Cultural Issues in the Understanding of Ethics in the Nursing Profession: Implications for Practice.

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DECLARATION:

Unless specifically indicated to the contrary this study is a result of my own work.

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CONTENTS

	Abstract	vii
1	**INTRODUCTION**	**1**
1.1	Underpinnings of Ethical Reasoning in Nursing	2
	1.1.1 Influences on Ethical and Moral Reasoning	3
	1.1.2 Towards a Broader Cultural Understanding of Moral and Ethical Issues	4
1.2	Purpose of the Study	6
1.3	Methodology	6
1.4	Definitions	7
1.5	Outline of this Study	8
2	**THE RESEARCH CONTEXT**	**10**
2.1	What Is Ethics?	10
2.2	The Historical Evolution of Ethics	11
2.3	The Moral Significance of Nursing	12
2.4	The Nature of Nursing Ethics	14
	2.4.1 Teleological Theory	14
	2.4.2 Deontological Theory	15
	2.4.2.1 Autonomy	15
	2.4.2.1.1 Informed Consent	16
	2.4.2.1.2 Paternalism	18
	2.4.2.2 Beneficence	19
	2.4.2.3 Justice	20
2.5	Ethical Codes of Conduct	21
	2.5.1 Ethical Codes in Nursing	22
	2.5.2 South African Ethical Regulation for Nurses	23
2.6	The Notion of the Self in Ethical and Moral Theories	27

2.7 Indigenous Psychological Approaches to Understanding Ethics 29
2.7.1 Collectivism as an African Indigenous Approach to Self 31
2.7.2 An African Conception of Morality 33
2.7.2.1 Power Issues in Morality 35
2.8 Hermeneutic and Dialogical Approaches to Ethics 37
2.8.1 Narrative as a Hermeneutic-dialogical Approach 41
2.9 Concluding Comments 42
2.10 Research Questions 43

3 METHODOLOGY 44
3.1 Setting and Participants 44
3.2 The Interview Schedule 46
3.3 Justification for the Interview Schedule 46
3.4 Piloting 47
3.5 Procedure for the Main Study 48
3.6 Design and Analysis 48
3.6.1 The Design of the Study 48
3.6.2 Analysis 49
3.7 Reliability and Validity Issues 53
3.7.1 Reliability/Dependability 53
3.7.2 Validity 54
3.7.2.1 Internal Validity 54
3.7.2.2 Interpretive Validity 55
3.7.2.3 External or Theoretical Validity 55
3.8 Ethical Issues 56
3.9 Summary 57

4	**RESULTS**	**58**
4.1	Conceptions of Morality	58
	4.1.1 Morality as Empathy, Consideration or Respect for Another	59
	4.1.2 Morality as Dedication and Commitment to Service	62
	4.1.3 Morality as Thoughtfulness	62
	4.1.4 Morality as a Consultation Process	63
	4.1.5 Morality as Principled Action	64
4.2	Ethical Conduct as a Balance Between Principles and Specific Circumstances of Each Patient	65
4.3	Simultaneous Existence of Various Perspectives of Morality	66
4.4	The Role of World-views in Moral Reasoning	67
4.5	The Role of the "Other" or "Internal Audiences" in Moral Decision-making	71
4.6	Influences Informing Reasoning about Ethical Issues	72
	4.6.1 Influences of One's Upbringing, Particularly, One's Family	72
	4.6.2 The Influence of Religion	74
	4.6.3 The Influence of the Hospital / Clinic Setting	75
4.7	Power Issues in Ethics	76
4.8	Conclusion	79
5	**DISCUSSION**	**80**
5.1	World-views and Morality	80
5.2	Understandings of Morality	82
	5.2.1 Morality as Empathy / Consideration / Respect for Another	82
	5.2.2 Morality as Dedication or Commitment to Service	85
	5.2.3 Morality as Thoughtfulness	86
	5.2.4 Morality as a Consultation Process	88
	5.2.5 Morality as Principled Action	89
5.3	Ethical Conduct as Reflexivity	90

5.4 Positions in Perceptions of Morality 93
5.5 "Internal Audiences" in Moral Decision-making 95
5.6 Significant Influences in Morality 95
5.6.1 Family Influences 96
5.6.2 The Role of Religion in Morality 97
5.7 Conclusion 98

6 CONCLUSION 99
6.1 Implications of the Study 100
6.2 Recommendations 100

REFERENCES 101

APPENDICES
Appendix A: The Interview Schedule - The English Version 111
Appendix B: The Interview Schedule - The Zulu Version 112
Appendix C: Matrix Displays Used to Summarize Data 113
Appendix D: An Example of a Consent Form 114
Appendix E: A Sample of an Interview Transcript - English Version 115
Appendix F: Analysis of Appendix E 117
Appendix G: A Zulu Version of Appendix E 118

ABSTRACT

The study explored moral and ethical dilemmas experienced by Black nurses in a local community clinic. In particular, it examined the influences of the concept of self or personhood in nurses' ethical and moral decision-making. Influences of culture and family on morality were also investigated. Using the interview methodology developed by Gilligan (1982), nurses were asked to tell stories involving moral dilemmas in their work. Interviews were analysed using the voice-centred relational method. This method involves reading the interview narratives a number of times, each reading focusing on a particular aspect of a respondent's narrative. Results show that nurses often find themselves caught between two opposing moral and ethical viewpoints in their practices. On the one hand are hospital procedures, which are informed by universalist approaches to the person and the moral. From these are derived ethical principles emphasizing individual autonomy and choice. On the other hand, the majority of patients subscribe to a communal view of personhood. From this perspective, to be moral entails knowing one's position and responsibilities within family and community. Dilemmas arose from nurses' identification with patients' moral perspectives while realizing that this could lead to "unethical" conduct, (given their training and current codes of ethics). It is recommended that moral and ethical deliberations should dialogue with alternative, marginalised, viewpoints, in order to be culturally responsive. It is further recommended that ethics be conceptualised as a practical-moral engagement, rather than a detached application of knowledge.

CHAPTER ONE

INTRODUCTION

The purpose of this study was to explore cultural issues in nurses'[1] understanding of what constitutes a morally and ethically relevant situation and how this impacts on their work, and in particular, ethical problems encountered. The study also investigated how nurses made sense of the ethical procedures within the hospital context, especially as these are applied to patients from a predominantly collectivist[2] cultural background. Furthermore, this study sought to explore how concepts of personhood influence the understanding of moral and ethical dilemmas. Ethical theory has been largely influenced by Western values of self-contained individualism (Olsen, 1992). Moral reasoning in Western philosophy espouses a notion of self that is autonomous and self-sufficient (Ikuenobe,1998; Menkiti, 1984). It is this understanding of self that seems to be contained in a number of ethical theories. The notion of self as an autonomous being may de-emphasize the role of socio-cultural factors on individual development. Social and cultural influences are central in an African[3] view of life (Ikuenobe, 1998). This study proposes the utilisation of hermeneutic-dialogical approaches to the study of ethics (Gambu & Mkhize, 2000). This framework makes it possible to take cognisance of an African conception of the person, amongst others, as a major influence in individual development. From the African perspective, the self is not isolated but connected to the community (Ikuenobe, 1998). The shift from understanding ethics as a context-free to a context-bound phenomena signals the opportunity for cultivating more culturally grounded and indigenously useful forms of experience (Gergen,

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[1] Unless indicated to the contrary, nurse(s) refers to Black African nurses

[2] Although the term "collectivism" is used, these culture are not entirely "collectivist", but allow for the simultaneous existence of various orientations (Bakhtin, 1981) within a single personality

[3] While these views are neither entirely African nor the only perspectives in Africa, they nevertheless are shared by many societies in Africa

Gulerce, Lock & Misra, no date given). Since ethical theory has been largely influenced by Western moral thought, it follows that African nurses have been influenced by these understandings of the moral in their training and setting. This chapter begins with an overview of ethical perspectives within the practice of nursing and ultimately proposes a culturally informed perspective in the understanding of decisions involving ethics in collectivist societies.

1.1 Underpinnings of Ethical Reasoning in Nursing

The practice of nursing is, by its nature, an ethical enterprise (Allmark, 1992; Burkhardt & Nathaniel, 1998; Gibson, 1993; Sullivan & Decker, 1988). Throughout history nurses have been confronted with ethical dilemmas involving issues such as confidentiality and informed consent, to mention but a few. These dilemmas require nurses' attention in safeguarding patient rights. It is inevitable that nurses are faced with interpersonal and intra personal conflicts in their daily practise. Burkhardt and Nathaniel (1998) argue that the ability to address moral issues is at the heart of nursing today. The abortion debate, questions related to stopping ventilatory support and brain-death legislation are a few examples of issues from the health arena that have spurred public interest in ethical decision-making. As highlighted above, nursing ethics in general tends to be influenced by individualistic, universalistic perspectives which are contrary to the communal approach to life prevalent in collectivist societies. Therefore, it is important to explore the influences of other moral codes on ethical decision-making.

There are many possible understandings of moral issues and hence ethical decision-making is likely to be influenced by these understandings. Theories and principles used to address ethical problems in health care are drawn mainly from Western moral philosophy. Teleological and deontological approaches have been the most frequently used in addressing ethical issues in health care (Sullivan & Decker, 1988). Teleology measures the rightness or wrongness of actions by looking at the consequences of actions. Deontology on the other hand, focuses on duties and assumes that the features of the actions themselves determine whether actions are right or wrong. This perspective holds that there are universal principles that are inherently good independently of their consequences. From this perspective, to act morally is to perform what is rational, universal

and desirable for the whole human race regardless of the consequences (Gibson,1993).

1.1.1 *Influences on Ethical and Moral Reasoning*

Moral development research has been largely dominated by cognitive-developmental approaches, such as Kohlberg's (1981) ethic of justice which tended to ignore culturally-mediated explanations in favour of 'context-free' and universal explanations. Adhering to the deontological approach, cognitive developmental theorists saw moral development as a stage-like process with thinking becoming more differentiated with each stage. The stages of moral thought were regarded as universal and objective. From a universal understanding of moral theory has likewise emerged a universal conceptualisation of ethics. As in medicine and other related professions, three main principles have since come to embody nursing and other ethical codes of conduct. These are the principles of (a) respect for autonomy, (b) beneficence and (c) justice. *Autonomy* refers to granting individuals the freedom to hold their own opinions and act upon them as long as their actions produce no moral violation. In the spirit of autonomy, nurses are expected to help their patients to be involved in the decisions that affect them and their destinies. The notion of informed consent is based on this principle. *Beneficence* entails benefitting the person by protecting her/him from harm and promoting her/his welfare. Gibson (1993) argued that beneficence is considered as a duty in the nursing context, because nursing aims at promoting the well-being of patients. The *justice* principle prescribes that people be treated according to what is fair or due. The application of justice in health care services pertains to the allocation of services and resources (Sullivan & Decker,1988). At a microeconomic level this would entail developing strategies for receiving an organ for transplant, for instance.

The above-mentioned principles are problematic because they fall short in explaining the complexities inherent in the process of moral decision making. The principles assume an individualistic, autonomous notion of self that acts independently of external influences. As a result, it is not acknowledged that in some societies the concept of the person is different, such that individuals are defined interdependently, taking into account their relationship with others and the social milieu. Furthermore, ethical codes tend to be devoid of cultural understandings of what

it means to be ethical or moral. For example, in justice ethics, context is ignored, thereby ruling out the considerations of culture and power issues in real life ethical decision-making. Thus, universal approaches see ethical principles as context-free. This study aimed to address this issue by exploring situated understandings of ethics in a society that is largely communal but has its institutions largely influenced by Western, universalist approaches to ethics. Furthermore, the study explored how nurses negotiate the dichotomy between their Western training in ethics and their cultural background.

Recently, there has been a growing awareness of the limitations of deontological approaches (e.g., cognitive developmental) in moral reasoning in general (Gilligan, 1982; Olsen, 1992), and when applied to nursing ethics (Olsen,1993) and diverse cultural populations in particular. Cognitive-developmental approaches fail to capture the multiple modes of moral reasoning evident in different cultural groups and hence, the multicultural possibilities that may exist in deciding on ethical conduct. Howard (1991) puts it succinctly in his argument that when an inference is made about issues of meaning in people's lives, (such as, what moral or ethical action to undertake in a particular situation) 'universal' theories lack the rich resources to deal with these. Apart from being individualistic, developmental-deontological theorists tend to overlook the complexities of relationships and responsibilities inherent in moral dilemmas.

1.1.2 *Towards a Broader Cultural Understanding of Moral and Ethical Issues*

Gilligan's (1977; 1982) relational ethic of care and responsibility was developed in response to Kohlberg's ethic of justice (McCarrick & Darragh, 1996). Gilligan is one of many authors who acknowledge that moral reasoning is based on more comprehensive world-views (Dien, 1997; Jensen, 1997; Miller, 1997). Her model has its roots in interpretive and hermeneutic traditions (Tappan & Brown, 1992) and relational theory (Mauthner and Doucet, 1998). The ethic of care emphasizes ethical action rooted in a contextual understanding of specific situations. It announces that self and other are interdependent and exist within networks and webs of relationships (Gilligan, 1982). Relational obligations are seen as paramount in determining the right course of action. Such a model affirms a standard of moral maturity measured by responses to concrete

situations, rather than the ability to stand outside a situation and justify one's actions in terms of universal moral principles.

