CHAPTER 69

Ethics and Nursing

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INTRODUCTION

At the heart of psychiatric–mental health nursing lies the interpersonal relationship between the nurse and a person experiencing some form of distress. Both are part of a web of relationships encompassing family, friends, colleagues, organizations, communities and wider society. All these groups have an interest in and expectations about the nature of the relationship between the nurse and person. Individuals often find themselves in relationships with nurses at a time of extreme powerlessness, distress, vulnerability and estrangement from others, and this is compounded by the stigmatizing effects of being labelled and treated as mentally ill. How the nurse exercises power, behaves in relation to the person, and balances the expectations and wishes of all interested parties have profound ethical implications.

Ethics are concerned with human action, what one ought to do, and forms of belief about right and wrong human conduct.[1] Ethics may also be viewed as the basis for choosing the kind of professional life we believe we should lead, so that we need not look back with regret in the future.[2] The practical purpose of ethics should be to provide guidance to the nurse on the 'right' course of action in a given situation. Nurses are involved in ethical inquiry whenever they spend time considering what they should do in relation to others and may be said to be practising ethically when they choose to do the right thing and can provide an ethical justification for their actions. In the field of psychiatric–mental health nursing, uncertainty about the right course of action or ethical problems are encountered on a day-to-day basis and hence nurses require highly developed skills in ethical reasoning and ethical problem-solving.

ETHICAL THEORY

An ethical problem may be said to arise when moral principles conflict in a given situation. An ethical dilemma may be likened to an avoidance–avoidance conflict in which there may be several alternative courses of action but each one of them is negative or in some way punishing. Examination of conflicting principles can alert one to a problematic ethical situation. However, the solution to the problem may not be readily apparent. Seedhouse[3] suggests that a willingness by health workers 'to do the right thing' or 'to be moral' is insufficient to ensure ethical practice, that people need tools in the form of an understanding of ethical theory and philosophy to guide and justify their actions. It is beyond the scope of this chapter to provide more than a sketch of some of the key features of a few ethical theories.

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Deontological Theories

Deontological theories are concerned with 'duty' and beg the question 'What is my duty in a given situation?' Many people believe it their moral duty to obey God. However, this can be problematic as there are irreconcilable differences between people regarding the will of God and many people who deny the existence of a divine voice of authority. An influential alternative to theological ethics was proposed by Kant, who suggested a universal law, which demands '… that we should only act in accord with a given principle or set of principles if we can, at the same time, reasonably will that it should be binding on all others through space and time.'[4] In many instances Kant's 'categorical imperative' prescribes a very clear duty to act. For example, it would be unconscionable to lie to anyone regardless of the consequences because of the chaos and damage caused if all people were permitted to lie in all circumstances. The ability to reason is central to Kantian notions of morality, and, without the capacity to reason, one cannot enjoy full status as a moral citizen.

Consequentialist (teleological) Theories

A broad range of theories hold that actions may be judged good or bad depending on the consequences they produce, i.e. the means to varying extent justifies the ends. Contention exists over what counts as good consequences (e.g. material gain, happiness, freedom, dignity) and whose good should be promoted (e.g. self, the in-group, the profession, society, or all people equally). Utilitarianism is a theory that proposes that an act may be judged good or bad depending on whether it promotes the greatest balance of good over bad, happiness over unhappiness, and pleasure over pain. The world tends to be viewed in terms of peoples' collective and overall interests. When considering where to invest scarce health resources a utilitarian perspective would require an investment to ensure the greatest good for the greatest number. Whilst at face value this appears appealing, it may also serve as a justification to discriminate and alienate minority groups, or minority points of view.

Moral Principles

When people make statements such as 'it isn't fair' or 'do no harm' they are perhaps unwittingly appealing to moral principles. Whilst there may be disagreement about which principle might carry the most weight in a given situation, or how principles might be used, there is general agreement that the principles of autonomy, non-maleficence, beneficence and justice underpin ethical behaviour in health care.

Autonomy is a principle that implies that people ought to be free to choose and act any way they wish providing their actions do not violate or impinge on the moral interests of others. Autonomy means having respect for the self-determination or decision-making of others. Maintaining or promoting people's autonomy and some form of equitable partnership poses one of the greatest ethical problems for psychiatric nurses in their relationships with people in distress.[5–8] In psychiatric–mental health nursing, autonomy is frequently overridden in the interest of promoting the principle of beneficence or 'doing good'. Unfortunately, what counts as good and who should be the arbiter of what is good are contentious questions. For example, some people argue that suppression of symptoms through medication is a hindrance to real recovery and that the adverse effects of psychotropic drugs are often worse than experiencing the illness itself.[9] Forcibly administering medication against a person's will is a clear breach of a person's autonomy, yet may be justified by the health professional as being in the person's best interests. Such actions are always ethically problematic and require a legal mandate to act.

