are looking after. You must learn to cut your own problems out, whatever they are and leave them off duty* [Kirstie].
Establishing closeness with care recipients was impaired when nurses’ personal prejudices interfered with the care they delivered to the resident.

*At handover the registered nurse said that the resident, who was Dutch, was exhibiting difficult behaviour because of his cultural background. She said this at handover ... I looked around at the other nurses and they had startled looks on their faces, my hair just stood up on end ... that particular registered nurse did not look after the resident at all well. She obviously believed what she said and it showed in the way she cared for him, as far as I’m concerned that was unethical behaviour [Emma]*

In summary, the element, establishing closeness, refers to the positive feelings of warmth and affection that the nurses in this study felt for the nursing home care recipients. The discoveries revealed that when the nurses established closeness they felt that they were in a better position to make sound ethical decisions because they had the opportunity to understand the ethical problem from the care recipient’s point of view.

The nurses believed that they were ideally placed to establish closeness with residents and their families by virtue of the fact that they established strong relationships with care recipients that could last for years, and because nurses in general spent larger amounts of time with them than did other health care professionals. Sometimes establishing closeness was difficult for reasons that may be unclear to the nurse, in these circumstances it was necessary for the nurses to bracket any negative feelings they may have in order to get on with the job of caring for the care recipient and making sound ethical decisions.

Establishing closeness was possible when the nurses connected with residents and their family, focussed on them, and made time to be with care recipients. Connecting, focusing and making
time described the everyday practices demonstrated by the nurses which enabled them to establish closeness with care recipients. The sub-elements associated with the element, establishing closeness appear in table 4.3

Table 4.3 Sub-elements associated with the element ‘establishing closeness’.

<table>
<thead>
<tr>
<th>Element</th>
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4.7.1 Connecting

The sub-element ‘connecting’ emerged from the nurses’ descriptions of the way in which they participated in the experiences of the nursing home residents and their families. Connection with care recipients occurred when the nurses were sensitive to others by empathising with them and when they tried to appreciate what the residents and their families have been, and were currently experiencing.

*It is a very hard to put your parent or relative into a nursing home. Families can feel guilty, angry or confused, or a whole range of other emotions. The families may have really struggled with the idea of the nursing home, they may have been managing all sorts of problems at home by themselves like incontinence, or wandering due to dementia. We have to bear that in mind, we have to work through all that with the family. It helps you to ... sort of, make a connection with them ... an ethical nurse will see the importance of that [Clarissa]*

The nurses described how they used a range of strategies to achieve connection with residents and their family. Strategies such as taking a personal interest in their needs and feelings and
responding appropriately to them indicated to the resident and their family that the nurse was genuine in her desire to connect with them.

> When the families are having a hard time accepting the changes that are occurring in their mother or father, it can be very difficult for them. They can feel embarrassed and anxious about their parent’s behaviour. They remember their parent when they were at their best, we don’t ... and it’s important that we let the families know that we realise that their parent was young and beautiful once, that they weren’t always an old man or lady with bizarre behaviours [Kirstie]

Connection was enhanced when the nurses maintained physical and emotional closeness to residents and their families. Strategies such as sitting close to them, touching and hugging them indicated to the resident that the nurse was connected with them on a physical level.

> I like to sit close to the residents, to give them a hug and a kiss. I will often just sit on their bed with them and have a cuppa. Early in the mornings it can be quiet and I can have a quiet chat. We can talk about a whole range of things and they can open up and tell you their worries. It is important to get that information, everything can be useful for their care [Mary]

Emotional connection involved the nurses communicating to the care recipients that they were genuinely concerned for the care recipient’s well-being.

**Melissa:** How do you establish a close relationship with a demented resident?

**Daisey:** It’s to do with approaching them in the right way, listening to what they have to say to start with whatever it is. Taking it seriously, starting with their problems and dealing with these problems whatever they are. Not belittling them, reassuring them, telling them that we will have things looked into. Most of them can take this sort of information on board, so long as you
One strategy the nurses used to strengthen an emotional connection with care recipients involved bending the nursing home rules. In the following example Mary’s willingness to bend the rules on occupational health and safety served to deepen the connection that she felt for the resident.

The resident told me that one of the things that she missed most was seeing the sunrise in the mornings. So each morning I was on duty I would pull her bed away from the wall so she could watch it ... It was an occupational health and safety hazard! I think a lot of the other nurses tripped over that bed ... but the resident loved seeing the sunrise, she looked forward to it whenever I was on duty (laughs) [Mary]

Anne reported another incident of ‘rule-bending’. This example of rule-bending eventually resulted in the strengthening of the connection between Anne and the family members of a deceased resident. In the following extract, she described her actions following the death of a resident. The nursing home policy stated that deceased residents must be moved to the morgue within one hour of their death and family and friends can view the body in the morgue. At the time of the resident’s death, the nursing home’s owners had commenced a major re-building program for the nursing home and parts of the original building were vacant and awaiting demolition. When the resident died the morgue was situated in a disused portion of the nursing home. Anne believed that it would be too distressing for the family to see the deceased resident in the soon-to-be demolished building, and chose to keep her body on the ward instead.

The nurses were waiting for Rachel’s family to arrive to say their goodbyes. They were expecting the family to arrive at any moment. The family consisted of Rachel’s very devoted sisters. The family were expected at any time. Rachel had been a resident of (...) for a very long time. She had dementia and was deteriorating slowly over the last few
years. Many of the staff had become quite fond of her ... word had got around and a number of nurses from all over the nursing home were arriving on the ward to say their goodbyes to Rachel. A number of the old wards have now closed and even though the morgue is still useable, it is now in a deserted part of the nursing home. Nobody goes down there any more and they have a spooky deserted feel to them. I didn't want to move Rachel down there where she would be all alone, so I spoke with the other nurses and suggested that under the circumstances we would leave Rachel where she was ... the nurses agreed. I was concerned for Rachel's sisters who I knew wanted to see Rachel. I decided that it would be far more comforting for them to see Rachel in the familiarity of the ward that had been her home for so long. It would be distressing to take them through the deserted corridors to the morgue. So Rachel stayed on the ward and after her sisters saw her, was collected by the funeral directors from her bed. Rachel's sisters appreciated our thoughtfulness and told me later that it had meant a great deal to them, they'd never forget it [Anne]

Two other strategies the nurses utilised to connect with care recipients involved them striving to understand the resident's complex care needs and caring for the resident and their family as one unit. Two situations in which the nurses believed that it was especially important to form a deep connection with care recipients was when residents were dying and also when they had dementia.

The nurses described to me how they connected with residents by seeking to understand the complex nature of their care needs. This was achieved most effectively when nurses worked in collaboration with the resident's family. Without exception, the residents living in the nursing home experienced a range of physical, cognitive and social difficulties that prevented them from living in their own homes. In most cases, they also experienced age-related disorders such as heart disease and dementia. An understanding of the resident's complex and dynamic care needs were enhanced when the resident's family were consulted and included in planning the resident's care.
Now we see so much more input from everyone, compared to how it used to be in aged care ... The family is SO important, when you have information from the family it helps so much. You can get information about how the resident was employed and what they like to do. This helps you to understand what they do or what they say now that they are dementing. Without that information, sometimes what they say or do can make no sense at all. When the family is involved it makes a BIG difference. [Mary]

It was essential, the nurses believed, that they cared for the resident and the family as one unit, thereby increasing the connection between the nurse and care recipients.

*When I was working at (...) we cared for a lovely lady who was quite demented, she knew that she was like that and of course that distressed her. She was becoming more and more distressed because she was losing the plot and her behaviour would become so difficult that we'd have to call in the daughter. The daughter would try, sometimes it would work and sometimes it wouldn't ... I remember one particular day, I had the feeling that the daughter was being a bit aloof, we were probably just the same because the nurses were getting really hassled with the woman. The resident's behaviour was very difficult and the nurses had everyone else to care for as well as this particular resident. I think the nurses were beginning to resent the resident because of the huge amount of care she required so I had to try to understand it from the daughter's point of view, and so in a sense we were caring for both of them, not just the resident, and because we took that approach, we got to know them both so well, and we got to understand the complex family dynamics. That really helped!* [Kirstie]

Later Kirstie described how she recognised that the resident’s daughter was having difficulty coming to terms with her mother’s behaviour and how she actively sought to connect with her to help her understand that Kirstie genuinely cared for both her and her mother.

*I happened to see the resident's daughter on the balcony and she was crying. I went out to her and I said “Look, I realise it is terrible to see your mother like this”, she said “you have no idea” I said “I have got an*
idea ... I know that your mother was a very smart woman, she had lovely clothes, she had her hair done, she was a well travelled woman ... this is a tragedy. You are seeing your mother disintegrate before your eyes”. She said “yes, I am human you know” I said “yes I know” ... I said “have a good cry and you'll feel much better”. And I held her while she sobbed, then I made her a coffee and said “have a smoke and get over it and come back in when you are ready and we’ll start all over again” [Kirstie]

Connecting with the care recipients became particularly important to the nurses when the resident was dying. A heightened awareness by the nurse of the resident's needs meant that their end-of-life choices could be upheld.