Gilligan (1982) is one of many authors to highlight that the moral experience of individuals cannot be interpreted in isolation from its social context. Although she made a great theoretical contribution in broadening normative approaches to development, her theory lacks sensitivity to the role of cultural factors in the process of development (Miller, 1994; 1997). Gilligan was concerned mainly with gender issues and thus offered a limited view of the influences of social factors on individual functioning. Furthermore, she did not concern herself with power considerations that go hand in hand with gender issues. Hermeneutic and dialogical perspectives offer a better framework to understand the role of culture and social context. As will be shown in subsequent sections, these approaches facilitate the incorporation of indigenous perspectives in understanding ethical and moral concerns by, inter alia, utilising research methodologies that are relevant and meaningful to cultural groups being studied *(narratives, in this case)*. Indeed, the hermeneutic and dialogical perspectives allow for the shared experiences of individuals[4], *particularly those marginalised by society,* to be interpreted together in order to understand and transform the social context (Tappan, 1991). From this point of view, ethical awareness is enhanced by society's capacity to "read" underlying political and cultural themes through critical reflection and dialogue. While current ethical codes of conduct do reflect a cultural conception of what is the right thing to do in particular circumstances, that understanding reflects a predominantly Western perspective, often assumed to be universal. Although current ethical codes are based on concepts which are assumed to be objective and value-free, in reality they are deeply rooted in Western values that advocate rational individualistic ideals (Kim, Park & Park, 2000). As such, they can be characterized as imposed *pseudoetics*, not true universals. Furthermore, if one adopts Howard's (1991) conceptualisation of narratives as a shared understanding or framework through which people make sense of themselves and the world, current codes of ethics are also cultural narratives embodying a particular view of the world, a view that is supported by

[4]This description fits that of the nurses chosen for this study

many authors such as Brunner (1990), Collins (1998), and Widdershoven (1993).

1.2 Purpose of the Study

The purpose of the study was to explore ethical dilemmas faced by nurses in their clinical setting. The focus was on investigating nurses' understandings of moral dilemmas and ethical issues, and how such understanding influences decision-making in the work place. It was also important to explore the notions of personhood inherent in nurses' understandings of ethics. An exploration of contextual and cultural factors playing a role in the resolutions of ethical dilemmas was also undertaken (e.g., religious and family beliefs).

1.3 Methodology

A revised version of the voice-centred, relational method originally developed by Brown and Gilligan (1991) and adapted by Mauthner and Doucet (1998) and Mkhize (1999) was used for the purposes of data collection. This research methodology is based on the hermeneutic and dialogical approaches to understanding concrete, lived aspects of human experience (Tappan & Brown, 1992). This theoretical framework has been adopted as it allows one to probe deeper into the socio-cultural basis of ethical and moral understandings. Using an interview schedule that had been developed for this purpose (see appendix A), nurses were solicited to narrate a story embodying a moral dilemma within their nursing environment. The cultural, social, familial and religious influences were explored through probing questions. This method of analysis allows for the exploration of people's narratives in terms of their relationships to the people around them and their relationships to the broader social and cultural contexts. Furthermore, the method recognises that language, like the living person, exists in a web of relationships (Brown & Gilligan, 1991). For this reason a person's experience, can be understood only if these relationships are taken into account. The voice relational method enabled me as a researcher to trace and untangle the relationships and context constituting the participants' psychic life and the bearing these had on their ethical decision-making. The method is discussed in detail in Chapter 3.

1.4 Definitions

Key and controversial terms are defined below in an attempt to establish positions taken in this study. While operational definitions are given, the meaning of these terms cannot be understood in isolation from the complete work. Their meaning will therefore emerge or unfold as they are used throughout the study.

a) Culture is a complex concept with a plethora of meanings. For the purposes of this study, Levine's (1986, cited in Howard, 1991) definition of culture is assumed. In line with this definition, culture is understood as a common formulation of ideas including the intellectual, moral and aesthetic standards prevalent in a community and the meanings of communicative actions. Through these standards people make sense of themselves, their actions and the world. This definition is similar to the one adopted by Brunner's (1990) who maintained that culture is a "system by which people organise their experience and knowledge about, and transactions with the social world" (p.35). Similarly, Geertz (1973) and Christopher (1996) saw culture as 'webs of significance' which endow our lives with meaning and coherence. It is through these webs of significance that structures such as family and other institutions, and indeed our own behaviour, are made sense of (Christopher, 1996). The notion of culture envisaged here is not a monolithic one. However, in line with the principle of dialogism that is the cornerstone of this work, it allows for a simultaneous existence of multiple, sometimes even opposing points of view within a single personality.

b) Hermeneutics is defined as the art and discipline of interpretation (Tappan & Brown, 1992). As a method, it is concerned with studying the lived, concrete aspects of people's lives, the focus being on how participants make meaning of their own experiences. It is concerned mainly with ontology (i.e., the question of Be-ing).

c) Dialogism: refers to the conversational quality of human experiences (Bakhtin, 1981; Bandlamudi, 1994; Sampson, 1993). The focus is on what happens between people in dialogues that they engage in with each other. Dialogism maintains that it is at the point of

contact or encounter with the other and his / her perspective, that the sense of the self and realities are co-created. In so doing, dialogism accentuates the intrinsically social and historical origins of our views about the self and the world.

d) Self-contained individualism: refers to the notion of self as an autonomous being, free of external constraints (the individualistic concept of self) (Sampson, 1993). This approach sees the self as analogous to a bounded container, separate and distinct from other similarly bounded selves. The self is treated as above the social order, with the social context existing only as a means for the realization of individuals' ends (Miller, 1994). Due to the prevalence of this notion of self in Western societies (e.g., Markus & Kitayama, 1994), it is alternatively referred to as the "Western" notion of the self in this study.

e) Collectivism refers to the relational, interdependent concept of self. This approach defines the self in relation to others *(the collective)*, with diffuse boundaries between "self" and the "non-self" (Miller, 1994). The distinguishing feature of collectivism is the consideration of the implications of people's actions for the wider collective (Fijneman *et al.*, 1996). This perspective acknowledges the influences of socio-cultural factors on the self. In the light of this framework, there is no such thing as a free, autonomous self.

f) Participants refers to black African Nguni nurses chosen for the study

1.5 Outline of this Study

This chapter has highlighted the influences of Western moral thought on ethical theory and in particular, the dominance of deontological approaches in nursing ethics. While their utility in moral issues cannot be dismissed, their limitations cannot be overlooked either. In an attempt to address this issue, a broader understanding of moral issues has been introduced, a perspective which will be expanded on in the following chapter.

Chapter 2 begins by conceptualising the term "ethics". The need for nurses to concern themselves with ethical and moral issues is then explored. The South African nursing code is reviewed, particularly the perspectives which inform it. Hermeneutic and dialogical approaches are presented as an alternative to the understanding of nursing ethics. Chapter 3 outlines the methodology adopted in the study. Chapter 4 gives an illustration of how the methodology was implemented in arriving at the conclusions made in the study. Chapter 5 highlights the conclusions reached and the implications of the study.

CHAPTER TWO

THE RESEARCH CONTEXT

This chapter presents a theoretical and contextual foundation of the study. In line with Maxwell's (1998) recommendation, it is entitled "the research context" as opposed to "literature review". Maxwell argued that the term 'literature review' is misleading as it influences one to treat 'literature' as an authority to be deferred to rather than as a fallible source of ideas about what is happening in the field. The term 'research context' seemed to be well suited for purposes of this chapter, as it aims to critically synthesize and evaluate the perspectives which inform nurses' understandings of ethical procedures within their hospital context rather than to merely describe other people's writings, consequently treating these as divinities to be accepted indisputably. The chapter begins by addressing the question of what is meant by the term 'ethics', followed by the historical evolution of moral theory thus highlighting the relationship between ethics and morality. The question of why nurses should concern themselves with ethics is explored. The discussion then moves on to explore the nature of nursing ethics, looking at perspectives which inform the current understanding of ethics in health care. The chapter concludes by presenting indigenous psychological approaches as alternatives to be taken into consideration in understanding ethics.

2.1 What Is Ethics?

The study of ethics relates to the meaning of such concepts as good and bad, right and wrong, "ought" and "duty" (Rumbold, 1999). That is, it is concerned with the justifications on which people pronounce that certain actions are right or wrong and whether one ought to do something or has a right to something (Burkhardt & Nathaniel, 1998; Olsen, 1992). In this way ethics are reflective and theoretical (Baelz, 1977). Ethics offer a process by which moral theory is put into practice. The study of ethics attempts to provide a medium for formulating responses to moral dilemmas (Rumbold, 1999). In this way, ethics aims to present a framework for dealing with moral issues (Bandman & Bandman, 1990). In this study, the terms ethics and morals are used

interchangeably, the reason being that, when a discussion is made about ethics applied to a particular discipline such as nursing, it is inevitable that the theoretical and practical problems become entwined (Rumbold, 1999). It could be argued that, if ethics is to be of use in terms of furnishing a particular framework for decision-making, it has to concern itself with practical problems (Rumbold, 1999). Moral theory serves as a foundation for ethics as it is through an understanding of a people's theories of the good life that one can make sense of why they regard actions or conduct as good or bad, right or wrong. Thus, the following section briefly outlines the historical development of the codes of ethics.

2.2 The Historical Evolution of Ethics

The rationale behind acknowledging the traditional development of the study of ethics, partly addresses the importance of ethics in health care. This sections seeks to answer such questions as: "why are ethics necessary?" The abuse of power in human experimentation necessitated the development of ethical guidelines in human research (Rumbold, 1999). Instances of the abuse of power in human research are for example, the *Nazi* and *Tuskeegee* experiments (Bandman & Bandman, 1990). During World War II, Nazi doctors carried out a vast range of torturous experiments on inmates in concentration camps. For example, cancer was introduced to human subjects and the progress of their excruciating death was recorded. Others were stood naked for many hours in below-freezing temperatures and were subsequently warmed up to observe at what points they showed vital signs of life. Many people died in the process of these experiments (Babbie, 1992). As a consequence of Nazi medical atrocities, the Nuremberg Code, an international guideline, came forth following the Nuremberg doctors' trial (Bandman & Bandman, 1990; Christakis, 1992; Stark, 1998).

Between 1932 and 1972 a 40-year experiment was conducted to study the differences between those syphilis patients who were treated with penicillin and those that were not treated (Burkhardt & Nathaniel, 1998). This came to be known as the *Tuskeegee studies*. A public nurse assisted in persuading over 300 black men to abandon the penicillin treatment, even though it had already been tested and was available (Bandman & Bandman, 1990). The Tuskeegee experiment

was a dreadful atrocity since it violated the principle of justice. The abuses of human rights on both the Nazi and Tuskeegee experiments contributed to the codification of the Nuremberg Code which was incorporated in the Declaration of Helsinki (Bandman & Bandman, 1990). It was concern about medical experiments such as these that led the World Medical Assembly to draft a set of ethical guidelines known as the Declaration of Helsinki (Rumbold, 1999). This illustrates the parameters within which researchers may practice, and differentiates between non-therapeutic biomedical research involving human subjects and medical research combined with professional care (ibid.). The former refers to research on volunteer healthy persons and patients for whom the experimental design is not related to the patients' illness while the latter pertains to patients for whom there is a relationship between the experiment and their health. The former is also referred to as non-clinical biomedical research while the latter is also known as clinical research. The Nuremberg Code and the Declaration of Helsinki commanded that informed consent be obtained from all subjects undergoing research (Rumbold, 1999). This arose out of the need to protect human rights (Bandman & Bandman, 1990). It is from this point of view that ethics became so crucial in medical and other health settings. The following section explores the rationale for nurses to concern themselves with ethics.

2.3 The Moral Significance of Nursing

In South Africa (and perhaps throughout the world) nurses make up the largest group of health workers (Mellish, 1981). They operate at primary, secondary and tertiary levels of care and have close contact not only with patients but their families and communities as well. At a primary level, patients and their families look up to nurses for information and support when facing difficult issues compromising their health. At a secondary level, nurses are actively involved in safeguarding and strengthening treatment modalities such as life-support systems (Bandman & Bandman, 1990). At a societal level, nurses are expected to play a fundamental role in health organizations and legislative bodies (Allmark, 1992). It is very likely that nurses will play a role in the transformation of the health sector (Mellish, 1981). Like other health care professionals, nurses tend to be faced with ethical decision-making in their working lives, given the nature of their work. Therefore, it is crucial that one understands the importance for nurses to be familiar

with ethics.

Nurses need to be familiar with ethics for several reasons. Firstly, as pointed out earlier, it is inevitable that nurses, irrespective of colour or creed, are faced with moral or ethical problems in their daily work. Occasionally, the ethical nature of the problem faced may be explicit, such as having to decide whether or not to tell a terminally ill patient the truth about his/her condition (Rumbold, 1999). At times, however, the ethical component of the problem may be subtle, for example, a nurse refusing to work in a family planning department as a consequence of his/her religious beliefs about contraception. Secondly, some advances in technology and medical expertise such as organ transplants and in-vitro fertilisation raise ethical concerns whose resolution is not to be found in any traditional ethical codes (Rumbold, 1999). Although ethical debates surrounding these issues are beyond the scope of this study, such debates revolve around patients' vulnerability and the conceptualisation of procreation. Finally, the world-wide trends towards a shift in the understanding of nursing and health care necessitates that nurses be familiar with ethics. Rumbold (1999) argued that there was a time when it was thought that the beliefs and values of a nurse and a patient always conformed to the shared value system of the wider society. However, at present there is a recognition that a multi-cultural and multi-faith society exists which does not necessarily always conform with the values of a nurse. Rumbold's argument touches on the importance of considering the cultural issues of both the patients and the nurses in health care delivery. This is useful for the purposes of this study because although nurses and patients came from collectivist cultures, nurses had been influenced by Western ideologies in their training. Later, it will be shown that one of the essential elements in current nursing ethics is respect for patients' autonomy. This entails respecting the patient's wishes and for the nurse not to impose his/her beliefs on the patient. It is one of the purposes of this study to examine how nurses negotiate this dichotomy, given that the dominant values and beliefs in their culture may be at odds with those prevalent in health care institutions. Undoubtedly, health care and nursing in particular, are of their nature a moral or an ethical undertaking (Burkhart & Nathaniel, 1998; Gibson, 1993; Rumbold, 1999). Therefore, an understanding of ethical or moral theories will guide a nurse on an appropriate course of action, although it would not furnish him/her with the

answers (Gibson, 1993). Sullivan (1988) echoes the same words when he argues that knowledge of ethical and moral theories will assist nurses in analysing issues and articulating ethical positions. Ethics are seen as providing concepts and language used in ethical positions that the nurses adopt. If ethics play such a crucial role in nurses' work, it is worth looking at the nature of nursing ethics.