'Madness', more latterly 'mental illness', has long been recognized as a class of experience which may profoundly affect the capacity of people to make free and rational choices. Plato is credited with saying 'A man … either in a state of madness, or when affected by disease, or under the influence of old age, or in a fit of childish wantonness, himself no better than a child …' could not be held accountable for his crimes.[10] The Kantian notion of morality is focused on the rational being,[11] and someone who is unable to reason from this point of view is unable to possess free moral agency or be held to account for their actions. However, people's reasoning is seldom totally impaired.

Mental health professionals are often called upon to make judgements about a person's capacity to make autonomous choices for official purposes (e.g. to determine whether a person requires civil commitment under a Mental Health Act) and during their everyday encounters with people. Even when people are deemed to be severely mentally ill, with some degree of impaired judgement, they are likely to continue to possess intact decision-making capacity in at least some areas. Health professionals therefore require skill in recognizing the person's current strengths or 'ablement' in order to protect and promote a person's autonomy.

Non-maleficence means to do no harm and has long been claimed as 'the first' principle of ethical health care. The meaning of harm is open to interpretation but certainly extends to psychological, social or spiritual harm or suffering. The principle of non-maleficence would provide justification to condemn any act, which might cause another avoidable suffering. The principle of non-maleficence requires nurses to take heed of the experience of patients and first recognize the potential suffering that illness and treatment may cause. For many

people the experience of treatment and hospitalization is fraught with traumatic and harmful experiences as illustrated by an extract from Susie's story:[12]

> … Nothing compared with the horror of this psychiatric unit. It was the most traumatic experience I have ever had … It was just total madness, twenty four hours a day, no privacy, all my personal belongings were stolen. I was sexually abused by another patient. I was assaulted. I had no safe space. They were trying to de-stim [sic] me in a very unsafe environment … using punishment.

As well as considering Susie's story in terms of non-maleficence, one may also consider that she had been treated unjustly and did not deserve to be exposed to abuse in any circumstances. Justice is a term that may be considered in many ways. For example, justice may be considered as fairness, as revenge (retributive justice), as an equal distribution of benefits (distributive justice) or as equality. Justice in its various forms is a central ethical concept, is used as a justification for action and breached in a myriad of ways in relation to people with mental illness.

The various conceptions of justice can come into play in any given situation. Often, this is a recipe for conflict, as illustrated here:

> John is a person who went without treatment for a psychotic disorder because he lived in a rural area where services were not available. He shot and killed a family member when psychotic believing him to be possessed by a devil. He was found not guilty of murder because of insanity and was remanded in a psychiatric forensic unit for treatment. He responded quickly to treatment but was not released for some years for fear of the public reaction to a 'murderer' not serving a reasonable sentence. On discharge he was unable to find reasonable accommodation because of the publicity surrounding the case and was unable to find employment because of a history of mental illness.

That John went without early recognition, treatment or care is an issue of distributive justice. Despite responding to treatment, and presumably posing no great risk to others if adequately supported, his continuing incarceration became an issue of retributive justice (or punishment). This in itself was unfair as he was found 'not guilty' because of insanity. Neither was his experience of discrimination 'fair' when he was discharged. The principles of retributive justice and justice as fairness conflicted in John's situation and no doubt impeded his recovery.

Sometimes the ethical principles at stake in a given situation may be vague but they may be refined further into moral rules. For example, the rule 'tell the truth' (veracity) arises from the principle of autonomy, which recognizes that rational people ought to be free to choose. Telling a lie therefore would deprive a person of the information needed to make a rational choice and so nurses are obliged to be truthful towards people they care for. While telling a blatant lie may be ethically indefensible in many situations, telling the 'whole truth' can sometimes be destructive. Lawler[13] coined the term 'minifism' to describe '… verbal and/or behavioural techniques which assist in the management of potentially problematic situations by minimising the size, significance, or severity of an event involving a patient'. 'Good' health professionals are likely to modify their 'gut responses' or manage their self-presentation in their interactions with people in order to minimize the harmful impact of revealing their responses. For example, a nurse may be disgusted by a person's incontinence or body odour. However, being brutally honest about their feelings may shame the person or otherwise cause them a loss of dignity. To prevent such harm, the nurse may sensitively prompt or assist the person to attend to self-care. The person may ask 'This must be really disgusting?' or state 'I'm disgusting', but sensitive nurses will modify their response to minimize the incident and maintain the person's dignity.