We were caring for a resident who was very ill, the doctor thought that he would only survive for a few more days. He was ordered four to six hourly morphine which we were giving him. But at 4.30pm he was due for his next dose of morphine ... his condition had deteriorated considerably and we knew that if we gave it to him then he would die. But he was very frightened of dying, he'd told us that he wanted to be with his wife, and we knew that his wife was on her way and she had told us that she wanted to be with him when he died, they were a very closely knit couple. So I decided to wait until she came in before I gave the morphine, it was only a matter of 20 minutes ... because we knew that they wanted to be together, just the two, when he died, so I gave it when she was there with him as he slipped away [Mary]

Forging a connection with confused, demented residents by seeking to include them in decisions about their care, remained a constant challenge for the nurses. When the physiological changes of dementia resulted in severe short-term memory loss, the nurses were required to be highly sensitive to the way they communicated with residents. The nurses tried hard to give residents information in a form that they could understand so they reported using short unambiguous sentences and providing information at a time when the residents were most receptive.
You try to explain it as simply as you can in the hope that they will understand. You work on the assumption that they haven’t understood half of what you have said. You have to pick your time, I’ve found with dementing people that early morning is best, or when they are well rested. Mostly you have to say it all over again but you can see understanding in their faces, you get close to them that way [Daisey]

The unique needs of confused and dementing residents meant that nurses needed to be highly flexible in their approach to resident care. Flexibility enabled the nurses to understand the ever-changing needs of residents and in this sense to deepen their connection with the resident.

I think that in aged care you can’t be rigid in your approach to your work. Because of the residents’ conditions you have to be flexible ... sometimes if you are trying to get a confused or dementing resident to do something, and they won’t, then it is better to leave them alone for a while and come back later. Quite often they are more receptive then ... just recently I tried to get a demented lady to take her morning medications. She refused so I said “OK have a sleep in”. When I got back to her later she scolded me and said “I’ve been waiting for these” so I apologised for being late. [Mary]

One nurse explored the negative effect connecting with residents had had on herself. She raised the issue that it was possible that nurses could become too close to care recipients and form a connection that could eventually become detrimental to the nurse’s health. Speaking from personal experience, Pamela described how her ability to manage the stresses involved in gerontic nursing was increased when her work involved working in a variety of wards in the nursing home. When she remained working on the one ward she formed very close connections with residents which, she believed, caused her to feel overwhelmed and burdened by their problems.
I tend to take too much of the resident’s problems on board ... I’m happier when I don’t know them as well and then I don’t become so involved ... it’s easier now that I move around to different wards, it was more difficult when I was on the same ward all the time [Pamela]

The nurses in this study described how they connected with care recipients in order to establish closeness with them. The research discoveries revealed that sound ethical decision-making was facilitated when connections between care recipients and nurses were strong. Connection was enhanced when the nurses took a personal interest in the care recipient’s needs and feelings and responded to them, when they maintained physical and emotional closeness and when they bent nursing home rules for the benefit of the care recipient. Enhancing the connection also occurred when the nurses sought to understand the complex care needs of the resident and when they cared for the resident and their family as one unit.

4.7.2 Focusing

The next sub-element, contained in the element establishing closeness, came to be known by me as ‘focusing’. Focusing referred to the way in which the resident and their family were helped to feel that they were the immediate focus of the nurses’ care.

You need to concentrate on the resident who needs your input, emotionally and physically ... you need to see them as unique individuals by concentrating on them completely ... I remember caring for a demented resident who would get up at 3am every day. Some of the nurses wanted to sedate him so he would sleep the night through. But I wondered why he always got up at that time so I spoke with the family. It turns out he was a
baker all his life and he was just doing what he had always done all his working life [Kirstie]

Maggie and Mary described how, in the past, they had experienced aged care facilities where focusing on individual residents was not encouraged. Care delivery functioned according to a routinised approach of care where residents were viewed as tasks to be dealt with in the course of a busy day. The assumption that all residents had the same needs and that their needs could be met in the same way underpinned this approach of care delivery. Maggie’s comments reflected an approach to care dominated by paternalistic attitudes toward mentally ill older people. According to this approach to care, residents’ safety was paramount and individual differences could not be accommodated as this might jeopardise the safety of the other residents.

**Maggie:** We nurses had a responsibility to ensure that the psychogeriatric patients remained safe ... we did this by having a ‘herding’ mentality.

**Melissa:** A ‘herding’ mentality?

**Maggie:** We used to herd them, we wanted them all in the dining room so we herded them all in together, they couldn’t stay in their rooms, they had to get up, they had to eat. When they were in the dining room we would lock the door. Then we could see all of them, that was all part of it, the observation. We could see what they were eating, how their posture was, how their mood was, we could see them and we knew that they were safe. We knew then that they weren’t climbing over the fence ... I found meal times the worst ... we had very old, very ill people who had little understanding of English and you’d herd them to the dining room to eat food that they hated ... for practical purposes you’d rationalise it to yourself by thinking that the Mental Health Act covers people in these situations and they had seen the magistrate.
Mary described the dehumanising effects of a routinised approach to care, where the resident’s needs were secondary to the smooth functioning of the nursing home organisation.

*In the past, some nursing homes worked by following the routine. That was very sad, it then becomes like an assembly line. The assembly line becomes the most important thing then, not the resident.* [Mary]

The physical layout of the research site seemed to be important to the sub-element, focusing. At the time the study was conducted the residents lived in communal settings where their living, eating and sleeping spaces were always shared with other residents. It was very rare for residents and nurses to have the opportunity to be alone and thus, at any one time, the nurses’ could expect that their attention would have to be divided between more than one resident.

*My first impressions of (...) ward will always stay with me. I remember that it was mid afternoon and most of the residents were sitting on the verandah enjoying the sunshine. Some of the curtains were drawn and this bathed the ward a warm blue hue. Sitting among the residents were nurses. They were chatting quietly and one was doing a resident’s hair. I could see that each nurse was focused on a resident. I could hear the nurses chatting and laughing with the residents, they did not always spend much time with the residents but in the brief time they did have, I could see that they were focused on the individual resident.* [Melissa]

The practice of focusing involves the nurses ensuring that the resident and their family felt that they were the focus of the nurses’ attention. Focusing was very important to the nurses in this study in this study even though some nurses had experienced gerontic nursing care that did not value focusing. Focusing was enhanced largely through the nurses seeking to understand the resident’s current actions and behaviours in the context of their past life experiences. Information gained about the resident through focusing could inform the nurses’ ethical decision-
making however their ability to focus on residents could be affected by the physical context of the nursing home.

4.7.3 Having time

The registered nurses in this study reported feeling challenged to establish closeness with care recipients within the time constraints imposed on them by their heavy workload. The sub-element, having time, refers to the way in which the nurses strove to give the time to care recipients that they could within their busy day’s work. Pamela and Kirstie both described how this aspect of establishing closeness was very difficult as they felt that there often was not enough hours in the day to do everything they believed that the residents and their families deserved.

*When the residents have important things to discuss, with you, sometimes they want to talk about their own death, or the death of someone close to them. Sometimes the things that are worrying them are very private matters, things like money problems or even legal problems. You just have to have the time to talk with them... no matter what else you have to do, it is important that you let them know that their problems are important to you... but this is not very easy, there is always so many other things to do* [Pamela]

*The resident’s daughter was very upset. She felt angry and guilty about her mother’s behaviour. So I sent the daughter outside for a smoke and a coffee, and I went with her. She broke down and cried. I said “come inside when you are ready” and when she did I made sure that I made the time to discuss things with her* [Kirstie]

An integral aspect of having time for care recipients involved the nurses recognising that residents or family members had something important to discuss with them. Often this involved the awareness on the nurses' part of non-verbal cues that the care recipient might exhibit.
Sometimes you have to read their body language to know that they have something on their minds. Maybe a relative who is normally very friendly avoids you or doesn’t seem their usual selves. That can be like a trigger, and a light goes on in your head and you start to wonder what is behind their behaviour. Then of course you have to do something about it. You have to approach them so that you can understand [Clarissa]

Having time for care recipients could be incorporated into other activities the registered nurses were required to perform.

With one particular lady I’d always sit next to her for a moment when I would give out the morning pills. I’d give her a hug and we would have a cuddle and a laugh. She liked that and so did I. We could have a chat ... when it was quiet in the mornings we could have a little talk about things. We would talk about a lot of important things that way [Mary]

Not having enough time to connect with care recipients was a source of frustration to the nurses. A number of them were of the opinion that the government’s lack of funding for aged care was the reason for their heavy workloads and subsequent lack of time to spend with residents. They argued that if spending for aged care was increased, more qualified staff could be employed and the residents would benefit from improved quality of care.

About ten years ago I thought that the government was doing it right in terms of aged care. They had increased funding and they were making improvements in the standard of care that residents in nursing homes received. But with the present federal government everything has gone downhill. They have reduced funding, and that’s just not right, OK? It makes me very angry [Emma]

Having time, the third sub-element of establishing closeness, involves nurses recognising that care recipients needed to have some time with them and providing them with that opportunity.
The nurses were required to be creative and flexible in their approach to having time with care recipients and this often took the form of nurses incorporating opportunities to have time with other care-related activities. When the nurses created opportunities to have time with residents they found that they were in a better position to discover important aspects of the resident’s life which may potentially impact on their ethical decision-making. The nurses reported feeling frustrated that they could not have more time with care recipients.