2.4 The Nature of Nursing Ethics

A great deal of what has been written about nursing ethics is derived from bioethics (Rumbold, 1999; Sullivan & Decker, 1988). As noted in Chapter 1, the most frequently used perspectives in addressing issues in health care are teleological and deontological theories. For this reason, these approaches are discussed in more detail below.

2.4.1 *Teleological Theory*

From this perspective, right conduct is defined in terms of the goodness produced. Consequences are weighed according to cost-effectiveness and usefulness so that the greatest good for the greatest number are realised (Burkhardt & Nathaniel, 1998; Gibson, 1993). The most well known teleological theory often applied in health care is utilitarianism (Allmark,1992). Utilitarian theory considers the moral rightness of actions in terms of consequences yielded by that action. Thus, according to utilitarians acts are morally right to the degree that they enhance pleasure and minimise harm (Edwards, 1996). In utilitarianism the end justifies the means. The overriding consideration is the maximisation of utility, so that any act which might be considered to be morally objectionable would be morally correct (Edwards, 1996). For example, if a patient refuses a supposedly life-saving treatment, a utilitarian theorist would try to evaluate which course of action maximises utility. If treating this patient against his wishes is thought of as serving to enhance utility, then the patient will be treated. If the patient dies as a consequence of strongly resisting such enforced treatment, a utilitarian would still consider his/her action justified. Acts that are in conflict with the common moral judgement might be justified by their beneficial consequences (Pettit, 1991). Furthermore, the adoption of utilitarian ethics in the health care context condones the state of affairs which should be questionable. The adoption of utilitarian

considerations in the nursing context does not facilitate the acknowledgement of power issues inherent in decision-making (Edwards, 1996). Rather, it encourages their acceptance.

2.4.2 *Deontological Theory*

In deontological theories, duty is conceived of as the basis for morality (Sullivan & Decker, 1988). According to this framework, to act morally is to do what is rational and universal for all people without regard for consequences (Bandman & Bandman, 1990). Ethical actions are defined by other features inherent in those actions. Proponents of deontological theory derive the ethicality of actions from moral principles. Adherence to universal moral principles is a fundamental consideration (Beauchamp & Walters, 1989; Christakis, 1992; Faden & Beauchamp, 1986). These function as a foundation for ethical rules and as a framework for nursing ethics (Gibson, 1993). As mentioned earlier in Chapter 1, the three main ethical principles used in nursing ethics are: (a) respect for autonomy, (b) beneficence and (c) justice (Beauchamp & Walters, 1989). These ethical principles intermingle in a profound manner (Olsen, 1992).

2.4.2.1 Autonomy

The term "autonomy" literally means self-governing. It refers to independence and the freedom to choose (Rumbold, 1999). Autonomy also implies freedom of the self from the controlling interference by others (Faden & Beauchamp, 1986). In the health care context, nurses are expected to respect the autonomy of their patients and in cases where the staff feel that the autonomy of the patient has to be overruled, nursing staff are expected to offer justifications for their decisions (Edwards, 1996). Although the preceding statement shows that autonomy is not absolute as there are cases where it is overridden, it does highlight the central role of autonomy in nursing ethics. Burkhart and Nathaniel (1998) consider autonomy to be the dominant principle in deontological theory. As declared in Kantian philosophy, autonomous people are ends in themselves, they determine their own fate (Christakis, 1992; Faden & Beauchamp, 1986). The principle of autonomy is linked to the notion of self-determination and lends support to the belief that people have the freedom to make choices about the issues that affect their lives. The concept of autonomy is also closely linked to the notion of respect for persons (Gibson, 1993) and is an

important principle in cultures where individuals are assumed to be unique. However, in cultures where social structures are regarded to be above individual rights, the notion of autonomy (as understood in the West) is less meaningful (Burkhart & Nathaniel, 1998). For example, in collectivist societies it is believed that it is the community that determines the person (Menkiti, 1984). This is contrary to the notion of self-determination espoused by the principle of autonomy. In addition, authentic respect for persons entails being sensitive to people's diversities in terms of cultural values (Stark, 1998). In the context of nursing, this calls for an awareness that patients' values sometimes differ from those of the professionals.

It is very likely that autonomy would not flourish in a climate that does not allow for the self-sufficiency of individuals. For instance, let us consider a Nguni patient visiting a clinic due to abdominal pains. On examination, the consulting Nguni nurse tells the patient the pain is caused by a chronic ruptured appendix, notifies the patient the consequences thereof and recommends immediate surgery. In this case, an autonomous patient would be expected to make arrangements for surgery immediately. However in the situation where the index patient chooses to go home with the intention of discussing the matter with his/her family first before deciding whether or not surgery is ideal for him/her, what should the nurse do? Should the nurse act in the best interests of the patient *(paternalism or parentalism)* espoused by his/her training in an attempt to do no harm *(non-maleficence)* or should he/she respect the patient's wishes even if they are in conflict with what the principles of bioethics would consider as best. It is ethical dilemmas such as these that this study seeks to understand. In nursing ethics, autonomy for patients is often discussed in terms of broader issues such as informed consent and paternalism (Burkhardt & Nathaniel, 1998). These will be discussed briefly below.

2.4.2.1.1 Informed consent

Informed consent refers to a process whereby patients are informed of the possible consequences and dangers of treatments and are required to freely give their affirmation to a proposed health care procedure (Burkhardt & Nathaniel, 1998). Informed consent empowers patients to have the right to decide whether to undergo medical procedures before they occur (Bandman & Bandman,

1990). This necessitates that patients be given information in a language which will facilitate a clear understanding in order to make an enlightened decision (Rumbold, 1999; Stark, 1998). Informed consent also secures legal security of the patient's right to personal autonomy in regard to specific treatments and procedures (Burkhardt & Nathaniel, 1998).

For informed consent to be meaningfully implemented, one has to be capable of giving an informed opinion. Nursing ethics consider the competency of a person as crucial in informed consent (Edwards, 1996). In this context, competency refers to an ability to perform a certain task (Sullivan & Decker, 1988). It also pertains to the presence of critical internal capacities fundamental to self-governance (Faden & Beauchamp, 1986). According to this view, to give informed consent to undergo a medical procedure, one has to be *mentally competent* to undertake that decision. However, in the nursing context, some groups of patients are thought of as incompetent of giving informed consent. The incompetence of these patients is judged according to the nature of their psychological and physiological states. These groups of patients include (but are not limited to) children, brain damaged and unconscious patients who require life-saving procedures (Rumbold, 1999). In these cases, someone else has to make a decision on behalf of these patients. This reflects that it is the competency of the individuals as autonomous agents capable of acting on their behalf that is considered. Put differently, the competency for informed consent is determined in terms of the integrity of individuals' thought processes in the current nursing ethics.

The notion of informed consent tends to be problematic at times. Since it is based on notions of individual autonomy, it becomes inappropriate in cultures that do not espouse the concept of self-determination. This is by no means an indication that collective cultures are without concepts pertaining to the individual. Rather, it is an assertion that their understanding of the individual is different. In collectivist cultures the individual is determined by the community (Mbiti, 1970; Nobles, 1972). This implies that nurses and other health care professionals need to be informed of the values of societies in which they are working. It is comforting to know that there are emerging shifts in the understanding of informed consent and local ethics in general

(Gasa,1999; Richter, Lindegger, Abdool-Karim & Gasa, 1999).

Christakis (1992) is one of many authors to highlight the limitations of informed consent when applied to collectivist societies. He argues that the notion of informed consent becomes problematic because of cross-cultural variations in the perception of personhood. Western societies put emphasis on the individualistic aspects of the person and this is at variance with the relational view of self espoused in non-Western societies (Christakis, 1988). He sees this variation as having a number of implications. In as much as the notion of persons as individuals is negated, individual consent may be viewed as not essential in some cultures. Individual consent may be replaced by consent of the family or the community (ibid,; Stark, 1998). The issue of informed consent in the nursing practice is further complicated by the fact that nurses usually come in as the ones who are close to patients and have to convey this information to them.

2.4.2.1.2 Paternalism[5]

In cases where a patient's autonomy is overridden, nurses engage in paternalistic acts. In this context, the notion of paternalism translates to nurses restricting their patients' autonomy in an attempt to protect them from perceived harm (Burkhardt & Nathaniel, 1998). Nurses act paternalistically when they act in what is presumably the best interests of their patients. Thus, paternalism refers to actions which are for the benefit of another person but are not at the request of that person (Edwards, 1996).

In nursing practice, paternalistic acts need moral justification (Edwards, 1996). There needs to be strong justifications that patients are incapable of making autonomous decisions (Edwards, 1996). The fact that an action is perceived by the nurse to be of best interest for the patient is an insufficient justification for the implementation of that action. Sullivan and Decker (1988) and Edwards (1996) listed three criteria that ought to be satisfied for paternalism to be

[5] Although parentalism wold be a more appropriate term because paternalism has sexist overtones, paternalism is retained for purposes of clarity.

justified in the nursing context. Firstly, there has to be clear indications that the patient is not autonomous and particularly, not competent. Secondly, the patient has to be exposed to significant harm to warrant a paternalistic intervention. Finally, it must be ascertained that the patient will be highly likely to approve of the proposed paternalistic intervention at a later stage. It seems plausible to argue that paternalism can be thought of as a form of support when heartfelt concern for patients is coupled with an authentic judgment that a patient is indeed incompetent of an autonomous decision.

Although there are cases in which paternalism is clearly justifiable, in the nursing context this concept usually carries negative connotations (Bandman & Bandman, 1990; Burkhardt & Nathaniel, 1998). This is partially due to the recognition that historically patients' autonomy was frequently violated in the name of paternalism (Rumbold, 1999). For example, when alternatives for treatment were put forward to patients, there was a tendency of strong bias in favour of the health professionals' choice. Nurses would defend such a view on the basis that they were acting on the patients' best interests. Nurses tended to believe that because of their professional knowledge, they always knew what was the best interests of their patients. This kind of reasoning made nurses to ignore the role of multiple factors affecting physical outcomes. These factors include spiritual beliefs, culture and lifestyles, all of which must be taken into consideration when making ethical decisions (Burkhardt & Nathaniel, 1998). The notion of paternalism made nurses ignore power dimensions, which are crucial especially in societies with a history of group oppression. An abstract understanding of paternalism ignores the fact that because of their powerful position nurses may easily abuse their power when working with illiterate or semi-illiterate populations. An ethical relationship with patients requires an awareness and sensitivity to power and vulnerability issues (Stark, 1998).

2.4.2.2 Beneficence

The principle of beneficence is concerned with doing good (Burkhardt & Nathaniel, 1998; Edwards, 1996; Rumbold, 1999; Sullivan & Decker, 1988). In medical ethics, the value of benefitting a patient is considered as *the* foundational value (Faden & Beauchamp, 1986, Mellish,

1981). For example, an honoured principle in medical codes of ethics is "above all, do no harm" (Beauchamp & Walters, 1989; Faden & Beauchamp, 1986; Rumbold, 1999). The principle of beneficence includes the following four components, all of which have a common theme of promoting the well-being of others (Faden & Beauchamp, 1986). It affirms that one ought not to inflict harm, one ought to prevent harm, one ought to remove harm and one ought to do or promote good. In essence, beneficence necessitates that nurses behave in ways which benefit their patients. Similar to autonomy, the concept of beneficence is more complex than it initially appears (Burkhardt & Nathaniel, 1998). As indicated earlier, obligations for beneficence require that the nurse acts in ways that benefit the patient. However, in some cases this clashes with obligations to respect the patient's autonomy. That is, often what the nurse considers as good for the patient, runs counter to what the patient considers as good for himself or herself, and thus, undermines his/her sense of individual autonomy. Furthermore, if the understanding of the good is different across cultures, that ought to be taken into account. In the nursing context, clashes from these obligations often give rise to moral dilemmas (Edwards, 1996; SANC, 2000).

2.4.2.3 Justice

The principle of justice is concerned with fairness and appropriate treatment according to what is due or owed to persons (Faden & Beauchamp, 1986; Sullivan & Decker,1988). The concept of justice is based on the principle of respect for persons (Bandman & Bandman, 1990). At a macro-level this principle focuses on the distribution of health resources and is often referred to as distributive justice. However, for the purposes of this study the notion of justice will be confined to justice at a micro-level, that is, justice in the one-to-one health professional-patient situation. In this context, the concern is on determining whether or not nurses treat their patients fairly (Rumbold, 1996). Nurses tend to be engaged in decisions which involve the notion of justice in their daily working lives (Bandman & Bandman, 1990). The decisions may be about how to treat one particular patient over another. On what basis, for example, does a nurse make a decision to spend more time with a patient, knowing that as a consequence many patients may receive less time than they need? (Rumbold, 1999). Are the needs of a dying patient more deserving of the nurse's time than the needs of a patient who has just been informed of his/her HIV positive status?

In such cases, nurses tend to prioritize and in turn some patients receive justice at the expense of others, such that a degree of unfairness becomes inevitable.

Justice arises out of the principle of respect for persons (Bandman & Bandman, 1990; Burkhardt & Nathaniel, 1998; Edwards, 1996). Since truth-telling is regarded as moral, then to not tell the truth to patients is to treat them unjustly. Accordingly, to withhold information from a patient is unjust (Rumbold, 1999). In the same vein, to deny patients their autonomy is unjust for it is converse to respecting them as persons. As it has already been indicated that autonomy is a weightier principle requiring stringent justifications if it has to be overridden, it follows that to compromise patients' autonomy is to treat them unjustly. However, in some cases to act on what the patient considers as best for themselves, in the light of individual autonomy, may not be the healthiest decision, although it may be just. Hence, nurses engage in paternalistic acts in these cases. This indicates that paternalistic acts are at odds with the principle of justice (Rumbold, 1996). Since nurses do resort to paternalism, this reflects that the notion of justice in the nursing context is difficult to achieve. An abstract concept of justice is hard to apply in real life, concrete situations as it ignores the ethically sensitive nature of the institutions in which we are embedded.

