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NEGOTIATING THE ETHICAL MINEFIELD OF PSYCHIATRIC NURSING PRACTICE

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Abstract

Psychiatric nursing practice can be likened to an ethical minefield. Nurses are often in the middle of the minefield and are pushed and pulled by forces, which are sometimes beyond their control. This paper signposts some of the more problematic areas of practice so that nurses may be equipped with at least a broad over-view of the ethical terrain.

Key Words: Ethics, psychiatric nursing, mental health.

Introduction

Psychiatric nursing has been described as an ethical 'minefield' (Byrt, 1993). This description sits uncomfortably alongside the ideals of nursing or the rhetoric of care. Nevertheless, extending this metaphor may provide a useful beginning point and rationale for exploring ethical problems in the psychiatric nurse - person relationship. A minefield implies a perilous place, fraught with a very real danger of being literally torn apart or irreparably damaged by the placing of one's foot in the wrong place. Like mental distress or illness, a minefield represents a place which most people wish to avoid. Only a fool would knowingly enter a minefield without a map, or at least some expertise in recognising signs of the hidden dangers. People with mental distress find themselves at the centre of this metaphorical minefield and the nurse has the choice to watch

passively from the margins or actively engage with the person in order to facilitate their safe passage. This paper aims to explore some of the ethical hazards inherent in the business of engaging with the person and negotiating a passage through the experience of mental distress and the mental health system itself.

Each person's experience and situation is unique and therefore the pursuit of a detailed and universal map of the ethical terrain of psychiatric nursing practice is futile. At best one can endeavour to describe the characteristics of certain known ethical problems, or provide a crude compass to aid direction. With this goal in mind it seemed logical to ask experienced nurses what they perceived to be the main ethical problems encountered in practice. With an expectation of being flooded with responses, I posted a request to an e-mail list group on psychiatric

nursing posing the question and, despite previous success in soliciting responses to questions (Lakeman, 1996b; Lakeman, 1997) received no immediate replies. The conclusions I drew tentatively, shared, and had confirmed by the group, were that psychiatric nurses express the ethical dimensions of practice in the stories they tell on a day to day basis. Moral judgements are so intertwined with clinical judgements and their everyday work, that the question was too big. I might well have asked "tell me everything". Barker and Davidson (1997, p.354) had also asked a similar question and received only five responses. They suggested that, despite heated debate within the group about issues such as behavioural control and physical restraint, nurses may view these as practical concerns with little to do with ethics in particular, or philosophy in general.

Ethics is concerned with human action, what one ought to do, and forms of belief about right and wrong human conduct (Beauchamp, 1991). Benner (1991) proposed that ethical expertise is embodied in the narratives or stories of those who practise expertly, and that practical ethical reasoning arises from a 'situated' knowledge of the person, family and community. When nurses spend time considering whether they should do this or that they are involved in ethical enquiry, however at a more fundamental level they are concerned with what they should do in very specific contexts (Barker, 1999). The usefulness of traditional theories of ethics which tend to emphasize the stripping away of

context, and the reduction of decision making to the weighing up of abstract universal principles from a detached position, has been called into question in recent years (Lützén, 1997). Spreen Parker (1990) suggests that the script of traditional ethics is like a foreign language which fails to reflect the reality of nurses' concerns which are intimately tied to relationships and a privileged knowledge of the patient.

The development of an ethic of care has been described as a "... way of understanding one's moral role, of looking at moral issues and coming to an accommodation in moral situations" (Manning, 1998, p.98). At the centre of such an approach is the supposition that 'connection' with, rather than detachment from people is a primary and fundamental way of being in the world and that an orientation of connection reflects a feminine 'voice' which has been silenced through traditional ethical discourse (Gilligan, 1995). What proponents of an ethic of care highlight is the centrality of language or more particularly discourse in the framing of ethical problems. Foucault (1973) described 'discourse' as the formulation of communicative processes on the basis of power. Discourse shapes reality as well as reflecting it. Goffman (1961, p.15) observed that "Every institution captures something of the time and interest of its members and provides something of a world for them."