The three sub-elements connecting, focusing and having time emerged as research discoveries that demonstrated the way in which the nurses sought to establish closeness with care recipients. The nurses easily provided examples from their own experience that illustrated how they undertook these activities in their everyday experience of managing ethical problems in a nursing home. The ease with which they described the element establishing closeness, through the sub-elements connecting, focusing and making time, indicated to me that this element and these sub-elements were of significant importance to the ethical decision-making approach, respectful relationships.

4.8 Doing the right thing

The third element of respectful relationships, doing the right thing, will be explored in the following section. The notion of doing the right thing informed the way the nurses conducted themselves in their professional lives as they went about managing the ethical problems they encountered in the nursing home. Doing the right thing referred to the way in which the nurses concerned themselves with what was right, fair, just and good for the care recipients and this element underpinned how the nurses managed many of the ethical problems they experienced.
The name for this element, doing the right thing, was taken directly from the transcripts of interviews with two nurses, Emma and Pamela. Emma expressed the view that:

_You don’t care for older people because you think that they could be your father or your mother, you just do it because you believe that it is the right thing to do. You just do the right thing. It’s basic, I mean it’s very basic for me. Is it a problem for other nurses?_ [Emma]

Pamela said

**Pamela:** You automatically try to support residents and hope that you are doing the right thing at the time... right thing? That leaves it wide open, it is something that you automatically do.

**Melissa:** How do you know that you are doing the right thing?

**Pamela:** It’s something inside you that tells you “I have to do this for this resident”. I think that a lot has to do with the way you were brought up. When you are brought up properly then you will know when you are, or aren’t doing the right thing.

The element, doing the right thing, comprises five sub-elements. Each sub-element describes the practices the nurses employed that enabled them to do the right thing in their ethical decision-making. The sub-elements associated with the element doing the right thing and which appear in table 4.4 are: practising gerontic nursing ethically, managing ordinary ethical problems, using ethical principles, balancing residents’ rights and working with colleagues. In the following section each sub-element will be explored in turn to illuminate the life-world of the nine gerontic nurses in this study.
Table 4.4 Sub-elements associated with the element ‘doing the right thing’

<table>
<thead>
<tr>
<th>Element</th>
<th>Sub-element</th>
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<tr>
<td>Doing the right thing</td>
<td>• Practising gerontic nursing ethically</td>
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<td></td>
<td>• Managing ordinary ethical problems</td>
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<td>• Using ethical principles</td>
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<td>• Balancing resident’s rights</td>
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<td>• Working with colleagues</td>
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4.8.1 Practising gerontic nursing ethically

The first sub-element associated with the element, doing the right thing, is the sub-element, practicing gerontic nursing ethically. Before proceeding, it would be useful for the reader to gain an appreciation for some of the situations in which the nurses found themselves which caused them to experience an ethical problem.

They described how they experienced an ethical problem when their values conflicted with the values of others involved in the resident’s care,

There’s a lot of situations in a gerontic nurse’s career where they feel that the personally correct or right thing to do is in conflict with someone else who is involved in the care of the resident [Sandra]

or where their views about what was right conflicted with the policies of the nursing home,

The nurses described a number of instances where they experienced an ethical problem when the goals of the nursing home, articulated through
the nursing home’s policy and procedures, conflicted with the rights or needs of a resident or their family [Melissa]

or when the physical layout of the nursing home prevented them from providing the care that they believed the residents required,

It’s just not fair when you have to care for demented and non-demented residents in the same ward. It is upsetting and frightening for residents to live with demented residents whose behaviour can be noisy or aggressive. It is very hard when demented residents go through the belongings of the other residents, residents who know what is going on and who get upset and angry about it. It creates all sorts of ethical problems. Which resident’s rights are the most important? The demented resident’s right to wander around safely, or the non-demented resident’s rights to privacy and security? [Clarissa]

or when the nurses upheld resident’s wishes with the knowledge that it could cause the resident or their family harm.

Mr and Mrs Grey were both residents at (...) nursing home. As Mr Grey’s condition continued to deteriorate he made it clear to the staff that under no circumstances should he be transferred to the local hospital which was about ten minutes drive from the nursing home. Instead he insisted on being transferred to another hospital that was about one hour away ... as he became more ill we had to abide by his wishes and so we arranged a transfer to (...) hospital. We were very worried about him, he was deteriorating quickly, and we wanted to send him to the much closer hospital, but he was adamant. No one was to send him there, he’d had a bad experience there in the past. There was no way he would go [Maggie]

Gerontic nurses who practiced ethically were believed to be so because they pondered the difficult ethical problems in their lives and because they concerned themselves with the rightness
or wrongness of their actions and the actions of their colleagues. In other words, the nurses in this study identified two aspects to being an ethically practicing nurse, the introspective aspect and the behavioural aspect. The introspective aspect meant that the nurses not only thought deeply about the ethical problems they encountered in the nursing home but also about ethical problems they encountered in their everyday life away from the nursing home.

*When you are the type of person who concerns yourself with your basic ethical beliefs ... then you would think about the difficult questions in life, about what is right and what is wrong, good and bad, I am talking here in terms of your personal and professional life* [Sandra]

The behavioural aspect of the ethically practising nurse involved the following behaviours as identified by the nurses in this study. The nurses described how these nurse would be acutely aware of the rights of others;

*This has always been a concern of mine. I've always thought that it was enormously important that people's rights were maintained* [Sandra]

assist residents to maintain autonomous decision-making about their care based on the resident's individual capabilities;

*Sometimes the resident just wants to stay in bed, so what is wrong with that? Just because a resident is demented doesn't mean we have to make all their decisions for them* [Mary]

deliver care that enhanced the dignity of the resident;
I often look at the residents and wonder “what were you like when you were younger? What did you do? What kind of life did you lead?” That is such an important part of the care we deliver, to remember that the residents were once young and full of life [Kirstie]

deliver care to care recipients in a respectful manner;

You have to respect others wishes, even when you don’t agree with them, even if it is hard for you to understand, you must respect their wishes [Daisey]

and deliver holistic care which incorporated the physical and psychological needs of the resident.

You must always approach the resident with the idea of human wholeness or whatever you want to call it [Emma]

Being an ethically practicing nurse also involved upholding their duty of care to care recipients.

We have a duty of care to the residents, registered nurses oversee the care delivered by other nurses. It is our responsibility as registered nurses to do that, it is our duty. We are the ones who have to go into the bathrooms and check that personal care is being done correctly [Emma]

For Sandra, practicing ethically involved identifying and striving to achieve agreed goals for resident care. Such goal-directed care helped ensure that resident care was focused on clearly defined outcomes that the resident, their family and the health care team understood. This
approach helped to reduce any confusion or misunderstanding that might otherwise occur and aided teamwork among the health professionals.

_When there isn't a commonality of purpose amongst nurses, then tensions and confusion can occur ... nurses need to do things with their clients, our role is all about doing and if we don't agree about how, where and why we are going to do something ... if we can't reach a commonality of purpose then the resident is going to become very confused. Potentially, that could be anti-therapeutic, then we are not doing the right thing by anyone [Sandra]_

Being an ethically practicing gerontic nurse was not easy. It was not uncommon for the nurses to feel confused, uncertain or frustrated about their ethical decision-making.

_To me, an ethical nurse has to take into account all sides of the argument, all views ... it means that each side of the argument is considered. These are always very curly questions ... they are difficult because they are about what is right and what is wrong, they are about different people's values, often opposing values ... you work in a grey area and sometimes it feels that you are walking a very fine line in deciding what is right and what is wrong. Sometimes you really don't know what to do [Sandra]_

One aspect of being an ethically practising gerontic nurse involved the registered nurse leading a team of nurses in the provision of high quality nursing care.

_The registered nurses are the concert-masters of the ward, OK? We have to keep one step ahead of everyone else, we have to have the full picture of what is happening with the residents ... as a registered nurse that is your responsibility, that is what an ethical nurse does [Emma]_

This lead to Mary feeling frustrated when she tried to influence other staff to change behaviours. She admitted that she found it a constant challenge.
I feel sometimes like I just repeat myself shift after shift ... sometimes it changes other nurses' behaviour, and sometimes it doesn't ... sometimes they accept what you have to say, but behind your back they ... (laughs and shrugs) ... but I know that I do what is right [Mary]

Emma expressed similar feelings of frustration when she commented,

I try to get the other nurses to approach their work in different ways. It depends who you are talking to though. Some nurses are interested and others just ignore what you have to say. Some just wipe your suggestions under the table and ignore you and just carry on doing it their way [Emma]

The nurses in this study identified a number of examples where they believed that gerontic nurses had behaved unethically. Unethical behaviour occurred when the nurses believed that the right thing had not been done and this had resulted in the resident receiving care that was sub-optimal. In the following example, Mary expressed her anger in a situation in which she believed that her colleague had acted unethically by refusing to administer morphine to a dying resident who was in pain.

I think that it is unethical for any nurse to refuse to give pain relief to a resident. It made me feel very angry that she wouldn't do it. The resident was an old man, he needed the morphine, to say that she wouldn't give it because she thought that he would become hooked on it was ridiculous [Mary]

4.8.2 Managing ordinary ethical problems

The second sub-element of the element doing the right thing related to the type of ethical problems that the registered nurses encountered in the environment of the nursing home. The nurses told of how they experienced a variety of ethical problems in this setting. However, there
was a predominance of ethical problems that did not involve life and death ethical decisions and which were referred to as ordinary ethical problems. While the nurses gave some examples of extra-ordinary, or life and death ethical problems they had encountered, the predominance of ordinary ethical problems in the life worlds of the nurses in this study, was a significant discovery of this research journey.