2.5 Ethical Codes of Conduct

Codes of conduct offer a framework for acceptable behaviour in a profession. Inevitably, they tend to be grounded on ethical principles and contain within them declarations of ethical nature (Edwards,1996; Faden & Beauchamp, 1986). The principles of respect for persons, autonomy, beneficence and justice discussed above, are usually expressed through a profession's formal code of ethics (Bandman & Bandman,1990; Burkhardt & Nathaniel, 1998). Ethical codes are deemed invaluable in that they facilitate the attainment of numerous essential functions. They assure the public about the delivery of a profession and in turn protect the public against malpractice (Keith-Spielberg, 1994; Swartz,1988). They also provide guidelines to aid in regulation and disciplining of professionals (Beauchamp & Childress; 1979; Rumbold, 1999). Furthermore, they offer a framework and guidelines on which professionals can formulate their decisions (Bandman & Bandman, 1990; Fine & Ulrich, 1988). Additionally, ethical codes of conduct aid in the attainment

of the following essential endeavours: facilitation for a formulation of a group as a profession; acting as a support system for individual professionals; assistance in meeting the responsibilities of being a professional and providing moral principles which *are thought to* (emphasis added) assist individual professionals in the resolution of moral dilemmas (Sinclair, 1993 cited in Wassenaar, 1998). Ethics can be seen as forming a central foundation of the health professions (Beauchamp & Childress, 1994; Dunstan & Shinebourne, 1989). Nurses's adherence to the accepted codes of nursing ethics in all professional activities, is considered a duty (Mellish, 1981).

2.5.1 *Ethical Codes in Nursing*

Ethical codes for nurses are conceptualised as statements of beliefs expressing moral concerns, values and goals of nursing (Bandman & Bandman, 1990). They are more concerned with responsibilities than with rights or duties and consequently begin with statements about general responsibilities which nurses are supposed to observe (Rumbold, 1999). When nurses make clinical judgements they are expected to base their decisions on considerations for universal moral principles inherent in the their code of ethics. The statements of the code are thought to provide guidance for conduct in maintaining nursing responsibilities consistent with ethical obligations of nursing (Rumbold, 1999). Ethical codes for nurses assume that the fundamental responsibilities of a nurse are: the promotion of health; the prevention of illness; the restoration of health and the relief of suffering in the care of patients including their families and communities (Bandman & Bandman,1990; Edwards, 1996; Mellish, 1981). The notion of responsibility is linked to goodness and to rightness and thus exercising professional responsibility implies making decisions based on premeditated resolutions (Tschudin, 1986). In exercising responsibility the nurse is expected to determine the course of action which will most benefit the patient (Rumbold, 1999). Nurses' ethical codes could be conceptualized as a means by which nursing defines itself as a profession.

2.5.2 *South African Ethical Regulation for Nurses*

Nurses registered with the South African Nursing Council (SANC) are bound by ethical regulations drawn up by National Parliament[6]. The SANC was established under an Act of Parliament and gets its directive from government and the South African public (SANC, 1978; 2000). Through the establishment of the Nursing Council, the nursing profession was granted liberty to run its own affairs, hence it also gets a mandate from the nursing profession as well (Mellish, 1981). In terms of Section 3 of the Nursing Act, the Nursing Council controls and exercises authority over all matters concerning the practice of nursing (SANC, 2000). These include strengthening the promotion of health standards of the South African community, enlightening the Minister of National Health on matters falling within the scope of the Nursing Act and instructing the said Minister on the amendment of the Nursing Act. In terms of these provisions, the Nursing Council sets standards for practice which include ethical rules and practice regulations. These regulations specify acts or omissions in respect of which the Nursing Council may undertake necessary disciplinary steps (SANC, 1985; SANC, 1990).

The South African Nurses' Association Code for Nurses (SANA) serves as a frame of reference for South African nurses. The code is believed to direct nurses to appropriate courses of action when faced with ethical dilemmas (Mellish, 1981; SANC, 2000). When making clinical judgements, nurses are expected to base their decisions on considerations of consequences and of universal principles both of which authorize and rationalize nursing actions (Bandman & Bandman, 1990). In this context, the code for nurses is believed to provide direction for conduct in undertaking responsibilities consonant with ethical obligations of the nursing profession. While the code for nurses (SANA) is deemed as pertinent to nurses' professional activities, the following section briefly reviews the code as it pertains to a cross-cultural[7] setting.

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[6] In South Africa, Parliament commissions the Nursing Council through the Nursing Act to regulate nursing practice (SANC, 2000).

[7] Although this study is based on South African black nurses, their training exposed them to a Western world-view regarding health-related matters which is contrary to that of their patients, hence, the term 'cross-cultural' is appropriate in this context.

The first fundamental principle of the code for nurses (SANA) states that the nurse provides services with *"respect for human dignity and the uniqueness of the client unrestricted by considerations of race, colour, religion, social or economic status, personal attributes, or the nature of health problems"* (SANC, 2000, p. v, emphasis added). This directive arises out of the principles of beneficence and justice. In line with beneficence (the doing of good) the nurse has to give services with respect for human dignity indicating that to withhold available nursing services would be a violation of this obligation and the principle of beneficence (Sullivan & Decker, 1988). In addition to considerations for beneficence, this directive touches on the principle of justice. In the spirit of fairness, the nurse is professionally obliged to make clinical judgements which are not influenced by racial, social, personal or health related issues. On a superficial level, it seems desirable and reasonable that when deciding between the comparative needs of two or more patients, a nurse has to treat them fairly and impartially. For instance, if two equally ill patients (say one is a tramp and the other is a hospital director) needed to be assigned the best qualified nursing staff, in the light of fairness and the doing of good, one would expect the staff to be assigned to these two patients indiscriminately. However, for most nurses in such cases, *their* interests would come into play, especially when resources are limited. Thus, illustrating that values and beliefs do play a role in ethical and moral decisions (Sullivan & Decker, 1988). In the preceding example, in all likelihood, the hospital director would be assigned the most qualified staff, illuminating what has been already indicated that in the cases where nursing resources have to be distributed to meet the demands or needs, nurses tend to prioritize according to their perceived needs (Rumbold, 1999). This indicates that an abstract notion of justice is hard to implement in real life situations.

The above-mentioned precept of the code for nurses (SANA) also directs nurses to make clinical judgements *"unrestricted by considerations of social...status or personal attributes"* (SANC, 2000, p. v, emphasis added). This implies that in an attempt to treat patients fairly, nurses are expected to nurse patients from different social backgrounds in the same manner, overlooking their differences. It could be argued that since hospitals ascribe to a code of ethics which endorses moral principles that are individualistic in nature, in line with the nurses' code, *all* patients are

likely to be treated according to individualistic ideologies. The underlying assumption in this directive is that notions of justice and beneficence on which the code is based are universally held by all people. Swartz (1988) puts it succinctly when he argues that an individualistic orientation of the code is based on the liberal understanding of the world *(that is, a world made up of autonomous beings)*. Surely, if the code emanates from an individualistic understanding of the person, it follows then that those people who do not succumb to the individualistic notion of selfhood are alienated by it. This implies that if the notion of fairness and the doing of good is based on a self-reliant understanding of the person, it could pose difficulties when applied to patients from collectivist cultures. Any conception of justice or fairness when applied to patients from collectivist cultures, in order to be truly fair, needs to address the notions of justice and the doing of good from a collectivist perspective. Indeed, experiences of particular people cannot be meaningfully explored and understood if their philosophical presumptions are not reckoned with (Nobles, 1972). This implies that when inferences are made about patients from collective backgrounds, nurses have to take into account their socio-cultural considerations. Ignoring *or not considering* socio-cultural issues in this instance would be akin to doing injustice to these patients. Therefore, the first principle of the code as its stands would pose difficulties when applied to patients from collectivist cultures.

Another tenet of the code for nurses (SANA) states that "*the nurse acts to safeguard the client and the public when health care and safety are affected by incompetent, unethical or illegal practice of any person*" (SANC, 2000, p.5, emphasis added). This professional obligation has non-maleficence and beneficence overtones, hence, it places the responsibility on a nurse to do no harm and promote goodness in the interest of health care. The role of a nurse is analogous to that of an advocate who is expected to be aware of any practices *by anyone* which might compromise the patient's health (Edwards, 1996). This implies that a nurse has to be knowledgeable of what constitutes harmful practices with respect to the patient's health. This requires an understanding of institutional policies and procedures as well as a conceptualisation of what is meant by the term "ethical" (Bandman & Bandman, 1990). As it has already been highlighted, the code is based on understandings of ethics which are devoid of situated cultural

conceptions of what it means to be moral. It could be argued that if a nurse working in a cross-cultural setting adhered to this directive as it stands, difficulties could ensue. Chances are that a nurse may use an abstract understanding of ethics in judging whether or not the patient's health is compromised by another person. If a person being judged does not identify with the same understandings of ethical practice as a nurse, conflict might be inevitable.

The above mentioned principle also places great responsibility on the nurse to determine what constitutes incompetence or legality of practices performed on a patient. By using power afforded by nursing knowledge and skills, the nurse decides what is best for the patient. Although the nurse is guided by institutional policies in this regard, the directive of this code presupposes that the hospital acts on behalf of the patient. The underlying assumption is that the hospital as an institution comprehends better what is good for the patient. No mention is made about the role of the patient's views in this regard. It is assumed that the nurse will use her power afforded by her expertise to protect the powerless patient against any malpractice and in turn do what is good for the patient. Perhaps an illustration is useful at this point. There are a few nurses who might not intervene if one of their patients decided to consume a herbal mixture from a traditional healer whilst on medical treatment. Certainly, the patient's behaviour could be understandable if one takes into consideration the cultural dimensions influencing people's conception of illness. Mpolo (1965, cited in Ogbonnaya, 1994) puts it succinctly when he argues that the dynamic nature of the African world-view must be considered when one deals with African people in sickness (and health) states. The secret selling of traditional medication within the hospital context or incidences of patients requesting time-out to consult with traditional healers are a few examples pointing at the need to take Mpolo's argument seriously. Thus, treating pathology from a collective background entails incorporating an African conception of illness in the treatment package.

While there is certainly a move in the current amended nursing code (SANC, 2000) authorising nurses to be sensitive to patients' beliefs, it only directs them to recognise patients' <u>appropriate beliefs and traditions</u> (emphasis added). The questions of what constitutes appropriate beliefs and who defines them, are not addressed. To complicate matters even further, the code

states that disregard (on the nurse's part) for the SANC rules of professional conduct is regarded as unethical (SANC, 2000). As it stands the code does not lend to its adaptation to suit particular needs. In this respect, the code does not allow for the possibility that in order to be ethical, one may have to break the rules (Swartz, 1988). Perhaps by upholding individualistic ideals, the code falls short in taking cognisance of more comprehensive understandings of reality.

So far an attempt has been made to illustrate the problematic nature of the nursing code when applied to people from a collectivist background. Overall, the code is projected in fairly universalistic terms. This stems from a particular ideological understanding of the moral which is clearly not universally shared. It has already been established that any understanding of ethics has at its core a particular notion of personhood. To this end, the code for South African nurses reflects assumptions about the self which are rooted in Western moral theory.

Conceptions of morality or ethicality are derived from theories of the self (Ikuenobe, 1998; Ogbonnaya, 1994). The following section reviews the concept of self in ethical theories with a view to showing that cultural notions of self have implications for contextualised ethical decision-making.

2.6 The Notion of the Self in Ethical and Moral Theories

Any account of ethics which does not take cognisance of moral theory is rudimentary. This study argues that it is only through understanding the traditional conception of moral theory that one makes sense of the individualistic hegemony inherent in ethical theories. Embedded in theories of morality and hence, ethics, are concepts of self or the person. For example, the three ethical principles cited earlier assume an individualistic, Western notion of self. This conception of self is not universally shared (Geertz, 1973). Moral theory has been largely influenced by Western values of individualism (Ikuenobe,1998; Walker, 1993). Following on positivist ideologies, our understanding of morality has been based on the concept of self as some kind of a bounded container, distinct from other similarly contained selves (Sampson, 1993). This notion of self affirmed an individualistic, autonomous sense of personhood that is free of any external

influences. Furthermore, it portrayed the self as an independent agent functioning without any inter-connectedness with others (Ikuenobe, 1998; Menkiti, 1984). It is this understanding of self that is inherent in dominant moral theories such as Kohlberg's (1981). In these theories, the notion of an unconstrained-self has been presented as if it is the only standard of judgement available to us (Kim, Park & Park, 2000; Markus & Kitayama, 1998; Sampson, 1993). In the quest for objectivity, moral issues have been treated as scientific constructs to be explained as context-free phenomena. This led to issues of meaning in peoples' lives being treated in an abstract manner, stripped of their context. This metaphysical perspective created an illusion in its theories of the person, by directing us to look inside the individual when our focus should be on exploring what happens between individuals (Sampson, 1993). As a result, moral theories have adopted an individualistic view of the person and the moral and in turn ignored the influences of the other. It is argued in this study that a different understanding of the person would have resulted in a different understanding of the moral, and hence, ethics.

Bakhtin's (1981) theory of dialogism has implications for the self-contained notion of the person. Bakhtin argued that meanings are created through a social discourse which calls for an interdependence between the self and the "Other". He proposed that meanings are not a property of individuals working in isolation but become illuminated when one's ideas come into contact with others. In this context, a dialogue with others is seen as significant in the individual's accomplishment of consciousness. It is only through a relation with another that the self becomes conscious of its being. The dialogical nature of the self transcends the one-sided view of the person (Bandlamudi, 1994). For Bakhtin (1981), there is no such thing as an independent, self sufficient individual. From this perspective, the view of the person as a contained-being is incomplete. In a similar vein, Sampson (1993) argued that the "essence" of the person is conceived socially through a dialogue and is consequently found in relations between people rather than emanating from within individuals. Dialogism entails the mutual embeddedness of self and the other, since it is only in terms of the other that the self becomes aware of its existence. The self is simply seen as an integral part of the collective unity which relies on the other to gain its identity (Nobles, 1972). From a dialogical point of view, there are many possibilities of

conceptualising the self, other than the individualistic. Furthermore, dialogism makes it possible for a person to be influenced by multiple perspectives because it allows for a polyphony of voices to exist within an individual (Bakhtin, 1981).