Reflection

- Which ethical principles do you value the most and why?
- When considering an ethical course of action do you primarily consider the consequences of the action or the action itself?
- What ethical theory do you identify with and why?

Virtues

A virtue approach to ethics emphasizes the moral character of the person through the question 'What sort of person should I be?' In practice, the resolution of ethical problems commences from a sensitivity to situations as ethically problematic[14] or that the person is vulnerable.[15] In the example outlined above, a nurse may be said to have acted compassionately by minimizing his or her response to the person's incontinence. Virtues provide the disposition that enables a person to reason well and to act according to the right reasons.[16,17] Virtues may also provide an intuitive choosing of the right course of action when moral principles conflict.

The virtues that nurses need depend on the roles they choose or are required to assume.[18] Early nurse education stressed obedience and loyalty to the doctor; however, contemporary nurses are likely to require other virtues, for example courage to realize roles such as advocate. Some virtues which are most useful for psychiatric nursing include:[17,19]

- *Compassion*: the capacity to share another person's suffering and appreciate their humanity and vulnerability.
- *Humility*: remembering that we do not possess all the answers, and inclines us towards listening and learning from others.
- *Fidelity*: which provides a commitment to help other people and reminds us that clients have a claim on us that endures even when they refuse the treatment we offer.
- *Justice and courage*: provide not only an inclination to do what is right and fair, but also provide a motivation to act to protect others' interests even at some personal cost.

Virtues may not be learned in the same way as principle-based theories of ethics. They are necessary, but insufficient to ensure ethical behaviour. However, virtues such as clinical knowledge and skill may be developed through such practices as reflection, good mentorship and supervision.

Reflection

Consider a nurse or person you work with whom you consider to be a virtuous person. How does he or she demonstrate virtue?

Criticisms of Traditional Approaches to Ethics

Traditional Western philosophical ethics has failed to provide an account of, or prescribe, a unifying morality that has utility in all situations. The impartiality and detachment associated with traditional ethical decision-making approaches is also at odds with the lived experience of psychiatric nurses, which is characterized by involvement and value-laden clinical judgement. Spreen Parker[20] suggests that dialogue between people concerning their individual needs, desires and values is seen to threaten the impartiality required to make principle-based decisions and '… moral reasoning is confined to an abstract monologue, rather than a relational, embodied dialogue between human beings struggling to make sense of deeply perplexing situations.' At least some nurses have suggested that traditional approaches to ethical problems are antithetical to the practice of nursing founded on an ethos of care, which stresses involvement and the highly contextualized nature of human relations.[21,22]

Further criticisms of traditional approaches to ethics centre on the failure of ethics to address the systematic and systemic oppression of whole peoples, cultures and groups such as the mentally ill. Johnstone[23] suggests that mainstream bioethics is ethnocentric and sexist in nature and has '… only limited practical value and application in the realms of clinical practice in the health care arena.' An evolving ethic of care[24] and feminist approaches to ethics[25] offer different lenses to examine the nature of ethical problems, and prescribe factors other than principles, for example relationships and institutionalized oppressive structures that require consideration in ethical enquiry.

Reflection

Principle-based and ethics of care approaches to ethical problems may lead to different outcomes or decisions depending on particular contextual factors. Consider the issue of preventing someone from attempting suicide. Ordinarily depriving someone of their liberty on the basis of something they might do could not be condoned from a principle-based approach.

- What factors might justify intervening to prevent suicide from a principle-based and ethics of care approach?

THE MANY ETHICAL DIMENSIONS OF PSYCHIATRIC NURSING

Culture and Moral Pluralism

Globalization facilitated by communication technologies, ease of travel and news media have made it increasingly obvious that people can and do have vastly different world views including conceptions of what is good or proper conduct. All people exist within and are inextricably part of a culture which colours the way they see, make sense of and interact with the world. Culture consists of the values or abstract ideals held by members of a given group, and the norms or definite rules and principles people are expected to follow.[26] Culture exists prior to ethics, not the other way round.[4] A cursory review of cultural differences reveals a moral pluralism, which must be explored and negotiated if nurses are to claim ethical sensitivity or practice. It is not enough to rely on tradition, appeal to authority, adherence to the law, or to simply follow instructions to ensure ethical practice. To act ethically requires as a starting point an awareness of factors that colour and shape our view of the world.