Sandra spoke at length about the occurrence of ordinary ethical problems. Interestingly, she described how ordinary ethical problems had the capacity to be both minor and major at the same time. They were minor ethical problems she maintained, because of their mundane, everyday nature, but she also described them as major problems because of the frequency with which they occurred in the communal-living setting of the nursing home.

*The major ethical problems we experience in aged care are in fact about minor things. They are about whether a resident can sit in one chair all the time, then it becomes 'her' chair ... or whether Mrs Smith can have cheese on her toast for breakfast instead of an egg. They are major problems because they are ongoing all the time, because people who live in residential care live in an entirely different situation to people who live in their own homes ... these minor problems are most important because we are likely to run into them on a daily basis. You don't run into extending life unreasonably in this setting on a daily basis, but the others you do ... and because of this they need to be addressed far more constantly and consistently in my view ... I don't think that ethically speaking, questions about extending life at all costs are any more important than questions surrounding whether Mrs Jones has the right to choose where she does or doesn't want to sit*  [Sandra]

Due to their ordinary nature these ethical problems, Sandra argued may, be sometimes in danger of being overlooked by gerontic nurses. Sandra warned that some nurses failed to see them as ethical problems and therefore saw them merely as practical nursing problems that required practical solutions.
Nurses forget that these types of issues are in fact ethical problems. They think of ethical problems as being about euthanasia... they tend not to think that the ordinary and mundane problems in aged care can in fact be ethical problems... what do they think they are? I guess they just see them as part of the daily grind of caring for the aged. They would be seen just as 'here we go again, Mrs Jones and Mrs Smith fighting about who gets to sit in the chair AGAIN' and they'd probably think that bloody Sandra is making a big deal out of it! They probably think that here Sandra goes again, she wants me to do something her way and I really don't have time, I have got other work to do [Sandra]

4.8.3 Using ethical principles

The third sub-element of doing the right thing refers to the way in which the nurses utilised ethical principles in the management of the ethical problems they encountered. The nurses described how they used the ethical principles of autonomy, beneficence, non-malificence and justice when they managed ethical problems. Rarely however did they use the language of principle-centred ethics in their interviews. Instead they described nursing actions which indicated that they understood the intent of the ethical principles, even though they did not name them as such. In the excerpts that follow I have ascribed my interpretation of the nurses’ actions in relation to ethical principles as they rarely used the language of principle-centred ethics themselves.

The ethical principle, autonomy, was spoken of frequently by Daisey, particularly when she described how she sought to involve residents with dementia in decisions about their own care. Daisey maintained that all demented residents should retain their right to make decisions about how they lived their lives for as long as they possibly could. This could be difficult when the resident was confused and their ability to make decisions was deteriorating as their dementia progressed. A constant theme in my interview with Daisey related to the ongoing challenge she
faced in ensuring that other staff understood that it was important for demented residents to have autonomous choice.

*You have to allow people their choices, but when they can’t see, when they lack insight into their own health, it can be very difficult ... I will strongly suggest something and I will always compromise* [Daisey]

Like Daisey, Sandra also spoke to me about the important role autonomy played in her practice as an ethical gerontic nurse. Sandra expressed to me the difficulty she experienced in knowing when to maintain resident autonomy and when to over-ride residents’ decisions.

*What right do gerontic nurses have to make decisions on behalf of another person? ... my role is not to be in control except where someone needs to be in control and isn’t ... it’s a needs based thing ... to have the power and to take control because I’m in a position where I can, is to me unethical. To have the power and to take control because my being in control will benefit the other person who I’m caring for is another issue altogether. And sometimes there is a very fine line to be drawn there ... at what point do I say that someone is no longer able to make decisions about their own care? ... and so I have to take control. Then when I take control it is a good thing for the resident ... the issue is that when I take control this is beneficial for the resident in these circumstances* [Sandra]

The ethical principle of beneficence, or doing good for others, was illustrated in the following excerpt from Mary’s interview. A central concern for Mary was that residents should remain pain-free. In the following example, Mary described how a nursing colleague had refused to administer a prescribed dose of morphine to a resident who was in the end stages of his life. Mary’s colleague was concerned about the secondary effects of addiction or death and therefore did not administer the pain killing injection to the resident. Mary recalled:
I came on duty and found that the nurse had refused to give the morphine to Robert because she said that it might cause his death or he may become addicted to the morphine. It’s not fair that he should be in pain, he needed the morphine, he was old and he was dying ... no matter what I said, I couldn’t convince the nurse to give it, so I gave it to him [Mary]

In another incident, Mary described how she drew on the ethical principle of non-malificence, or stopping something harmful from happening to an elderly diabetic resident who had terminal cancer. In this incident, Mary’s values about the use of life-extending interventions conflicted with the views of another nurse.

The registered nurse did his blood sugar level and of course it was low ... and so she put a naso-gastric tube down and began to feed the resident through that. I disagreed because he had terminal cancer and I thought that we would only be able to prolong his life for a short period of time and I didn’t want him to suffer. The other nurse’s comment was “I can’t let him die from the diabetes”. It didn’t matter what I said, the nurse couldn’t cope with the idea that this man could die on her shift. She wanted to prevent it, and he did rally a little. But I couldn’t convince her to take it out, so I did [Mary]

The ethical principle of justice underpinned many of the comments the nurses made about aged care nursing. The nurses made statements that indicated that they believed that it was only fair that older people receive quality nursing care in nursing homes.

The government has a responsibility to make sure that older people get the care that they deserve, it makes me mad when I see funding going to other projects and aged care misses out [Emma]

and

Older people have lived through so much ... we haven’t lived through that, we have no idea ... they deserve good quality care [Mary]
4.8.4 Balancing

In the context of this study, the sub-element balancing refers to the way that the nurses balanced the rights of residents with the rights of another person who was involved in resident care, or balance the rights of residents with the policies of the nursing home. This aspect of doing the right thing was not easy for the nurses because they were required to decide whose rights should predominate, and whose should not. I first became alerted to the notion of balancing after discussing the following ethical problem with a nurse at the research site.

_The resident had been writing very nasty letters to her daughter. The resident was very open about the contents of the letters, she showed them to the nurses. The nurses knew the daughter well and felt that she was a caring and loving daughter who did not deserve to receive such hurtful mail. The ethical problem arose for the nurses when the resident asked the nurses to post the letters. They didn't know what to do. Some nurses refused point blank to post them, others pretended to post them but destroyed them instead and others did as the resident wished. Whose rights should be upheld in this situation? How do nurses balance the rights of the resident and the rights of the daughter in this situation? Clearly, different nurses had different views on the right course of action._

[Melissa]

The nurses balanced the rights of residents with the rights of other family members. In the following example, Sandra described how she cared for a woman whose husband, the staff believed, was exhibiting signs of the early stages of dementia. The nursing staff experienced an ethical problem because they felt a responsibility to both the resident and her husband, but the behaviour of the resident’s husband sometimes meant that they were prevented from delivering care to the resident.

_The resident was very old and frail and her husband was a devoted man, entirely devoted to his wife. But his behaviour started to worry us and we_
began to think that he had early stage dementia. So, we had an ethical problem and it centred on the fact that she was the resident and she had certain rights, and we had a duty of care to her. But during his visits with her he would interfere with the care we were delivering to his wife. Sometimes he wouldn't let us attend to her basic nursing care requirements or he would speak to her in a manner that we thought was detrimental to her wellbeing. So where are our responsibilities to her and to him? It was clear that he loved her to distraction but he was unable to understand what her care needs were ... it all became very tied up and difficult [Sandra]

They also balanced resident's rights with nursing home policy.

Mary described to me how she re-arranged the furniture in one of the wards to enable one of the residents to see the sun rise each morning. Interestingly, in our interview, Mary admitted that she was causing an occupational health and safety hazard for the other nurses by doing this, but the focus of Mary's attention was the resident. In this case, the nursing home policy came second to the psychological needs of the resident and the right of the resident to have these very important needs met by the nurse [Melissa]

4.8.5 Working with colleagues

The final sub-element of doing the right thing involved the nurses finding ways to work with their colleagues in the management of the ethical problems they encountered in the nursing home. When the nurses spoke me about how they worked with their colleagues, they referred predominantly to their experiences with members of the medical profession. This does not mean that they did not concern themselves with establishing good working relationships to manage ethical problems with their nursing peers; indeed, a small number of nurses did express to me their concern for nurse-nurse relationships. However, the predominance of interview data relating to nurse-doctor relationships indicated that this was an issue that was of significant importance to the nurses as they strove to do the right thing.
An unexpected discovery that related to this sub-element was the discovery that the nurses felt that it was their responsibility to develop close professional relationships with doctors in order to do the right thing by the resident and their family. For this reason, close nurse-doctor relationships were valued highly by the nurses.