Dialogism highlights a need for a contextually-situated understanding of ethics. In the light of the inadequacies posed by universalistic ethics, particularly when applied to collective societies, this study proposes the incorporation of indigenous approaches in the ethics dialogue. In the words of Heelas (1981), indigenous psychological approaches are the "cultural views, theories, conjectures, classifications, assumptions and metaphors - together with the notions embedded in social institutions" (p. 3), which inform psychological phenomena. These approaches are recommended because they acknowledge that psychological reality is culturally determined. Furthermore, they embrace an understanding of what it means to be a person occupying a particular position in a society. The following section reviews these.

2.7 Indigenous Psychological Approaches to Understanding Ethics

Indigenous approaches to psychology arose out of a need to develop legitimate perspectives and methodological tools rooted in a culture under study, rather than depending on adopted ones (Ho, 1998). The endorsement of alien principles on communal populations was seen as a perpetration of errors of omission (Kim & Berry, 1993). Although a Western approach may explain phenomena well in the West, it cannot be presumed to do the same in a culture wherein it was not developed (Verhoef & Michel, 1997). This view is implied by Azuma (1985) where he argued that when psychologists look at a non-Western culture through Western lenses, they fail to comprehend significant aspects of the non-Western culture since their science does not equip them with schemata for recognizing these. The application of Western psychological approaches to other cultures has contributed to a lack of appreciation of the culture of non-Western societies (Verhoef & Michel, 1997). Accordingly, the arbitrary application of Western concepts to populations who do not share the Western world-view is inappropriate at best, hence the development of indigenous approaches. Indigenous perspectives arose out of a need to develop contextual theoretical frameworks which are culturally embedded and representative of a people's

history (Verhoef & Michel, 1997). Approaches are indigenous to the extent that they reflect the cultural views, theories, metaphors and assumptions about the nature of people under study and their relations with their environment (Heelas, 1981; Kim & Berry, 1993). They aim to analyze phenomena within a cultural context employing concepts, belief systems and resources distinctive to the culture under investigation. The focus is on authorization and interpretation of an appreciation that people have about themselves and their world (Kim & Berry, 1993). Indigenous approaches have socio-cultural dimensions which are central in the concept of self, for what we are, is carved by the socio-cultural (Heelas, 1981; Kim, Park & Park, 2000). These approaches to psychology highlight awareness rooted in cultural, political and historical contexts (Kim & Berry, 1993). They examine how people interact with their environment by allowing for the lived experience of a target population to be studied from *their* point of view. In addition, societies characterized by the existence of cultural diversities highlight a need for different types of explanations and interpretations of phenomena (Berry & Kim, 1993; Kim & Berry, 1993). As such, indigenous approaches are more appropriate in societies (and institutions) with plurality in culture, such as South Africa in general and the nursing situation in particular.

Indigenous approaches to psychology endorse a context sensitive approach to morality and ethics (Ikuenobe, 1998; Menkiti, 1984; Ogbonnaya, 1994; Sampson, 1993). These perspectives highlight that human beings operate within socially constituted worlds (Gergen *et al.*, no date given). This is crucial in a country like South Africa where institutions such as hospitals and clinics, are often modelled after Western, often individualistic approaches to ethics which is in contrast with the values of the larger society and therefore likely to lead to conflict in nurses. Issues such as the Abortion Act passed by Parliament in 1996, further complicate the issues of ethics in societies, especially within the African communities (Taitz, 2000). The Abortion Act of 1996 endorses the right to free, safe and legal abortion on request. However, the Act is met with resistance in many African communities where termination of pregnancy is still considered a taboo in spite of the individual's freedom of choice espoused within the abortion legislation. The abortion Act is additionally clouded by the fact that traditionally people from collectivist societies espouse a holistic approach to life, where everything, including God, ancestors and the living, is

connected (Ikuenobe, 1998; Myers, 1993; Verhoef & Michel, 1997). Ontologically, this view assumes that reality is inseparably spiritual and material (Myers, 1993). To this end, abortion symbolizes weakening or undermining the web of connections which are central to life. Therefore, differing responses towards the current Abortion Act reflect that comprehensive views about the world inform moral judgements and reasoning about issues such as the termination of pregnancy (Emerson, 1996).

Indigenous approaches suggest an alternative unit of analysis by negating the individualistic bias affirmed by mainstream approaches. This reflects an awareness that the importation of Western psychology to communal societies represents a form of cultural supremacy that perpetuates colonization of the mind (Ho, 2000).

The next section discusses collectivism as an example of an indigenous approach to self that is relevant in South Africa. This approach espouses the predominant mode of conceptualising the self found in Sub-Saharan Africa in particular.

2.7.1 *Collectivism as an African[8] Indigenous Approach to Self*

It has been established that moral theories and hence ethics embrace particular notions about the self. Collectivist societies are characterised by great concern for others (Fijneman *et al.*,1996). Consideration of the implications of one's behaviour on others is a central feature of collectivism (ibid.). Emphasis is put on interdependence among people in the community. Collectivists also place value on obedience, a sense of duty and are prepared to sacrifice personal interests for collective interests (Fijneman *et al.*, 1996). Values such as conformity, social harmony and co-operation are supported in an attempt to enhance smooth ingroup relations (Schwartz, 1990).

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[8] Although there are within group differences in African cultures, within these variations there is common understanding that co-operation and harmony are valued over individualism (Menkiti, 1984; Nobles, 1972; Verhoef & Michel, 1997).

Any understanding morality in collectivist societies, commences with an awareness of their conception of the person and community (Ikuenobe, 1998; Menkiti, 1984; Ogbonnaya, 1994). The collectivist framework contends that an individual's identity is inseparable from external influences which comprise of the socio-cultural environment (Ikuenobe, 1998). The self is bonded to others and the social context. One's identity is symbolized by a fundamental relatedness to others, as opposed to being autonomous and independent (Markus & Kitayama, 1991 & 1998; Fijneman *et al.*, 1996). Moreover, in collective societies, personhood is regarded as part of a larger fundamental unit, such as the extended family, the community and the universe (Ho, 1998). Instead of describing the person by reference to personal attributes, the African view of the person gives supremacy to social structures and interpersonal dispositions such as families, work groups or social roles in defining the person (Markus & Kitayama, 1998). There is a sense of fellowship and kinship between the individual and others. As such, the African conception of the person necessitates that the concerns of a community ought to take priority over similar considerations of an individual (Ikuenobe, 1998). So, the notion of self-identity that the individual comes to be bestowed with, epitomizes the collective beliefs and norms of the community (Ikuenobe, 1998). This does not imply that the self is selfless, but that the self is community (Verhoef & Michel, 1997). This is echoed by Mbiti (1970) when he defines an African view of the person, summed up as *"I am because we are, and since we are therefore I am"*. This argues for an inter-dependent construal of self which characterizes collectivist societies. This is similar to the notion of *ubuntu* espoused by Nguni people, hence the saying *"umuntu ngumuntu ngabantu* (an individual is only a person as a consequence of his / her connectedness with others[9]).

Inasmuch as the Western culture puts emphasis on individuation, the African conception of the person stresses connectedness with others. When the former espouses the doctrine of "I", the latter embraces the notion of "we", enhancing social embeddedness. To this end, a person from collective societies is more likely to give up personal concerns for collective considerations

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[9] In this instance, others being, family, community or any significant others in an individual's life.

and to give priority to sharing possessions with members of the community (Fijneman *et al.*, 1996). In addition to the community, the self is also seen as connected to ancestors, the yet unborn, and all of the universe (Ikuenobe, 1998). It is this collective understanding of the person that is unappreciated in the dominant theories of morality and ethics. Such an understanding is adopted by a significant proportion of the population in Africa (Ikuenobe, 1998; Menkiti, 1984; Ogbonnaya, 1994; Sampson, 1993). Collectivism recognises that by treating the individual as the most accessible unit of analysis, traditional moral theories have in turn ignored social and cultural influences on the moral domain. Accordingly, the African notion of person and community facilitates for a better understanding of the moral.

The call for indigenous and collective understandings to ethics does not indicate that individualism plays no role in African life (Gambu & Mkhize, 2000). Indeed, Bakhtin (1981) is one of many authors who argued against the individualistic-collectivist dichotomy. For Bakhtin, many voices or perspectives can be discerned within the individual, hence, the possibility of individualism and collectivism existing together, although sometimes in conflict. Therefore, people from collectivist societies vary in their needs for independence and interdependence. This is echoed by Wertsch (1995), who argued that to interpret human action solely on individualistic or collective terms is reductionistic at best. He proposed that human action should be seen as providing a context within which the individual and the collective are understood as interrelated. The following section gives an outline of what it means to be moral from a collective perspective.

2.7.2 *An African Conception of Morality*

Morality in African cultures is not codified into a set of abstract principles. Rather, it is historically and socio-culturally embedded (Ikuenobe, 1998). It unfolds from the process of living and is grounded in the context of communal life (Verhoef & Michel, 1997). In the quest for social harmony, greater emphasis is placed on interpersonal responsibilities which are seen as a duty (Miller, 1994). Doing one's duty in enhancing good social relations is perceived as meeting a social necessity and realizing one's nature. Accordingly, the community and extended families which are characterised by diffuse mutual obligations, are indispensable to morality (Schwartz,

1990). In this sense, morality in African societies is situated in a particular social context. It is an embodiment of the needs of a community (Menkiti, 1984). People are closely connected to each other within a lifestyle directed towards the other (Verhoef & Michel, 1997). When African people refer to "we" they mean a completely synthesized collective "we" (Menkiti, 1984). In many African communities, all people are regarded as members of one's family and are consequently acknowledged as father, mother, brother or sister in spite of genetic relationships (Verhoef & Michel, 1997). This collectivity necessitates responsibility and concern for others (Menkiti, 1984; Ogbonnaya, 1994; Verhoef & Michel, 1997). By being responsive to each others' needs, all people play a role in enhancing the connected web of relations. In particular, elders in collective societies illuminate the cornerstone of communal life (Ikuenobe, 1998; Verhoef & Michel, 1997). They are regarded as a fundamental part of the community. For example, the oldest person within the family has the task of conducting family rituals and for maintaining a good relationship with ancestors (Verhoef & Michel, 1997).

The nature of morality in collectivist societies is such that the individual is obligated to the community. From the collectivist framework, morality is duty-based and contextual (Miller, 1994). This view is concisely expressed by Mbiti (1970) where he argues that the central belief in African culture is that nothing and no one can exist alone. Interdependence is favoured over separateness, such that life is conceived holistically and ontologically (Myers, 1993; Verhoef & Michel, 1997). Everything is connected and interrelated, ancestors, humans, plants, God and animals (Ikuenobe, 1998; Verhoef & Michel, 1997). Unlike the Western view where the individual object is perceived as occurring in itself, no creatures exist within the African world-view without relationship (ibid.). Morality and hence ethicality, is also determined by how much individuals are able to attune their needs to meet the needs of the community (Ikuenobe, 1998; Nobles, 1972). Ikuenobe (1998) further notes that when reference is made about moral reasoning of people from collective backgrounds the focus is on 'what *we* ought to do' versus 'what *I* ought to do'. In this instance, "we" symbolizes the moral traditions of the community which the individual has internalised (Ogbonnaya, 1994). These reverberate within the individual and act as guide in every facet of life.

Collectivist approaches espouse a socio-culturally embedded notion of morality as opposed to the decontextualized, transcendental view of Western ethics (Markus & Kitayama, 1998). The following section reviews power issues which are inherent in moral theories and hence, ethics.

2.7.2.1 Power Issues in Morality

Social embeddedness is conceived of as crucial in collectivist societies because it enhances a sense of kinship amongst people. Fitting in with others is pertinent to the sovereignty of social structures (Markus & Kitayama, 1998). Each individual is situated uniquely within the community hierarchy in relation to age, kinship, character, wealth and gender (Verhoef & Michel, 1997). Within each hierarchy there are duties, obligations, rights and privileges imposed by the moral sense of the community (ibid.). This parallels the notion of self as a social representation. From this perspective, one's relative positioning in socio-political and historical context influences one's comprehension of significant experiences (Oyserman & Markus, 1998), such as decision-making, for example. As such, collectivism places great importance on age, social roles and statuses of some people within the community (Ogbonnaya, 1994). The elders are recognized as having a higher status than others (Menkiti, 1984). To this end, elders in a community are perceived as fundamental repositories of what it means to be moral (Ikuenobe, 1998). In the words of Menkiti (1984) "what an old man sees sitting down, a young man cannot see standing up" (p.173). Elders attain their power through their lived experiences which are thought to reflect wisdom (Ikuenobe, 1998). By implication, age is an important determinant of status in African societies (Nobles, 1972; Verhoef & Michel, 1997). Individuals of a certain age group are expected to have a particular understanding of society and are addressed according to this understanding (ibid.). In particular, young people are expected to show regard towards elders and to command them with respect conferred by their social status in the community. Behaviour is judged according to how responsive one is to others to whom one is interdependent (Markus & Kitayama, 1998). Accordingly, young people are obliged to respect the wishes of the elders in order to enhance their kinship which promotes interdependence in the community. Since collective societies place high regard for social harmony, young people are often subordinate to the authority of the elders.

The young are always encouraged to be obedient and to conform to elders. In turn, the elders are expected to behave accordingly, dispense their duties in a manner that further promotes harmony (Paris, 1995). Otherwise, they lose the respect due to them.