The traditions and practice of Western psychiatry and psychiatric nursing arise largely from Western values and views of health and wellness. These views are value laden. They are embedded in institutional processes and are often taken for granted by health professionals. For example, most health professionals would accept the 'holistic' notion of people being biological, psychological, social and spiritual beings, although in recent years biogenetic models of distress have been loudly championed within psychiatry.[27] Western psychiatry and psychiatric institutions tend to view the origins of mental distress as biological, which might in turn manifest as

psychological or social symptoms. Treatment is primarily biological (i.e. drug treatments) with adjunctive psychological (e.g. psychotherapy) or social (e.g. family education or therapy) interventions. In contrast (as illustrated in Figure 69.1), people from traditional indigenous cultures such as Australian Aboriginal or New Zealand Maori are likely to conceive of distress quite differently, viewing the root cause of distress as being of spiritual or social origin, giving rise to psychological or biological symptoms. The problem itself may be located in the family group or community rather than the individual.

In traditional cultures, when a person manifests with what may appear to be symptoms of psychosis or depression, the problem may be viewed as arising from some spiritual or social transgression possibly of a family member or an ancestor. Treatment may involve prayers or rites, or 'making good' the perceived wrongdoing. In such circumstances a biological deterministic view and treatment of the person may not merely reflect a difference of opinion or a benign approach to care but may cause irreparable damage to the person through removing hope of recovery or estrangement from those who might best be able to help.

The importance of respect for cultural difference and culture as fundamental to understanding and promoting health is being recognized (see the *ICN code of ethics for nurses*[28]). Respect for cultural difference requires as a starting point examining one's own values, and the 'taken for granted values and assumptions' that guide everyday behaviour. Culture permeates every facet of human understanding, and provides the threads of the moral fabric upon which may be woven the many relationships which psychiatric–mental health nurses enjoy.

Reflection

- What do you value?
- What is your personal understanding of the term mental health?
- Contrast your values and ideas about mental health with someone from a different cultural background.

Power and Discourse

It has already been suggested that people experiencing mental illness often engage in relationships with psychiatric nurses at times when they have diminished power. A practical purpose of ethics is to guide the use of power by health professionals. This power is often made invisible, or legitimized through the use of language, and often reflects the worldview of the dominant culture. Foucalt[29] described the formulation of communicative processes on the basis of power as 'discourse'. The world of clinical practice has its own language and logic, which is self-sustaining, in that it serves as a justification for action.[30]

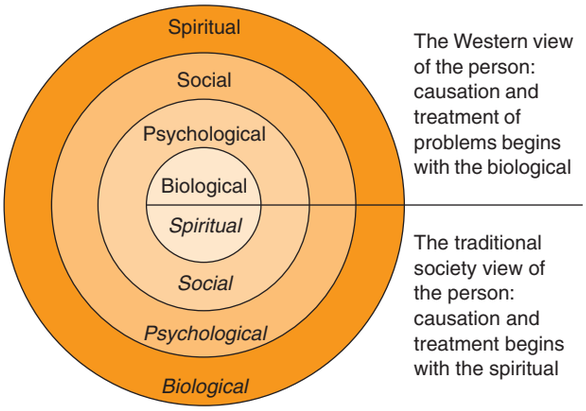

Figure 69.1 The western holistic view and the traditional cultural view of the person

The particular world view – or 'ideology' – to which clinicians are aligned in practice is founded on assumptions about what it means to be a person, what it means to be distressed, and what it means to nurse the distressed person. These assumptions are never value neutral. Almost invariably they are bound by culture and often serve to subjugate or take away the power of others. The psychiatric discourse shapes people's stories, which are invariably stories of dysfunction and pathology. This is not to say that psychiatric discourse is bad per se. However, it is wrong to assume that psychiatry has the only story to tell in relation to people who are distressed. Indeed, 'narrative therapy' acknowledges that the stories that communities of persons negotiate and engage in give meaning to their experience. Narrative therapy aims to assist people to tell alternative stories, or 're-author' their lives according to preferred stories of strength and courage.[31] In considering the moral lives of psychiatric nurses in relation to communities, groups and individuals, the nurse must be mindful of the power of language, attuned to the various discourses that shape reality, and open to alternatives.

Psychiatric Nurses and Society

It may be useful to think of the moral lives of psychiatric nurses as having many dimensions and encompassing a number of key relationships (Figure 69.2). At the 'macro' level nursing is part of society and reflects, maintains and promotes certain interests of society. Governments are concerned with the best way to tackle societal problems and dictate what is considered proper conduct towards others through the passing of laws and regulations.