*The attitude of “God I can’t stand that doctor, I can’t work with him” is not good. Some doctors mightn’t like old people but they are still the resident’s doctor. We CAN work it out, we MUST...the residents are the ones who win or lose by our relationships with doctors* [Emma]

*Some doctors just want to get in and get out of the nursing home as quickly as they can. They are hussle-bussle type people. They will walk away from you while you are talking to them and will walk away from the residents when they are talking to them ... you have to intervene for the resident, you do it for the resident’s sake. You have to make an effort to get along with the doctors, you have to do it for the resident’s sake* [Pamela]

The interviews indicated a sense in which the nurses felt that it was especially important to develop nurse-doctor relationships, because the environment of the nursing home was unlike a hospital environment where nurses had on call medical help 24 hours per day. In the special environment of the nursing home, the nurses were required to make ethical decisions about resident's care without the immediate support of medical staff.

*If you have a doctor working with you and you feel supported that is great. Support is absolutely essential because we have to make decisions where we are autonomous. We have to make decisions without anyone advising us* [Emma]

The nurses adopted a range of strategies that they believed enhanced the development of nurse-doctor relationships. They described how, in order to strengthen their relationship, they tried to
see things from the doctor’s point of view, they communicated to doctors in non-threatening ways, they did not overstep their professional boundaries and were assertive only as a last resort.

By trying to see things from the doctor’s perspective the nurses tried to develop an open attitude to the doctor, even if they did not agree with the doctor’s viewpoint.

*I said to Dr Sullivan once, ‘I don’t think you like old people’ he said ‘No I don’t’ and I said ‘Why do you come here then?’ and he said ‘Oh, it brings in the money’. He was honest with me and I respect him for that. And I understood him and I stopped getting angry and frustrated with him because I knew exactly where I stood with him* [Emma]

*Some doctors seem to love having nurses running around after them. But I have always looked at it in a different way [and that is that] they are so busy all the time. It helped me because if I know that a doctor has had a bad day then I’m extra nice to them and you get a very positive response from that kind of approach* [Emma]

By communicating any concerns they had about resident care in a non-threatening manner, the nurses believed that they could maintain good working relationships with doctors.

*You have to be very careful not to offend their professionalism – you have no right to do that, OK? But if a problem is not being managed well, and they say to you “When I saw the resident on Tuesday they were quite well” and in the meantime it’s now Saturday, you have to go through the whole thing again to get them to intervene. Then you may get a positive or a negative response from that. But most of the time, even with a doctor who is a real culprit at it, they will at least come along to see the resident. They might say “if you really think that, then I will see the resident”. What a BIG favour (laughs) ... but you must do it carefully* [Emma].

Communicating with the doctors in a non-threatening manner involved the nurses arguing their case firmly, yet politely.
If I work with a doctor and I don't agree with what they are doing or proposes to do, well it depends on the situation and what they are like. You have to be a bit careful. I might say "yes fine we'll do it your way but do you think that this may work?" ... and then I put forward my idea and if they say to you "I want do it my way" then I will suggest "can we bear this one in mind? We will try what you want but can we bear my idea in mind?" [Kirstie]

In a later interview Kirstie recalled:

**Kirstie:** I worked with a doctor who you had to be careful with when you discussed things, how you phrased things.

**Melissa:** What do you mean?

**Kirstie:** You'd say "don't you think we should do this or that?" jolly it along a bit or "I thought of something the other day, what do you think?" You've got him on side then. If you had thought of some treatment for the resident and you were not sure if it was going to work or not, it was useless unless you had got the doctor on side so at least you could try.

Two nurses referred to how they thought that it was very important that they remembered their professional place in all their interactions with doctors. Emma believed that nurses were unprofessional if they overstepped their professional boundary with doctors.

*Sometimes you have to play games with doctors, and sometimes you must be very assertive, but you can't overstep your limit. You are assertive within professional boundaries. I'm very professional, I never overstep my mark [Emma]*

Only as a last resort would nurses become assertive with doctors. Only when other strategies with doctors had proved unsuccessful did they feel compelled to be assertive with doctors in order to do the right thing by the care recipients of the nursing home. Assertive behaviours most commonly took the form of nurses demanding that doctors follow the nurses' instructions.
We had tried other ways to get the doctor to do what we felt was the right thing for the resident. I was exasperated and I said to my nursing colleagues “I don’t agree with what is going on here, what the doctor is doing for this resident”. My colleague said “you try getting him to do that” I said “I don’t care! I’ll stand over him if I have to, enough is enough!” ... Some doctors need to have it said to them in plain English, you have to say “Doctor, we need this and you MUST DO IT NOW”. You find that when the resident needs care and when the doctor won’t come in and deal with that care, then you have to turn around and say “doctor, isn’t it time you came in to see her, she’s not well and we have rung you X number of times, and we have documented it in her notes” ... sometimes it gets to the point where you have to say to the family “the doctor is just NOT doing the treatment he should and we can’t keep sending your parent off to hospital every time they get sick, just because the doctor won’t come in”. You have to bite the bullet sometimes. It can be tricky because people tend to like their doctors [Kirstie]

Assertive behaviour also took the form of nurses persistently trying to change the doctor’s mind about an aspect of resident care. The nurses believed that they were far more experienced in certain clinical matters, for example wound care, compared to their medical colleagues. In the following excerpt, Pamela described how she was assertive with a doctor by persistently being like a ‘squeaky door’ in order to get him to change his ideas on how a wound should be managed.

_I think that nurses have a lot more experience than doctors when it comes to healing wounds, but it sometimes takes a lot of hard work to change doctor’s ideas ... sometimes you have to be like a squeaky door to let them know that you know something and to get them to say “try it your way”... but you have to keep at them_ [Pamela]

The element, doing the right thing, which consists of the sub-elements, practicing gerontic nursing ethically, managing ordinary ethical problems, using ethical principles, balancing and working with colleagues, is the final element of the ethical decision-making approach elucidated in this chapter. Doing the right thing refers to the way in which the nurses in this research made
sound ethical decisions. The sub-elements associated with the element describe nursing practices that the nurses adopted in order to do the right thing, or make sound ethical decisions.

Two significant discoveries that unfolded during the course of this aspect of the research journey were that the nurses frequently encountered ordinary ethical problems in their experience of working in a nursing home and that while they utilized ethical principles in the ethical decision-making, they rarely used the language of principle centered ethics. Instead, the nurses demonstrated how they could express the intent of ethical principles without using the words autonomy, beneficence, non-malificience and justice.

Another significant discovery contained within the element, doing the right thing, related to the nurses' belief that it was their responsibility to develop strong professional relationships with doctors in order to do the right thing, or make sound ethical decisions that would benefit nursing home residents and their family.

In the next chapter, the implications that respectful relationships has for future gerontic nursing practice, education and research will be elucidated. However, before exploring these implications, the reader is invited to increase their knowledge of the interrelationships that exist between the elements that constitute respectful relationships, to revisit the research question and to reflect on the value of the journey's means of transportation, naturalistic inquiry, as a vehicle for answering that question.
CHAPTER 5

THE RESEARCH JOURNEY’S END

5.1 Reflecting on the journey’s discoveries

My journey into the life-worlds of nine registered nurses have led to discoveries about an area of gerontic nursing of which very little was previously known. This journey’s discoveries have led to understandings about an ethical decision-making approach for gerontic nursing, respectful relationships, that had previously remained undiscovered.

Semi-structured interviews with registered nurses working in an Australian nursing home were analysed to reveal research discoveries that indicated that the nurses utilised respectful relationships to inform and support their ethical decision-making. Respectful relationships, which is the means by which respect is conveyed to nursing home residents and their families, were described by the nurses as being professional, familial, collegial and reciprocal in nature.

Respectful relationships were enacted when the nurses had self-respect, when they established closeness with nursing home residents and their family and when they did the right thing or made sound ethical decisions. These three elements were comprised of eleven sub-elements. Each sub-element referred to gerontic nurses’ behaviours and related to specific elements of respectful relationships (see figure 5.1).
RESPECTFUL RELATIONSHIPS

An approach to ethical decision-making for gerontic nurses

**ELEMENTS**

*Having self-respect*

- Making personally-fulfilling ethical decisions
- Being courageous
- Being reflective

*Establishing closeness*

- Connecting
- Focusing
- Having time

*Doing the right thing*

- Practising gerontic nursing ethically
- Managing ordinary ethical problems
- Balancing
- Using ethical principles
- Working with colleagues
As has been stated previously in chapter three, the elements that constitute respectful relationships are interrelated. Having self-respect was found to be foundational to establishing closeness and doing the right thing. Doing the right thing, related to the nurses making sound ethical decisions and in the context of this research journey doing the right thing became the collective goal of having self-respect and establishing closeness. Thus, doing the right thing came to be seen as the goal of the approach to ethical decision-making, respectful relationships.

5.2 Revisiting the research question and the means of transportation

The remainder of this chapter seeks to illuminate the research journey’s end by drawing together the knowledge gained from the reviewed literature and the research discoveries to answer the research question articulated in chapter two: ‘How do registered nurses in a nursing home make ethical decisions?’ Knowledge emanating from these two sources is interwoven in this chapter to reveal understandings about an approach to ethical decision-making, respectful relationships, which was found to be useful for a group of Australian registered nurses working in a nursing home.

As a research journey based on the tenets of a qualitative research approach, this research has described the shared practices and common understandings that emerged as constitutive of ethical decision-making and gerontic nursing practice. As previously stated in chapter three, naturalistic inquiry, as an interpretive research methodology, does not seek to predict or control the phenomena under investigation, nor does it seek to generate universally applicable theory. The discoveries that emerged from this research journey are understandings about the life-world of nine registered nurses as they managed the ethical problems they encountered in a nursing
home. The research discoveries indicated that the nurses used respectful relationships to assist and support them in their ethical decision-making.