The African perspective, considers social relationships as the underpinning of morality (Verhoef & Michel, 1997). From birth, the individual from a collective society is instructed to honour the elders and the community who are in turn expected to behave in a manner that is befitting of this respect (Paris, 1995). This perspective of morality is inseparable from a way of life, it entails knowing one's position, and obligations within the social structures which include the family and the community. In this instance, morality is fundamentally concerned with the maintenance of good social relationships as opposed to the preservation of individual rights and justice (Verhoef & Michel, 1997). Furthermore, morality in collectivist societies is dynamic, relative and context bound (ibid.). In judging a moral situation, the following variables are taken into account: "who did what to whom?", "under what circumstances?", and "what were the consequences?" (ibid.). Morality in traditional African societies shows the dynamics of the status hierarchy (Mbiti, 1970). In presupposing an interdependent construal of the person, collectivist conceptions of the moral espouse a duty-based, contextual understanding to ethics.

The following section reviews hermeneutic and dialogical approaches to ethics. It is argued that hermeneutic-dialogical approaches to understanding phenomena are one of the better tools available to the researcher interested in exploring indigenous and contextualised psychological phenomena (Mkhize & Frizelle, 2000). Hermeneutics and dialogism help us to move beyond the individualism-collectivism dichotomy, by allowing for the possibility of a simultaneous existence of these. Bakhtin (1981) is one of many authors who argued against the individualistic-collectivist antimony. He maintained that an individual can hold various positions or perspectives, which continue to influence the psyche and are sometimes in conflict with each other. Similarly, Wertsch (1995) argued that human action should not be interpreted using individualistic or societal terminology in isolation. He postulated that human conduct should be viewed as providing a context within which the individual and society *(the collective)* are

understood as complementary. Drawing on philosophical hermeneutics such as Gadamer (1975) and the ideas of Bakhtin (1981), it is argued that hermeneutic-dialogical approaches make it possible for us to integrate indigenous perspectives into mainstream science whilst allowing for the exploration of culture-bound phenomena. Hermeneutics does this through Gadamer's (1975) notion of the fusion of horizons[10] of understanding, whereas Bakhtin's (1981) dialogism facilitates this process by recognizing the polyphony of perspectives within a single personality. Therefore, it is possible for people from collectivist societies to hold both the individualistic and collectivist perspectives, although these are sometimes marked by inconsistencies. While there are obviously some critical differences between Gadamer's (1975) hermeneutics and Bakhtin's (1981) dialogism in particular, for the purposes of this work, only the common points are of interest (the reader is referred to Gardiner (1992) for a detailed comparison of the two philosophical traditions).

2.8 Hermeneutic and Dialogical Approaches to Ethics

Hermeneutic approaches to morality postulate that an adequate understanding of human action should appreciate the meanings, purposes and intentions of people in their context (Mkhize & Frizelle, 2000). The hermeneutic tradition also strives to understand lived experience within its historical and socio-cultural contexts (Kashima, 2000). To this end, the hermeneutic framework is arguably an example of an approach that makes it possible to accommodate voices and perspectives from collective societies, particularly, through the notion of the fusion of horizons. Gadamer (1975) argued that people are always situated within horizons or perspectives of understandings. From this framework, interpretation of real lived human experiences can only take place if we enter into dialogue with the horizons or the perspectives of the other, inevitably strengthening our understanding through the fusion of perspectives (ibid.). To this end, hermeneutics proposes that research into moral issues should take cognisance of indigenous perspectives in ethics. Not only should we enter into dialogue with other horizons, but both ours' and others' understandings need to be scrutinized to illuminate the ideological and power

[10] A detailed review of how this fusion takes place is beyond the scope of this study. The reader is referred to Warnke (1987) for a fuller elucidation of this concept.

dimensions that may be inherent therein (Gardiner, 1992; Habermas, 1971; Mkhize & Frizelle, 2000).

In line with postmodernism, hermeneutics presents a more balanced option to the supposedly objective, logical-reductionist approaches assumed in science (Retan, 1997). This perspective challenges assumptions about truth and emphasises contextualism, locating human experience as its focus. The consideration in hermeneutics is on lived human experience as opposed to abstract scientific issues. The notion of lived experience refers to the practical nature of our being in the world. Understanding refers to a process by which a person secures an entry into another's lived experience (Tappan & Brown, 1992). Comprehending the social world commences with taking into account the perspective of the other (Bandlamudi, 1994). Consequently, in acknowledging others' perspective we contemplate their responses and behave in manners that are culturally appropriate. The hermeneutic and dialogical approaches to morality address the historical and psychological realities of lived experience of the person whose life is being interpreted (Mkhize,1999). This is achieved because when we interpret another's experience, our own values, biases, assumption come into play and influence what is being interpreted (Tappan & Brown, 1992). Our backgrounds or horizons of understanding, influence the way we shape the world. Thus, from a hermeneutic approach, we gain understanding in terms of what we know and in particular in terms of who we are (Mkhize & Frizelle, 2000). These local understandings have been largely ignored in current ethics.

While foundationalist or essentialist approaches to interpretation regarded the meaning of human action as confined in the act itself, hermeneutics appreciates the fact that our interpretations and our interpretive strategies are shaped by the values of "interpretive communities" in which we are embedded (Fish, 1980 cited in Tappan & Brown, 1992). Thus, the interpretive community of which the interpreter is a member plays in role in shaping the interpreter's interpretive strategies (ibid.). Unfortunately, the current scenario is such that when ethics are interpreted certain communities are ignored. This is ironical because in interpreting lived human experiences, we enter into a dialogue with the perspective of others. To this end,

ethics need to reflect the dialogical nature of moral reasoning. Not only should we enter into a dialogue with others when we make decisions about moral issues, but both ours' and others' perspectives need to be critically addressed to untangle the ideological and power dimensions that might be intrinsic therein (Habermas, 1971). The socio-cultural nature of hermeneutics and to a larger degree, the dialogical methods proposed by Bakhtin (1981) allow for the exploration of power, gender and other social and political factors in the process of moral and ethical decision making.

Like hermeneutics, dialogism as proposed by Bakhtin (1981) in particular, argues for a synthesis between various perspectives. Bakhtin asserted that during the process of development an individual enters into dialogue with a number of social and cultural voices or perspectives. These voices, which may be shaped by articulations from grandparents and parents, including collective group understanding as reflected in cultural prescriptions, are conserved in the psyche, where they can engage in an *inner dialogue* with each other. Individual development necessitates appropriating the various voices that one is exposed to, a process which may lead to an *internally persuasive discourse.* This refers to an integration of the various voices in the formation of one's own. That is, although an individual is exposed to various perspectives in the course of growing up (e.g., cultural prescriptions of a good woman), internally-persuasive discourse occurs when people critically examine these to form an opinion of their own. Internally persuasive discourse differs from *authoritative discourse,* which is characterised by a discourse that is a reflection of others' positions or perspectives (such as, a woman believing in the superiority of men reflects the authoritative dominant discourse of male hierarchy). *Authoritative discourse* calls for unconditional obedience, refuses to be challenged, and therefore constitutes a *monologue* as opposed to *dialogue*. The imposition of Western theories of morality and ethics upon local populations, without taking into consideration the indigenous views of the moral and the ethical, is an example of authoritative discourse. In line with Bakhtin's (1981) theory, in reading people's narratives, we should be able to listen and identify a number of voices and perspectives which inform a person's resolutions in ethical decision-making. Exactly, whose perspective or voice is inherent in the codes of ethics? Who is actually speaking in these codes? Which voices have been

silenced or ignored? These are some of the concerns that the current study attempts to address.

For Bakhtin, dialogicality also includes a process known as *ventriloquation,* a situation whereby, in an utterance a voice (perspective) or set of voices speak *through* another voice. That is, in our speeches and utterances are reflected not only our positions, but those of the social groups that we belong to as well (i.e. reflects the views of his / her profession). This phenomenon highlights the fact that a person speaking with an individualistic perspective may at the same time be uttering a collective voice (Hermas & Kempen, 1995). For example, when a researcher gives an opinion about a particular issue, he/she does that as an individual and also as a professional. This reflects that one's actions as an individual are simultaneously the expressions of a group or culture to which one belongs (Hermas & Kempen, 1995). "In these cases individual actions reflect the conventions of the group and cultures that have left their imprint on people's selves." (ibid., p. 108). This has implications for codes of ethics in that they embody the philosophical assumptions and ideals of certain groups in society. The question becomes: Whose ideals are these?, Whose ideals have been ignored?, Which function does the exclusion serve? In the final analysis this indeed becomes a political question.

Hermeneutic-dialogical approaches could be conceived of as tools instrumental in breaking the silence of the perspectives which have been historically ignored in the codes of ethics. By addressing the individualistic-collective dichotomy, hermeneutic-dialogical approaches provide renewed insights into ethical issues. They facilitate a richer and responsive conceptualisation of moral issues. Thus, in elucidating the cultural issues involved when people from collectivist cultures make moral decisions, we enhance a better understanding of ethical issues. The question then becomes, how can these approaches be made sense of from a research point of view? The narrative approach is arguably better suited for studying contextualised phenomena and hence, it is discussed next.

2.8.1 *Narrative as a Hermeneutic-dialogical Approach*

The narrative approach is appropriate to the study of human lived experiences. When people are asked about moral dilemmas they have faced in their lives, they tend to construct narratives (Tappan, 1997). Narratives are stories which aim to present oral versions of personal experience (ibid.). Narratives are dialogical in nature because in the telling of the story we anticipate the responses of real or imaginary audiences (Day, 1991). They are best suited for investigating contextualised phenomena because they reveal much more than hypothetical dilemmas (Gilligan, 1982). The concept of the narrative is reviewed by Freeman (1997), whose main rationale for adopting narrative approaches is that they can explore the social, cultural, and temporal dimensions of human experience. He argued that mainstream psychology has placed emphasis on objectifiable, observable, and quantifiable phenomena while relatively neglecting human lives. As such, narratives are constitutive of culture as much as they emanate from it (MacIntyre, 1981; Ricouer, 1980). Sarbin (1986) sees the narrative as the organizing principle of human action. One primary function of a narrative in culture is to imbue a particular sequence of events with moral meaning (Tappan, 1991) such that to narrativize entails to moralise. Narratives in a culture provide common episodic structures that not only guide and direct how individuals interpret and make sense of actions and experiences over time but also shape and organise those experiences and actions.

The fact that narratives are culturally and historically embedded does not necessarily mean that there is only one narrative for each culture to narrate. Rather, culture provides a multiplicity of narratives within which are situated individual narratives (Mkhize, 1999). Societies have particular narratives or cultural tales which are passed down from generation to generation that guide and regulate human behaviour, feeling and thought (Bruner, 1990). However, narratives also change at the encounter with other perspectives. They are therefore subject to changes and re-negotiation over time (Gergen & Gergen, 1988).

The hermeneutic-dialogical approach to morality and hence ethics entails that we listen to people's narratives and interpret them. This aspect of listening should be "both in terms of what

they *(people)* know and understand of themselves and their context and what they may not necessarily know, but can be brought into play by the researcher" (Collin & Young, 1992, p. 9). Ethical decision making is a social enterprise and as such it could be explored hermeneutically through narratives. The perspectives which inform resolutions in situations which require moral reasoning can be captured through the narratives that people tell.

2.9 Concluding Comments

The review of the research context presented in this chapter suggests a need for moral and hence ethical issues to be placed within their socio-cultural context, particularly when applied to collectivist societies. This poses a challenge to institutions such as South African hospitals which, despite the recent democratisation process, are still characterized by a hegemony of Western ethics. These espouse an autonomous, disconnected view of the self that does not reflect the understanding of self of the majority of the population.

This chapter has shown that there are many understandings of the moral and hence ethics and as such moral decision-making is likely to be influenced by these understandings. A historical review of ethics in the health arena highlighted an individualistic orientation of morality based on abstract principles which are not universality shared. In addressing this issue, the study argued for a move towards indigenous approaches to ethics, particularly when applied to collectivist societies. Hermeneutic and dialogical approaches facilitate the incorporation of indigenous approaches because they emphasise the need to critically engage with various perspectives. These approaches were also recommended because they can potentially bridge the dichotomy between individualistic and collectivistic perspectives. The narrative approach provides an appropriate methodological framework for the study of moral and ethical issues because it allows for the exploration of cultural issues embedded in moral and ethical reasoning. The purpose of the current study is to explore cultural notions of morality and personhood and the implications thereof for the practice of ethics in the nursing profession.

Emanating from the theoretical context above, the study sought to address the following questions:

2.10 Research Questions

- What are the moral and ethical dilemmas faced by nurses in their work environment?
- What do nurses understand by 'moral and ethical dilemmas'?
- How do nurses' understanding of 'the moral' impact on their ethical decision-making?
- What is the relationship between the notion of personhood and moral / ethical reasoning amongst nurses?
- What is the role of institutions and belief systems such as family, community, and religion in the resolution of moral and ethical dilemmas?
- What is the influence of perceptions of power in moral and ethical reasoning?

The following section describes the methodology used in this study.

CHAPTER 3

METHODOLOGY

This chapter presents the methodology used in the study. It begins with a description of participants, their setting and the sampling method adopted. Because participants in this study were nested in one setting (i.e. nurses within one hospital), these are discussed simultaneously. This section is followed by an illustration of how the interview schedule was used to gather data. Threats to reliability and validity are discussed. The chapter concludes by addressing ethical issues in the study.

3.1 Setting and Participants

Participants for this study were drawn from a clinic in a medium-sized city in the Natal Midlands region. This site was an ideal choice because the researcher had already established a relationship of considerable mutual respect with the nursing staff. I[11] was a part-time staff member at the clinic, at the time. The selection of a familiar environment for a study has an added advantage in that one tends to be familiar with the bureaucracies of that environment, thereby saving a lot of time in the planning phase of the study. However, being part of a system may have disadvantages such as power dimensions. Attempts were made to minimize these with participants. This issue will be discussed later. The clinic selected for the study is at the heart of a local township and is community-oriented. It is a busy clinic serving hundreds of people, who come in the early hours of the morning and line-up in queues to ensure that they have a chance of being seen. The clinic is divided into the following departments, also found in larger hospitals: Antenatal Clinic, Family Planning, Maternity, Immunisation Clinic, Psychiatric Clinic, Pharmacy, Psychology Clinic, X-ray and Administration. The first five departments are nurse-working units and the remaining are serviced by their relevant personnel, such as a pharmacist in the Pharmacy unit. The clinic is open

[11] The use of a personal pronoun is not a oversight; rather it reflects an awareness that as a researcher I could not be independent of the field I was studying.

seven days a week and 50 nursing staff of different categories are employed amongst other health personnel. The clinic virtually operates like a mini-hospital.