The world of clinical practice has its own language and logic, which is self-sustaining, in that it serves as a justification for action (Goffman, 1961). This is graphically illustrated

by Morrison's (1990) grounded theory study of violence in a psychiatric unit in which she described a 'tradition of toughness' characterised by controlling, restraining and coercing patients. The values of staff in this unit were derived from a medical biologic deterministic ideology, which viewed the 'patient' as out of control and thus requiring a controlling response from staff. Paradoxically, there is considerable empirical evidence that 'controlling' or over-controlling may actually provoke much violence in psychiatric settings, but violent behaviour when viewed through the ideological lens illuminated by Morrison serves as a justification for further controlling practices (Lakeman & Curzon, 1997). The particular world view or 'ideology' that clinicians are aligned to 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 in relation to the person who is distressed.

Nurses as ethically compromised

It is arguable whether nursing has much control over the dominant discourse in practice and hence whether nurses are 'free to be moral' (Yarling & McElmurry, 1986). Carryer (1997, p.2) has challenged the presumption that nurses are capable of separating themselves from the dominant ideologies or ethos of the health care system which clearly remains medical and has suggested that nurses "...very clearly talk one language, and practice another". There is a seductiveness about power and the language of the powerful that

makes these immensely hard to challenge (Waters, 1999, p.114). This brief acknowledgement of the power of language and the power of hegemonic discourse has major implications for nurse-person relationships. For example, whether or not distress is viewed as arising solely from some disturbance 'within' the person, or as a consequence of a disturbance in the family, social group or wider society, will greatly influence the views of what 'should' be done in relation to that person. Even when the disturbance is hypothetically located outside the person (for example, a noxious home environment or homelessness) available 'treatments' are often geared towards the individual (for example, use of pharmacological agents).

Health professionals are constrained in action by what they know, how they frame problems and other pragmatic considerations. Seldom do clinicians enjoy the luxury of being able to sit back and pontificate about what they 'should' or 'ought' to do without consideration of what they 'can' do (available choices) and how those choices impact on interested parties. The homeless or hungry person with some form of mental distress clearly needs a home or a meal, yet health professionals are often constrained from providing either.

Psychiatric nurses are also cognisant of being involved in an occupation which is increasingly under the gaze of the legal system, media, wider society and various interest groups. Furthermore daily decision making involves balancing the interests of self, the person, families, individuals,

medical staff, employers and others. In the best possible world the psychiatric nurse would seek what Manning (1998) describes as 'accommodation', that is accommodating the needs of all, including self, when making a decision. However, one must also acknowledge that often nurses have to compromise their values, thus leaving them in a vulnerable position. For example, Lützén and Shreiber (1998) describe 'moral survival' strategies, or social processes used by nurses to manage or ameliorate ethical difficulties in workplaces. These include playing the doctor-nurse game, doctor-bashing, scapegoating and the breakdown of teamwork. Nurses may discard once cherished values in order to fit in or deal with the discomfort which inevitably arises when these values conflict with those of the dominant group (Lakeman, 1999).

It would do a great disservice to psychiatric nurses to fail to acknowledge the reality of various interest groups influencing or claiming an interest in their day to day ethical decision making. The language of 'patient rights' has come to permeate discourse in psychiatric services (Johnstone, 1999), and rights and remedies are enshrined in legislation. However, such developments do not ameliorate the ethical problems of practice, as nurses are challenged to consider 'how' they might promote and protect rights (for example, choice and autonomy) when society also demands that rights are subjugated under the umbrella of protecting itself from the perceived threat of those with mental illness

(calls for containment and control). Many of the ethical problems which 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. The nurse and the patient are 'pushed and pulled' by forces not immediately within their control, which makes traversing the ethical minefield of practice all the more perilous.

Sketching the map

The nurse-person relationship as the vehicle for the facilitation of growth and development of people has long been a popular notion in psychiatric nursing (Peplau, 1952). However, as Stevens (1998) observes, nursing theories have tended to be presentations of ideals which are based on assumptions of client safety and the benevolence of nurses, and do not contend with non-caring interactions and their consequences. The nurse-person relationship has the potential to promote growth but may also be a destructive force. Nursing theories (eg: Christensen, 1990), standards of psychiatric nursing practice and standards for mental health services (eg: Australian & New Zealand College of Mental Health Nurses, 1995; Ministry of Health, 1997) all emphasise and require some form of partnership and collaboration with service users. Maintaining or promoting client autonomy and some form of equitable partnership poses the greatest ethical problem for psychiatric nurses in their relationships with people in distress (Fisher, 1995; Forchuk, 1991; Garritson, 1983; Garritson, 1988;

Garritson & Davis, 1983; Lützén & Nordin, 1993).