The research discoveries revealed in chapter four enhance the body of nursing knowledge concerning ethical decision-making and gerontic nursing. The discoveries provide evidence to support the understanding that respectful relationships is an approach to ethical decision-making adopted by registered nurses working in a nursing home. The implications of this knowledge to gerontic nursing practice, education and research will be explicated in the following section.

5.3 Implications for gerontic nursing practice

A number of implications for gerontic nursing practice are explicated here, they relate to respectful relationships as an integrated approach to ethical decision-making, the important role of self-respect and the role of ordinary ethical problems in gerontic nursing practice.

5.3.1 Respectful relationships as an integrated approach to ethical decision-making

The first, and most significant implication this research journey has for gerontic nursing is that it points to an approach to ethical decision-making that was shown to be useful for a group of registered nurses in an Australian nursing home. The ethical decision-making approach, respectful relationships, can be described as an integrated approach to ethical decision-making similar to that described by Botes (2000b) in as much as respectful relationships demonstrated the nurses’ reliance on ethical principles and the ethic of care.
As an integrated approach to ethical decision-making, respectful relationships were enacted when gerontic nurses used the ethical principles of autonomy, beneficence, non-malificience and justice as aspects of doing the right thing. In addition to using ethical principles, their ethical decision-making was underpinned by an ethic of care through the establishment of closeness with nursing homes residents and their families by connecting and focusing, and by having time.

These understandings are important to gerontic nursing practice, as gerontic nurses need to be aware that there are alternative ways of thinking about ethical decision-making, alternatives that do not take for granted the hegemony of principle centred-ethics. Cooper (1989) calls on nurses to be aware that the utilisation of ethical principles may paint only part of the picture of their ethical decision-making process. The findings of this research journey support Cooper’s (1989) thesis.

The discovery that respectful relationships underpin the ethical decision-making of a group of gerontic nurses will have benefits for gerontic nursing practice. Understandings about the approach can stimulate discussion among gerontic nurses about their actual, as opposed to perceived, ethical decision-making practice. Such an approach, which stems directly from the everyday experiences of gerontic nurses, is a faithful representation of their gerontic practice and as such is a trustworthy base on which informed dialogue can begin. These understandings have the potential to enhance gerontic nurses’ capacity for critical ethical judgement and practical ethical decision-making. The implications of this approach to gerontic nursing practice may also extend to the formulation of nursing policy. In these instances, it would be an asset for policy makers to reflect on the actual approach to ethical decision-making that gerontic nurses use, and
incorporate this knowledge into policies that accurately reflect the life-worlds of nurses working in nursing homes.

Respectful relationships as an integrated approach to ethical decision-making, based on the application of principle-centred ethics and an ethic of care, extends the work of Botes (2000a,b) by including another element to the approach, namely nurses having self-respect. As has been previously stated, self-respect emerged from this research journey as an unexpected outcome, but one that was of central importance to the nurses' ethical decision-making process. Self-respect was found to be foundational to their ethical decision-making; it was found to be a precursor for establishing closeness with care recipients, doing the right thing and ultimately establishing respectful relationships with others.

5.3.2 The important role of self-respect

With the exception of Gaut (1983) very few scholars have explored the interrelationship between nurses' self-respect and their nursing practice. The outcomes of this research journey point to the highly significant discovery that gerontic nurses’ self-respect plays a central role in their ethical decision-making. This leads to another important implication for gerontic nursing practice. Namely, that in the world of gerontic nursing where nurses have reported feeling devalued and marginalised from their colleagues, their self-respect has still been able to flourish. Consequently, gerontic nurses need to reflect on ways that they and their colleagues can nurture their own and other’s self-respect. The potential benefits of this to residents and their families would be positive in that gerontic nurses who nurture their own self-respect, and the self-respect
of others would be well placed to make to build respectful relationships with care recipients and make sound ethical decisions.

5.3.3 The role of ordinary ethical problems

Another implication for gerontic nursing practice that evolved from this research journey was the way in which ordinary ethical problems played a vital role in the professional lives of the nurses. Ordinary ethical problems were those that did not involve life and death decisions and were considered by the nurses to be ordinary because they often constituted a daily part of their professional life. Ordinary ethical problems, such as deciding who should sit in which chair, or making a decision about the level of control a demented person had over aspects of their lives, were encountered regularly by the nurses.

The discoveries of this research journey provide data to support the views of Kane and Caplan (1990) that ordinary ethical problems play a significant role in the professional lives of health care professionals in aged care. Many scholars have demonstrated a very strong interest in the extra-ordinary ethical problems that occur in aged care. This preoccupation belies the experiences of the nurses involved in this research journey who revealed that they did not encounter extra-ordinary ethical problems on a regular basis. Instead, a recurring aspect of the nursing care delivered to older people in a nursing home related to the way in which nurses were called on to manage ordinary ethical problems. While extra-ordinary ethical problems were an aspect of the experience of managing ethical problems, the nurses' predominant everyday experience focused on the management of ordinary ethical problems.
That gerontic nurses frequently encounter ordinary ethical problems in their professional lives in a nursing home leads to another important implication for gerontic nursing practice. Nurses working in nursing homes should be encouraged to talk with their colleagues and others about the types of ethical problems they encounter. In the environment of the nursing home that abounds with ethical problems, it is of crucial importance that gerontic nurses understand the reality of their life-worlds and share those understandings of ordinary ethical problems with others in the nursing home environment. The sharing of such valuable insights will enable dialogue between gerontic nurses, other health professionals and care recipients to take place. Much can be gained from hearing the stories of others involved in the living and working environment of the nursing home and of the ethical problems they encounter, for without their stories, gerontic nurses have only a one-sided view. In this way, nurses, care recipients and other health professionals can work together to understand each other's point of view about the ethical problems they encounter in aged care.

The stories told to me by the nurses during this research journey reminded me that respectful relationships were embedded in the everyday practice of gerontic nursing in a nursing home, and as such may be at risk of being overlooked or going unnoticed. So the insights revealed to me by the nurses during this journey point to another implication for gerontic nursing practice, and that is that nurses should be encouraged to come together to talk about their ethical decision-making and the meanings that it has for them in their everyday practice.
5.4 Implications for gerontic nurse education

Nursing educational curricula concerning ethics and ethical decision-making predominantly include content that incorporate principle-centred ethics and the ethic of care separately as topics for discussion by nurses. During this research journey the nurses described how they integrated ethical principles and the ethic of care into the approach to ethical decision-making known as respectful relationships.

In the past many nurses have been involved in the development and implementation of ethics education programs which have centred on and perpetuated the notion that principle-centred ethics guide the vast majority of ethical problems that nurses encounter. Ethics education programs for gerontic nurses, such as those implemented in the past, have painted only part of the picture of ethical-decision making for nurses. By focusing on ethical principles they have failed to portray ethical decision-making in aged care in all its complexity. The new approach to ethical decision-making proposed here has the potential to change the way that gerontic nurses are educated about ethical decision-making. When gerontic nurses are educated about ethical decision-making based on the approach, respectful relationships, their education curricula will align faithfully to the reality of gerontic nursing as described by the nurses in this study. Gaining a better understanding of their ethical decision-making processes has important benefits. Benefits to residents and their families will stem from nurses being able to give better explanations for their ethical decisions to care recipients and other health professionals.

Nurses themselves can benefit from increasing their own knowledge of ethical decision-making. The findings revealed that nurses did not use the language of principle-centred ethics in their
narratives. Nurses have, in the past, been cautioned about the need for common use of principle-related language when discussing ethical decision with their colleagues. Johnstone (1999) has called on nurses to become familiar with the language of principle-centered ethics so that dialogue between colleagues and ethicists is possible. The ethics education program proposed here would include opportunities for nurses to understand the ethical principles they apply in their ethical decision-making in the context of respectful relationships.

A new approach to ethics education for gerontic nurses is called for. The new approach will draw on the understandings that evolved from the discoveries of this research journey. Much can be gained from such an undertaking. Gerontic nurses can gain a deeper understanding of their own practice when they are educated according to an approach to ethical decision-making that they can recognise as a faithful representation of their own experience of ethical decision-making.

Ethics education programs for gerontic nurses also need to focus on the ordinary ethical problems they encounter. Examples of ordinary ethical problems drawn from the experiences of gerontic nurses working in the field could be used as a basis for discussion of case studies and scenarios. This is not to imply that there should be no discussion of extra-ordinary ethical problems. Such an approach would be foolish as extra-ordinary ethical problems make up an aspect of gerontic nurses’ life-world. What is suggested here is that ordinary ethical problems should be given much greater priority in ethics education curricula as they represent a significant proportion of the ethical problems encountered by gerontic nurses in nursing homes.
5.5 Implications for gerontic nursing research

The findings of this study revealed the pivotal role that respectful relationships played in the ethical decision-making of registered nurses in aged care. The notion that nurses' self-respect can potentially impact on the respect nurses have for others, and ultimately on the care they deliver to care recipients, has received scant attention in the nursing literature. One of the few authors who has explored the relationship between self-respect and nursing care is Gaut (1983).