Following negotiations with the matron-in-charge at the clinic, twenty (20) Zulu-speaking nursing staff were selected for in-depth interviews. Apart from the differences in ranks, the participants differed in age and working experience. Their ages varied between 32 and 45 years and their working experience ranged from eight to 20 years. Four nurses were selected from each of the five nurse working departments. After the matron had issued the author with a list of all departments and names of staff members, nurse working departments were approached and details of the study explained to them. Nurses who were keen to participate in the study were chosen on the basis of rank, age and nursing experience. Given the results of the pilot study, the aim was to have a sample made up of professional and enrolled nurses with differences in age and experience. Sampling was *purposive* and *theory-driven* (Maxwell,1998; Miles & Huberman, 1994). In qualitative studies, the purposes of the research are central in sampling (Maxwell, 1998). Sampling was driven by questions such as: What am I trying to understand? In this study, the need was to understand in particular the indigenous perspectives informing nurses' understanding and resolutions of moral and ethical dilemmas. The study was also driven by the need to explore how the nursing staff made sense of the moral and ethical dilemmas they encountered within their profession, and how these influenced their behaviour. Sampling was also theory-driven in that, it was informed by the need to understand power dimensions in ethical decision-making as well as conceptions of particular notions of personhood.

Nine enrolled (staff) nurses and eleven professional nurses were interviewed. The two nursing categories differ in terms of training and responsibilities. An enrolled / staff nurse has had eight months of training and adorns white epaulets. The scope of work in this category includes taking blood pressure, dressing wounds and other administrative work. A professional nurse on the other hand, has had two years of training (in addition to the basic eight months) and is identifiable by the maroon epaulets. The scope of work in this category includes the administration of injections and blood transfusions, midwifery and other advanced procedures.

After qualifying as a professional nurse, one can go on and specialize in any area of interest such as psychiatry, midwifery, and family planning.

3.2 The Interview Schedule

Data was collected using an in-depth semi-structured interview schedule (see Appendix A). The creation of the interview schedule was guided by the *voice-centred-relational method* developed by Brown and Gilligan (1991) and adapted by Mautner and Doucet (1998). This method is said to be voice-centred and relational because it explores participants' narratives in terms of their relationships with other people (the relational component). It also takes into account the socio-cultural influences in which participants find themselves. The method is regarded as voice-centred because it focuses on the speaking subject (i.e. how individuals speak about themselves). Furthermore, it takes cognisance of the fact that how we speak about ourselves is a reflection of the perspectives held by our social and cultural groups. This process whereby collective voices are articulated in the self is called *ventriloquation* (Bakhtin, 1981). The interview schedule consists of open-ended questions that probe nurses around various issues concerning moral and ethical decisions in their work. Participants are invited to narrate a story in which they were faced with a moral and ethical dilemma in their work situation. This is followed by probes such as: "When you were in the situation that you mentioned, what kinds of things did you consider in thinking about what to do?", "Bearing in mind the decision you took, how did it impact on you as a person?", and "What was at stake for you in this dilemma?" (See Appendix A, for the rest of the interview schedule). Participants were also probed to explore the broader social, structural, and cultural influences on their narrative (Mautner & Doucet, 1998). These are influences such as family, community, religion, and other belief systems. Power, status, and gender dimensions that emerged in the narratives were also explored.

3.3 Justification for the Interview Schedule

Interviews were used for data collection because like other qualitative research methods, they yield data rich in detail (Maxwell, 1998). Furthermore, they were well-suited for the study of people's real lived experiences, a primary concern of the study. Qualitative research aims to

understand the world from participants' point of view and finding the meaning that participants give to their experiences (Maxwell, 1998; Patton, 1987, 1990). Emphasis is not on events per se, but the meanings that people attribute to them (Babbie, 1992). Interviews make it possible to probe for deeper meanings. To this end, the interview method was appropriate in that it enabled the researcher to explore people's beliefs, values and assumptions behind their actions (Mishler, 1986). In addition participants in this study were more likely to identify with the narrative approach given the centrality of the oral tradition in African cultures (Stead & Watson, 1998).

3.4 Piloting

A pilot study was conducted to test the feasibility of the interview schedule in this population (Bless & Achola, 1990; Bless & Higson-Smith, 1995). The researcher was interested in finding out whether or not the questions in the interview guide could be moderated. Furthermore, the pilot study was conducted to also gain some insight into the spectrum of responses that could be anticipated from the study. It was anticipated that the pilot study would serve as a platform for assessing whether or not other pertinent issues had been overlooked.

Pilot interviews were conducted on three professional nurses and two enrolled nurses from a local hospital. These interviews were conducted mainly in Zulu with English being used occasionally. Alternating between both languages for interviews was considered as appropriate as most learned African people seem to do so. This phenomenon is known as code-switching (Alyson, 1995; Kunene, 1994). Following the pilot study, question 12 was added to the Interview Schedule which initially had 11 questions. Question 12 is as follows, "Considering what you were taught to do in your training when faced with moral dilemmas and what you actually do in practical situations, is it the same or are there any differences?". This question sought to compare the nurses' theoretical understanding of ethical and moral issues with their practical applications in the nursing situation. This allowed for a comparison to be made between nurses' practical applications of ethics and what their training had taught them to do.

Piloting interviews proved useful in that it familiarized me with the voice-relational method. Initially, I tended to use a lot of leading questions which was corrected through structured supervision. Furthermore, piloting enabled me to have confidence in the method as my expertise was enriched with each pilot interview undertaken. By the end of the fourth interview, I felt ready to tackle the main study.

3.5 Procedure for the Main Study

After all the necessary arrangements had been made with the matron, the sister(s)-in-charge of the relevant departments were consulted and appointments were set with the participating nursing staff. Although there was an option of using the Clinical Psychologist's office as a venue for interviews, I opted to interview participants in their own departments. This was an attempt to separate boundaries between being a therapist-in-training and an interviewer. This strategy was welcomed by participants as it shifted power differentials between myself and the participants. However, much to my prior precautions, perhaps as a consequence of the sensitive nature of the study, some participants felt emotional at having to re-live painful issues in their lives, through interviewing. For these, support was given and appropriate referrals were made, where it was deemed necessary. Interviews were tape recorded (with the participant's consent) using an unobtrusive, microscopic, voice-sensitive tape-recorder. Each interview took approximately 30-45 minutes. All interviews were later transcribed, a procedure that lasted 8 hours on average, per interview.

3.6 Design and Analysis

The following section outlines the design and analysis of the study.

3.6.1 *The Design of the Study*

According to Maxwell (1998), research design can be conceptualised as the coherence between the study's purposes, the conceptual context, the research questions, methods and validity or reliability issues. The purpose pertains to the goals of the study, the rationale behind doing the study. The conceptual context (also known as research context) refers to the systems, theories

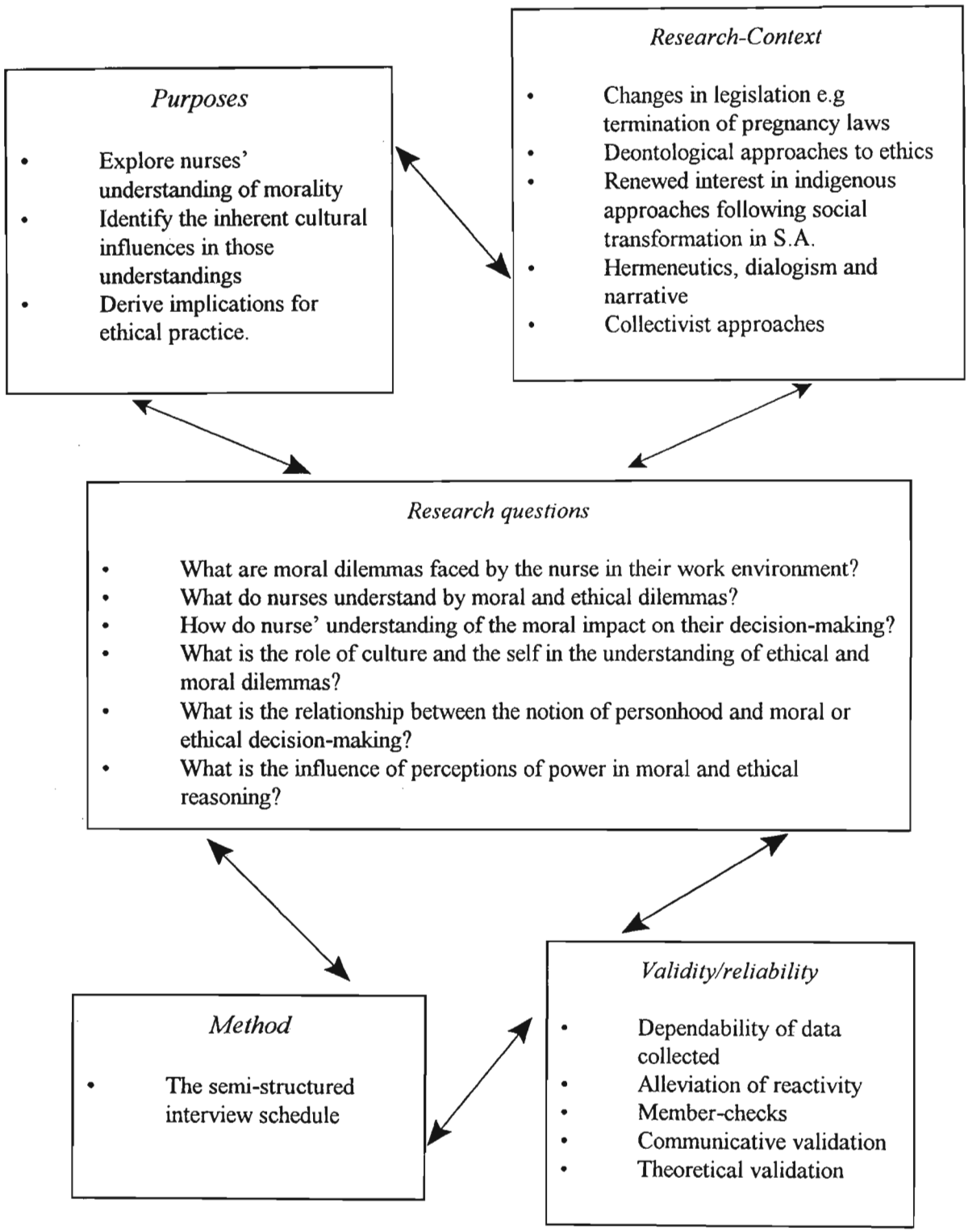
and assumptions that support and inform the study. The research context is a tentative construction of what the researcher thinks is happening in the study. This is composed of existing theory and research, experiential knowledge, pilot and exploratory research. This aspect allows the researcher to draw on all forms of experience in enriching the study. Research questions refer to what the researcher wants to understand by doing the study. Methods relate to what the researcher will actually do in conducting the study, the techniques that the researcher will adopt. Validity and reliability issues refer to threats that might compromise the integrity of the research. The research design which guided this study is illustrated graphically in Figure 1 below.

The bi-directional lines between the components of Figure 1, reflect the relationships among these. These relationships are two-way, rather than linear. The design shows that the research questions are linked to the purposes of the study, which are informed by appropriate theoretical models. Additionally, the methods used are intended to answer research questions while enhancing the dependability and validity of the data collected. Issues of dependability and validity are addressed in more detail in section 3.7

3.6.2 *Analysis*

An effort was made to commence with data analysis immediately upon completion of each interview. This is crucial because data analysis in qualitative studies is an ongoing process that takes place throughout and often beyond the research project (Mauthner & Doucet, 1998). Memos or field journals were written after each interview. The use of memos gains support in the assertion that even tape recorders cannot capture all the relevant aspects of social processes (Babbie, 1992; Taylor & Bogdan, 1998). Memos captured how I experienced each interview situation and how I reacted to it. They were thus crucial as they facilitated my thoughts about the relationships in the data and allowed for these thoughts to be retrieved during the main phase of data analysis.

Figure 1: Conceptualisation of the study



The interviews were then transcribed, each taking about as many as 8 single-spaced pages. Although it is ideal that transcription should begin at the end of each interview (Mauthner & Doucet, 1998), this was not often achieved because sometimes as many as three interviews were conducted per day. Analysis followed the reading method recommended by Gilligan (1982) and Mautner & Doucet (1998). This method recommends that each narrative be listened to and read several times, each reading tapping a particular dimension of the participant's lived experience. Each participant's narrative was read at least four times with different coloured pens being used to highlight the issues arising from each reading. In the first reading (Reading 1), I paid consideration to the unfolding of the story within the nursing situation as experienced by the participant. In particular, I concentrated on such things as metaphors, contradictions, inconsistencies as well as changes in the participant's narrative position. The focus on Reading 1, was thus on the story as experienced by the nurse, and my main role was to try to perceive the ethical or moral narrative through the eyes of the nurse. For example, paying attention to the recurrent metaphors in each nurse's narrative, enabled me to get a sense of his or her feeling states at the time when the event alluded to happened. Additionally, the first reading required the reflection on the implications of being in a powerful position of interpreting the narrative of the other.

In the second reading (Reading 2), I attended to the way participants spoke of themselves, that is, their sense of self (e.g. the individualistic sense of self, collectivist etc). The focus here was on reading for the voice of "I", the speaking subject in relation to "we" (significant others in the participant's life), the tensions between the two and how they are negotiated. For example, by exploring instances wherein shifts in each participant's sense of self occurred, I was able to identify the perspective which informed thought processes at the time. It is in this phase in particular, that I wanted to identify "who" was speaking in the narrative. This enabled me to become connected emotionally and intellectually with the participant, thus signifying an opening of self to the other.