The mentally ill have been and continue to be poorly served by societies and have often experienced abuse, infringement of human rights and discrimination. Most Western countries have now adopted the United Nations resolution on the protection of persons with mental

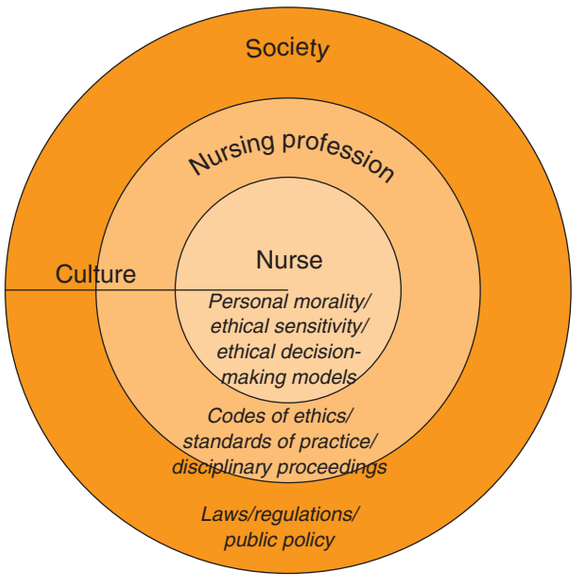

Figure 69.2 The moral lives of psychiatric nurses

illness and the improvement of mental health care.[32] This is an international agreement, which requires member countries to ensure that people with mental illness are able to exercise all the civil, political, economic, social and cultural rights enjoyed by others. It also sets out standards for care and treatment and articulates the right for people to be treated in the least restrictive environment.

In contemporary Western societies the criminal justice and mental health systems have a mandate for social control, i.e. legally mandated and defined roles to contain, control or modify certain types of behaviour deemed undesirable. The threshold for interfering with or restricting a person's liberty in order to assess or treat mental illness involuntarily has typically been raised to diminished rationality, lack of insight and imminent and serious risk of harm to oneself or others.[5] Social control functions involving surveillance, observation and managing difficult behaviours continue to be observed and described in nursing practice.[33] However, even if involuntarily assessment is legally mandated people continue to be entitled to claim other rights. Some rights claims require a clear legal and ethical duty of the nurse (e.g. the right to information requires that people be told of their legal status). However, in some instances it may be uncertain where the nurse's duty lies in relation to rights claims. For example, people may claim a right to legal advice or an alternative medical opinion. Nurses have a clear duty not to impede the person from seeking such advice but they may not be bound to facilitate it. The right to be treated with respect appears to be foundational, but like notions of beneficence it is open to interpretation.

In the best possible world one might safely rely on the laws of society as the framework required to behave ethically. Unfortunately, blindly following the law is perhaps the lowest level of moral comportment. Nurses who colluded in the extermination of the mentally ill in Nazi Germany and the labelling as mentally ill and forced medication of political dissidents in the former Soviet Union might claim that they were acting lawfully. However, few (at least from a position of detachment) would conclude that they were acting ethically. At best the law can provide only a crude guide to ethical behaviour in the nurse–person relationship through providing negative sanctions for extreme forms of immoral behaviour, e.g. physically abusing a patient, and defining the circumstances under which certain rights may be breached in the provision of treatment.

Reflection

- Make a list of rights
- For each right identified consider what duty a nurse may have in relation to those rights

Particular discourses may be taken up, promoted and shaped by social movements. Social movements are loose networks of people who share assumptions about particular problems and who cooperate, or individuals and organizations that participate in projects to address those problems.[34] There have been sustained criticisms of the coercive practices of psychiatry since the anti-psychiatry movement developed in parallel with human rights movements in the 1960s. The most famous advocates such as Szasz[35,36] challenged the existence of mental illness and maintained a critique of psychiatric authority that is often dismissed but has not been comprehensively refuted. More recently, a critical psychiatry movement has emerged[37] that is critical of coercive treatment and overemphasis on the biological explanations of mental distress but which seeks to reform psychiatry rather than challenge its authority. There might also be said to be a recovery movement – an offshoot of self-help, survivor movements and anti-psychiatry which aims to promote the idea of personal recovery. The evidence-based practice movement promotes a view that the practice of psychiatry and nursing should be based on the best available evidence. Reform and change in the labelling and treatment of people with mental illness has largely been a product of pressure from social movements. They often serve to illustrate problematic areas of taken-for-granted practice or contradictory philosophy and illustrate the social nature of the psychiatric project. The nurse needs to consider the assumptions underpinning these movements and the questions they raise and to consider how compatible they are with each other.

Reflection

A person is diagnosed with schizophrenia and compelled to receive a medication which is known to play a causative role in diabetes and is likely to lead to irreversible movement problems. From the perspective of the social movements outlined above, what questions are raised by this scenario?