Certain types of experience and behaviour identified as 'madness' or more latterly 'mental illness' have long been recognised as a class of experience, which may profoundly affect the capacity of people to make free, and rationale choices. Plato, for example 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 (cited in Conrad & Schneider, 1980, p.40). The Kantian notion of morality is focused on the rational being (MacKlin, 1982) 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 when acting under the influence of madness. Indeed the laws of most, if not all first world countries provide for an insanity defence for even the most serious of crimes, so that those who are considered insane are not held morally accountable under the law but are instead considered in need of some form of help. Nevertheless, any experienced health professional is likely to acknowledge that there are degrees of irrationality, and even when experiencing severe mental illness, many people are able to exercise reasoned choice in at least some spheres of decision making.

The extent to which a person's decision making capacity is impaired (i.e. their rationality) and what treatment should be provided are

'clinical' as well as moral judgements. However, in relation to compulsory treatment nurses seldom have any real power. Nurses are legally bound to administer compulsory treatments determined by the 'responsible clinician'. The latter is a role defined under the New Zealand Mental Health and Compulsory Treatment Act (1992) and is generally held by psychiatrists. In most cases nurses are likely to accept and respect the treatment decisions of psychiatrists, and in many teams this respect is mutual and differences in professional judgement are freely aired and compromises reached. However, in my role as clinical nurse and lecturer in New Zealand there have been many occasions when the perceptions of patient, nurse, and responsible clinician have been at odds and nurses have found themselves at the centre of the ethical minefield. On several occasions where nurses have objected to forcibly administering medication they have been reminded of their legal 'duty' to follow 'doctors orders', and have felt that to do otherwise would be akin to stepping heavily on a mine at huge personal cost. Nurses clearly have an interest in compulsory treatment, being the 'enforcers' of treatment and containment, but their freedom to do the 'right thing by people', or act as patient advocates is sometimes questionable.

Those nurses that are involved with administering treatment to people against their will (for example forcibly administering drugs) are involved in paternalistic practices. Beauchamp and Childress (1994, p.274) 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". However, the nurse-person relationship often becomes the vehicle for providing the treatment prescribed by others. This is problematic in that it does not ameliorate the ethical responsibility of the nurse. In many instances nurses have little freedom to act independently, however it must also be acknowledged that relative to the person whom they are charged to care for they also wield enormous power.

Forchuk (1991) asked psychiatric nurses working in both in-patient and community settings to describe ethical problems which they encountered in practice and found that most involved balancing the principle of 'doing good', or beneficence with client autonomy. Forchuk (p.381) did not explicate examples of what counted as 'good' but her observation that "...inpatient problems generally involved staff conflict" suggests some uncertainty and subjectivity. Any number of practices may be justified as in people's best interests. In one example the nurse chooses to take possession of a person's cigarettes and dispenses them on the hour. In this instance the nurse may offer a justification that this is in the person's best interests as left to his or her own devices the person would smoke all his or her cigarettes in a short space of time and become anxious and irritable. This example appears rather benign and if handled sensitively may not

compromise the relationship between the nurse and person. However, other methods of controlling or changing behaviour may be more ethically problematic.

MacKlin (1982) 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 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 (for example role modelling) for the purpose of bringing about change.

Not all nurses feel comfortable with the use of these terms to describe the methods they use to control or otherwise modify people's behaviour. They have negative moral overtones, whereas other terms used to describe influencing behaviour such as 'encourage' and 'manage' are morally neutral. Nevertheless, these methods reflect what nurses in many settings are required or choose to do in relation to the person in order to maintain control. Lützén (1998) described 'subtle coercion' as a common practice which may be conceptualised as an interpersonal and dynamic activity, involving one person (or several) exerting his or her will on another and requires judging patients competency, acting strategically, modifying the meaning of autonomy, justifying

coercive strategies and ethical reflection. In Lützn's study, the following incidents created conflicts in decision making and required the nurse to assess the person's capacity for autonomy and sometimes engage in subtle coercion: patients refusal of treatment, food or self-care, searching through and keeping patient's belongings, patients wanting to leave hospital, self-destructive behaviour, and patients being unable to communicate their own needs.