The gerontic nurses in this study demonstrated how Gaut's (1983) claim regarding the relationship between respect for self and respect for others can reflect the reality of nursing practice. The importance of this to nursing is significant. If gerontic nurses' self-respect has an influence on the respect they show to care recipients, which in turn impacts on the nursing care clients receive, then research into the area of nurses' self-respect is of critical importance. When nurses have an increased awareness of their own self-respect and its relationship with their ability to care, this may shed some light on the reasons why some gerontic nurses experience extreme stress, burn out and leave gerontic nursing altogether. An understanding of the role played by their own self-respect may go some way to alleviating some of the precipitating factors involved in gerontic nurses' stress and burnout. Ultimately this knowledge may have a positive impact on the recruitment and retention of nurses in aged care, already an area of nursing which suffers an unflattering image, and is thus seen by many nurses as an unpopular career choice.

Further research is needed that would examine the experiences of other nurses in relation to self-respect and ethical decision-making. Nursing knowledge could be extended by scholars who
undertake research into the role of self-respect in the life-worlds of ethical decision-making for nurse managers and executives. Within the discipline of nursing, similar studies could reveal the influence of self-respect in the ethical decision-making of nurses working in areas such as critical care, paediatrics, midwifery, palliative care and others.

What this discussion points to is the understanding that we as researchers must create opportunities to extend our knowledge of the role played by nurses' self-respect in their ethical decision-making. As we listen to the stories of other nurses we may find that self-respect plays a central role in their ethical decision-making just as it does for the nurses who participated in this research journey.

Further research is called for which builds on the work of this study to explore the nature of respectful relationships that emerge between nurses and clients in areas other than aged care. This research journey has revealed how four types of respectful relationships exist between gerontic nurses, residents and their family. These are familial, professional, collegial and reciprocal. These types of respectful relationships exist for the gerontic nurses who participated in this study. It may be useful for nurses in other areas of nursing to research the nature of the respectful relationships that develop between themselves and their client group. Similarities and differences may emerge between the gerontic nurses' understandings that evolved from this study and research undertakings with nurses in other areas.

Another implication for future research, highlighted by this research journey, is the need for research into the relationship between the physical environment of the nursing home and nurses’
ethical decision-making. Gorman (1996) highlighted the ethical problems that can occur for gerontic nurses when the physical context of the nursing home means that they have to care for demented and non-demented residents in shared living spaces. Austin (2001) explored how the contextual aspects of forensic psychiatric health care facilities may be the cause of ethical problems for nurses.

The literature review revealed that no scholars had explored the relationship between the physical context of nursing homes and gerontic nurses’ ethical decision-making. This area of future research would be useful not only from the point of view that the gerontic nurses could deepen their understanding of this unexplored relationship, but the knowledge gained from such research could assist professionals such as architects and interior designers in designing the living and working spaces of nursing homes. An awareness by these professionals of the relationship between the physical environment of the nursing home and nurses’ ethical decision-making would mean that this relationship could be taken into consideration in the design of nursing homes. Nursing home design of the future could then facilitate, rather than aggravate or impede, ethical decision-making for gerontic nurses.
CHAPTER 6
ARRIVING AT THE JOURNEY'S END

Just as travellers must come to the end of their journeys, so I also found that I had come to the end of my research journey. Arriving at the end caused me to take stock, and reflect on the personal experience of the journey.

The journey had been a long and tiring one. At times the roads I travelled were flat and the journey was not difficult. At other times the terrain was mountainous and I wondered if I would be able to continue. Sometimes the paths I travelled were convoluted and I wondered where they would lead me, and yet others proved to be dead ends where I was forced to retrace my steps. On one occasion I explored a completely unexpected path that lead me to make a discovery about nurses self-respect that astounded and surprised me. Had I not explored this path I would have missed the opportunity to make the exciting discovery that was eventually revealed to me.

The journey was an emotionally draining one. I felt exhilarated and enthralled by the journey itself and by the discoveries I made, but I also felt despondent and ready to give up when the journey did not progress the way I expected or at the speed I would have liked. Arriving at the journey's end was a particularly emotional experience for me as it was tinged with a sense of sadness and relief. Sadness because I was left with the feeling that I had finished with a part of my life in which the journey had taken a central role for a number of years. I was aware that I would never again travel on the roads I had come to know so well. I knew I would miss the travelling. However, added to the sadness was a sense of relief. Relief because I could now move on and look forward with anticipation to other research journeys and new discoveries.
My reflections at the journey's end also lead me to consider some of the limitations of this research journey. One limitation related to the sample size. A sample size of nine registered nurses from one Australian nursing home could be considered to be too small to make generalisations. However, generalisability was not my intention. The intention of this qualitative study was to highlight an area of gerontic nursing of which little was known, and where the discoveries could later be used as the foundation for the work of other researchers interested in gerontic nurses and ethical decision-making.

Another limitation related to the all female sample of registered nurses. As has been stated previously, this sample was the product of the predominantly female registered nurse work force employed at the research site. However, the inclusion of male nurses may have altered the discoveries and it may prove useful in the future to replicate this study and include male registered nurses.

Despite these limitations, this research journey provided discoveries that were trustworthy and transferable and which can inform the discipline of nursing and its researchers. These discoveries have the capacity to change the way that gerontic nurses think about ethical decision-making by illuminating an approach to ethical decision-making known as respectful relationships.

Therefore, I propose that 'respectful relationships' offers a useful foundation for understanding the ethical actions of registered nurses in a nursing home setting. As this approach is grounded
in relationships, it allows the special context of gerontic nursing’s ethical decision-making to be addressed in a meaningful manner. As an approach to ethical decision-making that is dependent on nurses having self-respect, establishing closeness with care recipients and doing the right thing, respectful relationships is a potential tool for nurses coping with the ethical problems that are an everyday aspect of their professional lives in a nursing home. Respectful relationships can guide nurses’ ethical decision-making as they strive to reach their goal and do the right thing.
REFERENCE LIST


Childress, J. (1990). If you let them, they’d stay in bed all morning. In R. Kane & A. Caplan (Eds.), *Everyday ethics: Resolving dilemmas in nursing home life* (pp. 69-88). New York: Springer Publishing Company.


Mattissona, A., & Andersson, L. (1995). Nursing home staff attitudes to ethical conflicts with respect to patient autonomy and paternalism. *Nursing Ethics, 2*(2), 115-129.


Quinn, C. (2001, March). When I have fears that I may cease to be. Paper presented at the Alzheimer's Association National Conference, Canberra, ACT.


Appendix A - Research information sheet

Research supervisor: Professor Lesley Wilkes

Researcher: Melissa Sinfield

Position: PhD student Faculty of Nursing and Health Studies

Host institution: University of Western Sydney Nepean

Contact telephone numbers: Home - Work -

A study of registered nurses' ethical decision-making in aged care

Research description

I am seeking information from you about the way that you manage the ethical problems that you encounter in aged care. I am seeking this information from registered nurses who work at your nursing home. I would like to gather this information by way of interviews with you and through the use of a short questionnaire.

I will also be asking you to provide me with the names of other registered nurses who you think may be interested in participating in this study. At the end of our first interview, I will ask you to provide the names of one or two of your colleagues at the nursing home. I will then contact your colleagues and invite them to participate.

All information you provide as part of this study is strictly confidential. No information which could identify you will ever be released. All data from this study will be kept in a locked storage area. I will have access to this area. Data will only be reviewed by myself and my research
supervisor and will be kept in a locked cabinet during the study and for a period of five years after its completion.

Your participation in the study is entirely voluntary and you have the right to withdraw from the study at any time. If you decide not to participate your employment at [name of research site] will not be affected in any way.

*Risks to you*

There may be a risk that some nurses may become distressed during an interview. If this happens, the interview will be stopped and counselling offered. A trained counsellor will provide counselling.

*Benefits to you*

You will be participating in a study which may result in improved nursing care for the aged.

*Consent*

You will be asked to give written consent to participate in this study. If you agree to be interviewed, you will be asked to sign a consent form. You can keep the original and a photocopy will be made for my information.
If you have any questions or are unsure about any aspect of this study please telephone me at home on ....... or at work on .......

Thank you

Melissa Sinfield
PhD student
Faculty of Nursing and Health Studies
University of Western Sydney Nepean
Appendix B – Research consent form

A study of registered nurses’ ethical decision-making in aged care

I ..................................................................................................................

have had explained to me by the researcher ..........................................

the nature and effects of the research: A study of registered nurses’ ethical decision-making in aged care.

I have been provided with an information sheet about the study which I have read and understood.

I understand that my participation in this study would involve:

1) Being interviewed by the researcher

2) Providing the name and contact details of one or two nurses who I think may wish to take part in this study.

▷ I have understood and am satisfied with the explanations that I have been given and hereby consent to participate in the study.

▷ I understand that the results of this study may be published and that my identity will be known only to the researcher.

▷ I understand that I may withdraw my consent at any stage without affecting my employment at [name of research site]

▷ I understand that should I wish to discuss this study with a person not directly involved with it I may contact the Ethics Committee at [ ] hospital on telephone number .......