- What social movements do you identify with?
- Who are the heroes of that movement?
- What values bind people together?
- What action or change is sought by members?

The Nursing Profession

Nurses are also part of a profession, which implies a body of knowledge and set of values held by its members. Professions exist only in the context of society and reflect many of the values of that society. Codes of ethics and standards of practice reflect the publicly declared values of professions. Theories, while less publicly accessible, provide professionals with some framework to understand and guide their work. Watson[38] has described nursing as a 'moral ideal'. Certainly 'grand' nursing theories paint an ideal picture of the nurse's work. No 'grand' nursing theory adequately deals with the problem or the role of nursing in compulsory treatment. Nevertheless, nurses can look to their profession for more specific guidance on how to be and behave in relation to other people.

Reflection

- Review the *ICN code of ethics for nurses*[28] and study the standards under each element of the code.
- Reflect on what each standard means to you. Think about how you can apply ethics in your nursing practice.
- Use a specific example from experience to identify ethical dilemmas and standards of conduct as outlined in the code. Identify how you would resolve the dilemma.

The nursing profession through regulatory bodies is able to censure members for behaving in an unprofessional (namely unethical) manner, or acting beyond the boundaries of professional conduct. At a less formal level nurses may regulate their own conduct through discourse about professional boundaries. A boundary marks out territory, or the margins of an entity. A boundary violation in relation to nursing practice implies that someone is not behaving as a nurse should, and that they are being something else. Boundary discourse appeals to elements of principle-based, rule-based and virtue ethics as well as etiquette. There are a number of potential areas of boundary violation:

- *competency*: practising beyond one's competency or training
- *roles*: practising outside of institutional roles or dual roles
- *physical contact*: inappropriate touching or sexual contact
- *space and place*: undertaking therapeutic interventions outside of usual hours of work or in an inappropriate geographic space (e.g. in someone's bedroom)
- *remuneration*: receiving or soliciting gifts or favours for work done
- *dress and appearance*: dressing provocatively or in an intimidating manner
- *communication*: using inappropriate, derogatory or overfamiliar language
- *intimacy*: becoming 'too close' to clients; disclosing too much about oneself.

Some boundary violations reflect unequivocally a wrongdoing. For example, most professional bodies take a dim view of practitioners having sexual relationships[39] with clients, in part because the client is always more vulnerable in a professional relationship. However, the margins of professional boundaries are often blurred. Nurses experience an ongoing tension between the need to maintain distance from clients and the desire to establish therapeutic relationships.[5] Distance may play a role in maintaining a sense of safety but a degree of intimacy is almost always needed to develop trust and identification with the helper. Physical contact may be an important communicative device that can convey compassion, and at times institutional roles may be unhelpful and confining. Nevertheless, consideration of professional boundaries is an everyday issue for most nurses.

Reflection

Consider each of the boundary areas described above, and for each identify behaviour which is:

- outside of the boundaries of professional nursing practice
- safely within the boundaries of practice
- on the margins.

Nurse and Patient

The nurse is in the centre of the circle and must perform activities in relation to people that are instrumental to the profession of nursing, wider society and in the direct interests of the person in care. This causes problems when the interests and demands of different parties conflict. The language of 'patients' rights' has come to permeate discourse in psychiatric services.[4] Such rights and remedies are enshrined in legislation. However, nurses are challenged to consider 'how' they might promote and

protect rights (e.g. choice and autonomy) at a time when society also demands that rights are subjugated, under the umbrella of protecting itself from the perceived threat of those with mental illness. Many of the ethical problems that arise within the psychiatric nurse–person relationship are a reflection of the tension which comes when the demands of society and of medicine conflict with the ideals of nursing.

As has already been discussed, a frequently encountered problem in psychiatric practice is balancing the principles of personal autonomy with beneficence. Another concept to consider is that of paternalism. Beauchamp and Childress[18] define paternalism as 'the intentional overriding of one person's known preference or actions by another person, where the person who overrides justifies the action by the goal of benefiting or avoiding harm to the person whose will is overridden.' Compulsory treatment is a dramatically paternalistic practice. However, far more frequent and subtle paternalistic practices include rationing a person's cigarettes, refusing someone permission to go for a walk or attempting to bend the will of another through coercive methods. Paternalistic acts are often justified by suggesting that the person has a limited capacity to act in an autonomous manner because of 'mental illness'.[40]

The method by which others try and influence or directly control another's behaviour may vary in terms of the gravity of the ethical problems that arise. MacKlin[11] described a continuum of interpersonal behaviour control methods:

- *coercion*: involving a threat of force or bodily harm
- *manipulation*: involving deception to change behaviour; a lesser threat or covert threat
- *seduction/temptation*: involving the offer of enticements; playing to the 'weak will' of another
- *persuasion*: involving reason and argument
- *indoctrination/education*: involving the provision of education or activity (e.g. role modelling).