Whenever coercive methods are used there is a potential ethically problematic situation in that the person's autonomy is compromised. Sometimes people are controlled in covert and subtle ways, for example a person is admitted voluntarily to an in-patient psychiatric unit but comes to appreciate that if they choose to leave they will be prevented from doing so by nurses. In other instances nurses may use force (for example 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 is legally sanctioned within psychiatric hospitals for 'therapeutic' purposes in order to prevent harm to the person or others. The use of the term 'therapeutic' is interesting in that there are few indications for either practice as 'therapy', that is curative or as a treatment for disease (Sykes, 1982). The prevention of harm (non-maleficence) through the use of such practices may well be justified in many situations, but describing these practices in the discourse of clinical practice as 'therapeutic' is

euphemistic at best. In one study on the experience of being restrained, the people who had been restrained did not view the practice as therapeutic, experiencing it as coercive, frightening, and a consequence of not following the rules on the unit or doing what they had been told (Johnson, 1998). In another study of young people's experience of being restrained or secluded, people described being traumatised directly or vicariously by observing other people being restrained, and feeling alienated from staff whom they perceived as "judgers" or "evaluators" (Mohr, Mahon, & Noone, 1998). These authors challenge coercive practices on ethical, legal and pragmatic grounds but acknowledge that nurses are often constrained by a lack of knowledge about non-coercive alternatives. Johnson (1998, p.203) describes the dilemma for the psychiatric nurses as, "one of trying to determine when to 'leap in' and take over for the patient who is losing control and when to 'leap ahead,' allowing the patient to use his or her own resources in order to regain control".

A further ethical problem related to the tension arising from balancing autonomy with beneficence, is maintenance of privacy. The two areas of privacy related to mental health care include access to personal information and access to personal space. Olsen (1998) suggests that privacy allows expression of characteristics and desires that one would not wish to reveal to others, and that freedom to control one's self-presentation is a central mechanism of personal identity. People within acute psychiatric inpatient services

are frequently under close observation or video surveillance and have severely limited opportunities to control self-presentation and 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.

Negotiating a passage through the minefield

When the ideals of nursing, as held by individual nurses, conflict with the requirements of practice (which it has been noted are not always within the control of the nurse) this gives rise to anxiety or discomfort. This discomfort may be analogous to what Lützén, Evertzon, and Nordin (1997) describe as 'ethical sensitivity' and requires some response from the nurse to reduce the discomfort (Lakeman, 1999). Controlling or coercive practices whilst ethically justified at times, threaten the 'positive connectedness' (Heifner, 1993) which is generally considered necessary for a truly helping relationship. Fisher (1995), who examined the ethical problems encountered by nurses working with 'dangerous' clients has highlighted the tension between the need to maintain distance from clients with the desire to establish therapeutic relationships. She suggests that distance was used to protect nurses from assault, maintain a sense of safety and manage their fears but that it in turn created "...long term, often unresolved, guilt,

shame, and grief in relation to professional identity and responsibilities" (Fisher, p.201).

The field of psychiatric and mental health nursing is broad and some nurses may choose to work in particular areas to avoid discomfort or enjoy greater autonomy in decision making. As one nurse with over forty years experience commented to me recently, "I loved working in acute inpatient care psychiatry but I will never return as I cannot be the kind of nurse that I want to be." This nurse presently derived more satisfaction in her semi-autonomous role in the community where she did not have to contend with the ethical problems of working with clients committed to in-patient care, but recognised that this work is absolutely essential. The challenge for the psychiatric nurse who chooses to work in the more ethically problematic areas of practice is to negotiate a passage through the ethical minefield, being fully cognisant of the dangers but with a conviction that they are doing the right thing.

Above all, nurses working in the psychiatric field must not be blind to the ethical dimensions of their everyday decision making and the social control function of their work. Nurses can not afford to take an armchair approach to the ethical problems inherent in their practice and further research on how experienced nurses negotiate these problems whilst maintaining positive working relationships with people (colleagues and patients) will assist others in negotiating the ethical minefield of practice.

Conclusion

From a principle based approach to ethics, the main problems encountered by psychiatric nurses in relation to people they work with involve balancing the principles of autonomy with beneficence. However, it must also be acknowledged that tension between these principles are played out in subtle ways, in the daily practice of nurses and in such mundane decisions as whether or not

to bath somebody who is non-communicative (Lakeman, 1996a). Ethical problems in clinical practice are frequently couched in the dominant language or discourse of clinical practice rather than the language of ethics. However, ethics may provide a different lens to view these problems and to clarify something more fundamental, namely what it means to be a nurse (Barker, 1999).

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