Signature __________________________ Signature of witness __________________________

Date ________________ Printed name of witness __________________________
Appendix C – Questionnaire

1. What name did you select for this research?

2. In which year were you born? (optional)

3. In which year did you complete your first nursing qualification?

4. What other nursing qualifications do you hold?

5. Do you have tertiary nursing qualifications?

6. How long have you worked at [name of research site]?

7. In total, how long have you worked in aged care?

8. What position do you hold at [name of research site]

9. Are you employed on a full-time, part-time or on a casual basis?
### Appendix D – Biographical information for the nurses

<table>
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<tr>
<th>Name</th>
<th>Year born</th>
<th>First qualification</th>
<th>Other Certificates held</th>
<th>Tertiary Qualifications</th>
<th>Number of years at the research site</th>
<th>Total number of years in aged care</th>
<th>Position at the research site</th>
<th>Work status</th>
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<td>yes</td>
<td>3</td>
<td>15</td>
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<td>Full-time</td>
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<td>Mary</td>
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<td>1974</td>
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<td>no</td>
<td>10</td>
<td>10.5</td>
<td>Management/clinical</td>
<td>Full-time</td>
</tr>
<tr>
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<td>no</td>
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<td>18</td>
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<td>Full-time</td>
</tr>
<tr>
<td>Emma</td>
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<td>1954</td>
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<td>no</td>
<td>3</td>
<td>10</td>
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<td>1963</td>
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<td>no</td>
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<td>9</td>
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<td>Part-time</td>
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<td>Maggie</td>
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<td>1981</td>
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<td>no</td>
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<td>14</td>
<td>Management</td>
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</tr>
<tr>
<td>Anne</td>
<td>1954</td>
<td>1987</td>
<td>no</td>
<td>yes</td>
<td>2</td>
<td>5</td>
<td>Clinical</td>
<td>Casual</td>
</tr>
</tbody>
</table>
Appendix E- Interview data from Kirstie and Mary

Melissa: What about the doctors? How do you include them in the ethical decision-making process?

Kirstie: I know that sometimes I can go on about things, I know that I can do a lot of talking, but I try not to (laughs). The whole thing is, and the whole point of it is that we should be able to nut things out, we should be able to say “I think this and this” and others could say “yes but don’t you think this, could we try it this way?”. If we all work it out then we will come up with a totally different answer because there are four or five heads together. That’s not detracting from anyone’s professional abilities, which is the problem that I had with Dr. Flynn. She felt that I was trying to tell her how to do her job. I was trying to point out to her that we have to write it down, we have to record what we are doing. It should become second nature because that is what we have to do for the resident’s sake. We HAVE to document everything.

Melissa: What types of ethical problems do you encounter in your work as a gerontic nurse?

Mary: A lot are day-to-day problems. Sometimes the residents say to me “I don’t want to get up today” I say, “that’s OK” and they say “what will so-and-so say?” because sometimes when the nurse comes on duty the resident takes the child role and the nurse is the mother and the resident feels like they have to do what they are told. I say “you can have the day in bed”. I can’t see a problem with that. These are the little things that can happen on a day-to-day basis.
Appendix F- Entries from Melissa’s reflective journal

December 20, 1998

I think an ethical nurse is one who becomes close to the resident and their family and who takes the time to understand their wishes and preferences. However, in order for a nurse to understand the resident’s needs from their own perspective, a close relationship needs to be built between them.

January 24, 1999

I’ve come to realise that an ethical nurse strives to build a close relationship with care recipients. Could it be that the quality of the relationship between the two is the key to the nurse’s ethical decision-making?

October 2, 1999

As I look at the interview transcripts it appears to me that time and time again, the nurses are talking to me about the relationship that evolves between themselves and the care recipients. It appears that this relationship is foundational to the nurse’s ethical decision-making.
Appendix G- Standard transcript editing methods

... Three ellipses were inserted where I deleted words or edited the interview transcript in order to assist the reader to understand the interview data.

(...) Three ellipses enclosed by brackets were inserted where the nurse referred to the research site, another nursing home or information that could identify another person.

[words or phrases] Italicised words or phrases enclosed in square brackets indicated that I had inserted text to assist the reader’s comprehension of the interview data.

WORDS Italicised upper case text indicated that the nurse emphasised these words.

(laughs) Expressions, such as ‘laughs’ enclosed in brackets indicated emotional responses and appear in the text precisely where they occurred in the interview.

Expletive All expletives were included in the transcript as interview data.

Mmm, Hmm Were removed from the transcribed interview data
### Appendix H – Themes and selected categories, codes and data sources

<table>
<thead>
<tr>
<th>Theme</th>
<th>Category</th>
<th>Codes</th>
<th>Data sources</th>
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<tbody>
<tr>
<td>Having self-respect</td>
<td>• Being courageous</td>
<td>• The nurses maintain their own values</td>
<td>• E 4.2.11-20</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• The nurses admit their own mistakes</td>
<td>• M1.4.25-35</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• The nurses feel equal to their colleagues</td>
<td>• M1.6.10-15</td>
</tr>
<tr>
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<td></td>
<td></td>
<td>• S2.8.1-30</td>
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<td></td>
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<td>• K3.5.10-30</td>
</tr>
<tr>
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<td>• K2.2.20-30</td>
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<td></td>
<td></td>
<td>• S2.8.1-30</td>
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<tr>
<td>Establishing closeness</td>
<td>• Connecting</td>
<td>• The nurses assist relatives to come to terms with the placement of their relative in a nursing home</td>
<td>• K1.3.25-30</td>
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<tr>
<td></td>
<td></td>
<td>• The nurses maintain physical and emotional closeness to the resident and their family</td>
<td>• C1.2.15-35</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• The nurses bend nursing home rules</td>
<td>• K2.4.5-10</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• The nurses empathise with the resident and their family</td>
<td>• M1.6.10-20</td>
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<td>• D1.1.30-40</td>
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| Doing the right thing | Working with colleagues     | • The nurses establish open communication with colleagues about ethical problems | • M4.1.20-30  
• E2.3.11-20  
• M1.1.20-35  
• E2.4.5-15  
• M1.8.20-30 |
|                     |                               | • The nurses seek to understand colleague's point of view              | • E2.3.25-35  
• K2.2.10-20  
• K3.6.15-25  
• K2.2.25-35  
• M1.2.15-20  
• K2.2.15-25  
• E2.4.5-10   |
|                     |                               | • The nurses work to find a collaborative solution to the ethical problem | • K4.1.7-15  
• M2.2.10-20  
• K2.2.10-40  
• E4.2.25-35 |
|                     |                               | • The nurses develop close relationships with doctors                  | • E3.2.20-30  
• P2.3.10-20 |
Appendix I - Data contained on the data collection master sheet

Date of initial contact with the nurse
Date of follow-up contact with nurse (if required)
Date information sheet and consent form was given to the nurse
Date consent form was signed
Date/s of interview/s
Duration of interview/s
Interview location/s
Date interview transcription was begun
Date interview transcription was complete
Date transcription was checked by the nurse
Date interview transcript was corrected by me
Date coding was completed
Date categorisation was completed
Date theme evolution was completed
Respectful relationships:

An approach to

ethical decision-making for

gerontic nursing

Melissa Sinfield

PhD thesis submitted
2001
University of Western Sydney
PLEASE NOTE

The greatest amount of care has been taken while scanning this thesis,

and the best possible result has been obtained.
Certificate of originality

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material written by another person nor material which to a substantial extent has been accepted for the award of any other degree or diploma of a university or other institute of higher learning, except where due acknowledgement is made in the text.

Signed .........................................................

Melissa Sinfield
We cannot discover new oceans
until we have courage to lose
sight of the shore

Anon
Acknowledgements

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I acknowledge the gerontic nurses who made this journey possible: Sandra, Mary, Kirstie, Emma, Pamela, Daisey, Clarissa, Maggie and Anne.
Dedication

I dedicate this thesis to the memory of my grandmother

Lucianne Buchanan Crawford

who died January 8, 1986

aged 85 years
Abstract

Ethical decision-making is an integral aspect of gerontic nurses’ experiences of caring for nursing home residents and their families. This thesis examines my journey into the life-worlds of nine registered nurses working in an Australian nursing home to explore how they manage the ethical problems they encounter in their everyday experience of nursing home life.

This exploration required an understanding of the issues relating to gerontic nursing, ethics and ethical decision-making. It became clear that the methods used by gerontic nurses to make ethical decisions have not been articulated.

The methodology adopted for this journey involved the interpretive, qualitative research method, naturalistic inquiry. Naturalistic inquiry was chosen because it provided a vehicle for understanding the nurses’ experiences of ethical decision-making from their own perspective and to relate discoveries that were faithful representations of each nurse’s own life-world.

Analysis of semi-structured interviews with nine registered nurses revealed that the nurses utilized an approach to ethical decision-making which has not been previously described. This approach, which I have called ‘respectful relationships’, was the means by which respect was conveyed to nursing home care recipients. The approach was identified as being professional, familial, collegial and reciprocal in nature.
This thesis revealed that nurses build respectful relationships with care recipients when the nurses have self-respect, establish closeness with nursing home residents and their family, and do the right thing. In the context of this research journey, doing the right thing is the collective goal of having self-respect and establishing closeness. Consequently, doing the right thing came to be seen as the goal of the approach to ethical decision-making, respectful relationships.

As an approach to ethical decision-making, respectful relationships is a potential tool for nurses coping with the ethical problems that are an every-day aspect of their professional lives in a nursing home. Respectful relationships can guide nurses’ ethical decision-making as they strive to do the right thing.
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