The use of, or threat of, force is considerably more ethically problematic than weaker methods of influence, but all attempt to override a person's free will and interfere with their autonomy. Lützén[41] described 'subtle coercion' as a common practice which may be conceptualized as an interpersonal and dynamic activity, involving one person (or several) exerting his or her will on another. This requires judging patients' competency, acting strategically, modifying the meaning of autonomy, justifying coercive strategies and ethical reflection. The following incidents create conflicts in decision-making and require the nurse to assess the person's capacity for autonomy and sometimes engage in subtle coercion:

- patient's refusal of treatment, food or self-care
- searching through and keeping a patient's belongings
- patient wanting to leave the hospital
- self-destructive behaviour
- patient being unable to communicate his or her own needs.

Whenever coercive methods are used there is a potential breach of ethics, in that the person's autonomy is compromised. O'Brien and Golding[42] suggest that there should be a prima facie ban on coercive practices. That is, every instance of coercion should be justified and a principle of 'least coercive intervention' should prevail.

Sometimes people are controlled in covert and subtle ways; for example, a person is admitted voluntarily to an inpatient psychiatric unit but comes to appreciate that if he or she chooses to leave they will be prevented by nurses from doing so. In other instances, nurses may use force (e.g. physically restraining a person), or otherwise more profoundly limiting their autonomy through the use of seclusion (preventing a person from interacting with others). The use of physical restraint and seclusion may be legally sanctioned within some psychiatric hospitals in order to prevent harm to the person or others. However, people often experience these practices as coercive, frightening, punishing and harmful.[43,44] In response to behaviour from patients that engenders fear in others, nurses are often constrained by a lack of knowledge about non-coercive alternatives to restraints or seclusion.[4] The ongoing development of intrapersonal skills to deal with one's own fear and anxiety, as well as the development interpersonal skills to diffuse the anxiety and allay the fear of others, is an ethical imperative for nurses.

Reflection

- How do you respond to fear and anxiety?
- How might your responses affect the care that you provide?
- What might you do to allay the fear of others?

A further area of ethical tension arising from balancing autonomy with beneficence is the maintenance of privacy. The two areas of privacy related to mental health care include access to personal information and access to personal space. Privacy allows one to express characteristics and desires that one would not wish to reveal to others *and* the freedom to control one's self-presentation.[45] People within acute psychiatric inpatient services are frequently under close observation or video surveillance and have severely limited opportunities to control self-presentation. People under the care of assertive outreach teams or receiving intensive psychiatric follow-up in their homes also experience an invasion of privacy. This can engender a sense of shame, embarrassment and violation. Surveillance can cause harm, and nurses must balance the potential harm of close monitoring and

breaching an individual's privacy with the potential harm that may arise if the person's privacy is maintained.

Technologies such as computerized databases and risk registers pose particular ethical problems and risks. Most jurisdictions have laws or regulations governing how information is collected, stored and shared. In practice, many people may have little awareness of what information is collected and stored about them. In electronic form such information may persist for years and be used for unintended purposes. Information about people's mental health status may be particularly stigmatizing. Nurses are often the collectors of information and as such are ethically obliged to inform the person what information is collected, for what purpose and with whom it will be shared.

Reflection

- Imagine how it might feel to have your behaviour constantly observed by others.
- If you have the opportunity, request colleagues or tutors to place you in a seclusion room or in physical restraints for an undisclosed period of time. Discuss the experience with others.

ETHICAL DECISION-MAKING

In practice, people rarely employ a formal ethical reasoning process when choosing how to act in relation to others. Benner[46] proposes that an ethic of care must be learned through experience, because it is dependent on recognition of '… salient ethical comportment in specific situations located in concrete specific communities and practices, and habits.' However, there will be dilemmas and problems which emerge in everyday practice that are perplexing or require nurses to highlight, negotiate and justify solutions to others, solutions to ethical problems. In such circumstances a problem-solving process may be usefully employed. It is beyond the scope of this chapter to provide a detailed account of any one ethical decision-making process (for further study, see references 3 and 4). All nurses, however, will be familiar with a basic problem-solving process which involves assessment, diagnosing, planning, implementing and evaluating. Assessment involves identifying and describing the relevant ethical elements in a situation. The following questions may be useful to consider in assessment:

- What is the situation (provide a rich description)?
- Who has an interest in the outcome of the decision and what are their views on the right course of action?
- What are the choices you have?
- What may be the possible consequences of each choice?
- What resources are required for each course of action?
- How might each choice affect relationships with others?
- What principles or values stand to be compromised by each choice?
- What principle or value should take precedence in this situation?
- What are the rights of the parties involved?
- What duties arise from these rights?
- What are the legal requirements in the situation?
- Who ought to be involved in decision-making?

After careful examination of a situation it may be found that there is no ethical problem at all, but rather there is a problem of communication, law or policy that can be resolved through means other than ethical reasoning. If it appears that a dilemma or ethical problem remains, goals need to be set and a plan of action made. The plan may involve compromise, negotiation, further consultation, education or mediation. Lastly, the plan needs to be carried out and evaluated. Teams or groups may undertake this process. Indeed, when faced with a dilemma it is generally better not to carry the burden alone, but to seek advice or supervision from others.

Limited Moral Agency of Nurses

Nurses may possess exceptional skills in ethical reasoning, but this does not necessarily confer the freedom to undertake the ethical course of action. Nurses are frequently constrained from exercising free moral agency.[47] In part this is because of the instrumental nature of nursing to medicine and the status of nursing within the healthcare system.[48,49] Quite simply nurses are often legally required to do the bidding of medicine, 'the team' or others. Profoundly ethical decisions relating to a person's rationality, insight, competency, or risk are couched as 'diagnostic' decisions or 'clinical judgements' which according to psychiatric discourse and frequently the law are the purview and territory of medicine. Nurses are often legally required to carry out 'doctor's orders' to administer drugs, contain people under court orders, restrain, seclude and otherwise restrict people's liberty. Nurses are often required to be the enforcers of compulsory treatment orders and contain the responses of people to being treated against their will. Yet, nurses are usually ancillary to 'clinical' and treatment decisions, or when decisions are made in 'teams' psychiatric discourse tends to dominate.

In a recent study, Lützén and Shreiber[50] found that the '… nature and resolution of ethical decisions about patient care were contingent on whether or not the

cultural or management milieu of the workplace was supportive of nursing practice, that is, a place in which personal and professional growth was encouraged or not.' They suggest that nurses working in some contexts have limited choices because they work in a system that does not provide opportunities to challenge assumptions and work towards changing non-therapeutic environments, without risking personal sanctions. Nursing ethics must contend with the problem of many nurses having little if any voice in ethical decision-making, and the problems of negotiating ethically problematic situations where the contributions and concerns of nursing are rendered invisible.[48,51]

Exposure to the ethical problems of practice can and ought to cause some moral distress. However, the power of discourse, the security of tradition and deference to psychiatric authority can lull the nurse into moral complacency, or the discarding of once cherished values. Moral discomfort may be functional if channelled into solving the problems of institutionalized oppression and hegemonic discourse which inhibit nurses from acting freely and creating a truly collaborative healthcare ethic.[49] Barker[52] suggests that '… we face a major ethical dilemma in choosing between our faith in biomedical explanations of ill-health, on the one hand, and listening to, and learning from, the people in our care … on the other.' It may be that a greater challenge is accommodating and valuing different points of view, multiple realities and above all not abandoning those people who find themselves in situations that provoke our own moral distress or discomfort.

A pressing and ongoing ethical problem that psychiatric nurses face is realizing the purpose of nursing in relation to people who are distressed or suffering. It is easy and at times enticing to reduce nursing to a set of discrete roles or tasks such as 'managing risk', assessment or administering treatments. However, while helpful, such tasks do not necessarily address what the person most needs, which may be to find meaning in suffering. As Frankl observed,[53] 'Suffering ceases to be suffering in some way at the moment it finds a meaning.' Assisting people to grow, find meaning in experience, connect with others and reconnect with self reflect elements of true caring which are constantly threatened by competing discourses and human nature which compels one to flee from suffering. A fruitful starting point for ethical practice regardless of the context is for nurses to reflect on and refine their own philosophical basis of nursing care.

Psychiatric–mental health nursing is an ethical undertaking. The psychiatric nurse is often involved in complex messy situations, involving real people who hold differing accounts of a situation and have different and conflicting interests. Above all, psychiatric nursing practice involves a relationship with people who experience suffering. Ethical practice is more likely when the nurses have knowledge of ethical theory, the possession of clinical knowledge and skill and virtues such as compassion, an awareness of one's own values and the values of others, and an awareness of the ethical dimensions of everyday psychiatric discourse.

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