In the third reading (Reading 3), I attended to how nurses spoke about the self-in-relationships. The focus here was on how nurses experienced themselves and their ethical dilemmas in relation to others (real/imagined, deceased/alive). Consideration was also paid to narrators' thoughts, feelings or emotions in relation to the significant others present in their narratives. For example, how did participants think or feel about these significant others.

The fourth reading (Reading 4), identified the cultural and social structures that had a bearing on participants' their ethical dilemmas. Particularly influences of dimensions such as nursing rank, family, religion, and other belief systems were identified. Emphasis was also on how these socio-cultural influences impacted on the understanding and resolution of the ethical and moral dilemmas they encountered.

These four readings do not follow a sequential format but feed into each other and the use of a different coloured pens was a means of simplifying this process (Brown & Gilligan, 1991). Furthermore, I entered into a relationship with the stories as told by each nurse by constantly reflecting on my cultural and historical background during the reading process. This entailed *inter alia* an attempt to relate my whole training as a psychologist to the values and assumptions that were emerging from the reading of the participants' stories.

In line with Mkhize's (1999) recommendation, matrix displays (see Appendix C) were created for each analysed interview. This was done as a way of simplifying the analysis further. Matrix displays were achieved by using an A4 paper in a landscape format, dividing it into six columns, the first column illustrating the identifying characteristics of the participant, columns two to five identifying the four readings and the sixth column being a summary of major themes. It is worth highlighting again that, this method is by no means sequential, the matrices only facilitate the identification of the relationships between the four readings, giving the overall picture.

3.7 Reliability and Validity Issues

Positivist, psychometric approaches to reliability and validity are notably inapplicable to qualitative research. Attempts to illustrate concepts of reliability and validity from a qualitative point of view are best demonstrated by Maxwell (1992), Mishler (1990) and others. They argue that from a qualitative point of view, reliability and validity do not depend on the existence of an absolute external truth against which an account can be compared (as is the case in quantitative studies). They recognise that interpretation is not devoid of the social context. As such the "interpretive communities" on which the researcher is a member play a crucial role in the creation and the validation of knowledge. The concept of "interpretive communities" refers to people's membership in certain cultural *(or institutional)* groups (Fish, 1980 cited in Tappan & Brown, 1992). To this end, our "interpretive communities" (e.g. our training as social researchers) condition the way we view the world, including the approaches we use in interpretation (e.g. a researcher from a collective background may adopt indigenous approaches in his/her analysis, depending on his/her philosophical tendencies). This approach relies on the identification of threats to reliability and validity as judged by the community of researchers in the field, as well as the development of ways to counteract those threats. The ideas of the above authors, and the recommendations of Miles and Huberman (1994) informed the reliability and validity considerations in this study. An attempt was made throughout the research to deal with validity and reliability threats. Threats that were anticipated in the study are listed below, together with indications of how they were addressed.

3.7.1 *Reliability/Dependability*

Miles and Huberman (1994) conceptualise reliability as the dependability of the methodology used in the research. Accordingly, reliability examines whether or not the research process was applied consistently in the cases observed. Interviews were transcribed as soon as possible to achieve dependability of the data collected. This also assisted the researcher to complement the interviews with her impressions whilst these were still fresh in memory. Memos were used to write my impressions of the interviews and issues that needed further elaborations. Furthermore, to enhance the dependability of findings and a high level of honesty among participants confidentiality and

anonymity were assured. It was also stressed that the study was not meant to evaluate their behaviour but to contextualise ethical practices with a view to improving them. The study mainly used an open-ended approach in an attempt to reduce reactivity effects, often cited as a problem in qualitative studies (Maxwell, 1998). This refers to the researcher's influence on the participants which makes them to behave in an atypical manner (Bless & Achola, 1990). Elimination of the effect of the researcher is impossible and thus the goal in qualitative research is to understand how it happens and how this affects the inferences made. Furthermore, the method sees the research as a process of co-creation of meaning, in which the researcher is by no means neutral. Since all the interviews were tape-recorded and transcribed, allowing for the physical traces of the participant's narrative, chances of distortion were minimised and in turn, dependability enhanced.

3.7.2 *Validity*

Three types of validity were considered for this study, namely: internal, interpretive and external/theoretical validity. Although these terms are appropriated from quantitative research, it is worth highlighting that they are conceptualised differently in qualitative research. The following sections briefly illustrate these types of validity as they pertain to this study.

3.7.2.1 Internal Validity

Internal validity refers to the credibility of the study, whether its findings make sense to readers and the people being studied, whose meaning is in question (Miles & Huberman, 1994). To assure internal validity, member-validations *(also known as member-checks)* were carried out. These refer to a process whereby findings are taken back to some original participants for feedback. It is a systemic process whereby the researcher requests feedback from the participants about some aspects of the study. Conclusions reached in the study were disclosed to some of the participants and feedback solicited. Member validations were conducted with ten participants. These were done to explore whether or not understandings of morality and ethical decision-making made sense to participants.

3.7.2.2 Interpretive Validity

Interpretive validity attempts to understand the conceptual categories used by participants to explain their world (Maxwell, 1992). Interpretive accounts are based on the language of people studied and are centred on their own words and concepts. Interviewers are likely to misunderstand participants' language since they do not have the opportunity to study it in its common usage (Bless & Achola, 1990). For example, in those instances in which participants used concepts the meaning of which was not immediately obvious to the researcher, the latter would rephrase these concepts in English and check whether that was consistent with the meaning. In addition, participants were asked to give specific examples to elucidate the meanings of the concepts they used. This is consistent with the notion of communicative validation (Kvale, 1987; 1995), which involves a verification of interpretation by means of a dialogue between the researcher and the participants.

3.7.2.3 External or Theoretical Validity

Traditionally, external validity is concerned with the questions of whether or not the findings of a study are transferrable or generalizable to other contexts (Maxwell, 1992). Where quantitative researchers speak about generalizability, qualitative researchers allude to transferability instead (Maxwell, 1998). Generalisation from sample to population is not the priority in qualitative research. Rather, the purpose of generalisation (or transferability) is theory-embedded (Maxwell, 1992; 1998; Miles & Huberman, 1994). It entails the development of a theory "that not only makes sense of the particular persons or situations studied, but also shows how the same process, in different situations, can lead to different results" (Maxwell, 1992, p. 293). Theoretical validation this study was achieved by reading for consistency between the findings and the theoretical frameworks that had been adopted, such as individualism, collectivism and hermeneutics. Conclusions reached could be largely accounted for on the basis of these theoretical positions.

Throughout the research process, supervision was sought and comments received served as strategies to deal with validity threats amongst other things. Soliciting feedback from other

people who were perceived as having expertise in the area such as nursing tutors, was also an invaluable tool in dealing with unreliable and invalid results. Maxwell (1998) argued that requesting feedback from others is a remarkably useful strategy of identifying validity threats and researcher bias. Ways of solving validity threats in qualitative research rely mainly on verification of accounts from the community under study (Maxwell,1992).

3.8 Ethical Issues

The researcher and the participants shared the same racial and linguistic backgrounds. To this end, each interview was approached with open-mindedness, taking cognisance of the possible within-group differences in the sample. Supervision was also sought before undertaking the study during which anticipated ethical concerns such as power differences between the researcher and participants were discussed. It was stressed that the researcher needed to keep in mind that her role in the institution where the study was conducted, was that of a researcher and not a therapist. This distinction was crucial because a month before the study was undertaken, the researcher had been a therapist-in-training in that setting. As such, her ranking had been higher than that of her participants. An ethical relationship with participants requires an awareness and sensitivity to power issues (Stark, 1998). In an attempt to diffuse power differentials and enhance voluntary participation, the role of the researcher was communicated (orally and in writing) to all participants. Anonymity and confidentiality were also assured to all participants. Although, permission for interviews was sought from the matron-in-charge, she was not involved in the actual selection of participants.

Informed consent was first negotiated verbally with the participants. Once both the researcher and participants were satisfied that each understood their respective roles in the process, a written consent form was completed with each participant (see Appendix C). However, although informed consent had been obtained, participants were made aware that they had a right to withdraw at any point whenever they felt uncomfortable.

The participants were also informed that the results of the study would be made available

to the institution in a limited summary form. In the interest of anonymity and confidentiality, it was agreed that all identifying characteristics be concealed wherever possible, including the name of the institution where the study was conducted. Furthermore, it was agreed that the summarized version of the study be put on the institution's notice-board. The notice-board is in a communal area and is frequented by all nurse for various purposes. This was regarded as better than placing the results in the institution's library which is closer to the matron's office.

3.9 Summary

The purpose of this study was to explore cultural issues inherent in nursing ethics. In particular, the emphasis was on how nurses from collective backgrounds negotiate the dichotomy between individualistic nursing ethics espoused in their code and culturally situated understandings of morality. This chapter discussed the methodology adopted in the study. Characteristics of the research setting and participants were presented. Approaches and techniques used in the collection and analysis of data were illustrated. Finally, validity, reliability and ethical issues were addressed. The results of the study are addressed in the following chapter.

CHAPTER FOUR

RESULTS

This chapter presents the results of the study. Interview extracts are presented to illustrate the main themes that emerged. Results indicate that nurses regarded morality as interpersonal sensitivity as well as adherence to principled ethics. The notion of morality is as a practical engagement with all perspectives open to oneself. These conceptualisations of the moral were marked by inconsistencies and influenced by different views of the world. Although interviews were conducted in participants' mother tongue (Zulu), they are presented here in English. However, in cases where it proved difficult to find the exact translations, closely matching versions are presented with Zulu quotes in parentheses. This was done to preserve some of the original richness of the data.

The results are organised as: i) nurses' conceptions of morality that influence their ethical decision-making; ii) ethical conduct as a balance between principles and specific circumstances of the patient; iii) simultaneous existence of various perspectives of morality; iv) world-views and morality; v) the role of the "Other" or "internal audiences" in moral decision-making; vi) influences informing reasoning about ethical issues; and vii) power issues in ethics.

4.1 Conceptions of Morality

Five conceptions of morality emerged in the study. To begin with a large proportion of nurses perceived morality as the ability to show empathy towards patients. This was linked to attending to patients with respect and to show consideration to their needs. Equally affirmed in conceptions of morality was an understanding of morality as the quality of thoughtfulness, i.e. to think for the other. Equally emphasised was the notion of morality as dedication and commitment to service and morality as principled action. On the other hand, some nurses conceptualised ethical conduct as a balance between universal principles and caring. These themes are illustrated below, with

extracts from the interviews. Concepts that have a direct bearing on moral and ethical reasons appear underlined in the extracts.

4.1.1 *Morality as Empathy, Consideration or Respect for Another*

As indicated, a large number of nurses conceived of morality as empathy, consideration or respect for patients. In this context, empathy means the ability to feel for another, signifying a sense of connectedness with others. A Zulu word often used to refer to this is *"ukuzwelana."*, which means feeling the suffering that someone else feels. This signifies the notion of drawing-in of another person in an effort to fully engage with him /her. Such a conceptualisation of the moral is in line with Gilligan's (1977; 1982) ethic of care which advocates that moral decisions are not only made on the basis of justice, but also take into account the pain they may cause for others. This theme is illustrated in the following extracts:

Interviewer : What does morality mean for you?

Interviewee 18 : For me, to be moral means a person who feels for another person, because if you are moral you are able to see that something is wrong . A moral nurse asks herself that if this was done to me, how will that make me feel?

Interviewee 11 : A moral nurse listens to you and answers you in a way that will make you to be mutually satisfied. A moral nurse tries to put himself/herself in someone else's shoes and then does something that he/she would like to be done to him/her... I always try to put myself in another person's shoes and then do what I would like to be done to me.

Interviewee 15 : Morality means not doing something that would hurt someone. A moral nurse even if she thinks of doing something wrong, pauses and asks herself, is this right what I am doing to this patient?

Interviewee 20 : It's about someone who thinks about other people's feelings *"ukucabangelana"*

Interviewer : Considering the way you resolved the situation, what does it say about you as a person?

Interviewee 14 : You know, when a person grows up, especially from rural areas there is this concept of love for one another "ukuzwana", and caring for another person "ukunakekelana" and respect because if a person comes to your home, you greet them, make them tea, even if it is your neighbour, you do not say that "oh he comes nearby, he must have had tea at his house", you make him tea, you give what you have....

The common thread that runs through the preceding extracts *(interviews 18; 11; 15; 7; 20; 14)* is the regard for others and the belief that being a moral nurse entails refraining from hurting patients at all costs. Furthermore, "feelings" are very central in these extracts. This is in contrast to Kohlberg's (1981) theorising, who maintained that feelings are at the periphery of moral thought. This affirmation of feelings within moral judgement was identified by Gilligan (1982) as being significantly different from traditional models of moral resolution. Consideration for other people was also cited by many nurses as being at the heart of what it means to be moral in a nursing situation. It was also linked to thoughtfulness and care towards ones patients. Similar to Gilligan's (1982) ethic of care, nurses are portrayed as having a responsibility and an obligation to nurture their patients. This theme is echoed by each of the nurses in the above extracts as the most specific component in their responses to a most general question.

The conception of morality as respect is well illustrated in the next extract which is about a professional nurse who confronted her colleague about her negligence towards a seriously ill TB patient. During the end of her shift, the narrator had given instructions that the patient be given three units of blood transfusion within 12 hours. Each unit was to take approximately four hours to finish. The narrator's colleague only gave the patient two units of blood and tried to administer the third unit within 30 minutes!

The extract begins when the narrator had already initiated contact with her colleague:

Interviewee 14 : I said, "why did you do such a thing" and she said that she did everything as I had instructed her to do. I asked her what would have happened if the client died. Would we

have had to lie and say the client died of pulmonary TB? I said to her: "why did you really do this?" and then said "let us try to do the right thing because this person is one of us *(meant that the patient is a Black person)*" I asked her how would she feel if this was done to her own father, because this patient was almost the age of our fathers. People should not be treated like this, old people should be respected....

Interviewer : What was the conflict for you in this situation?

Interviewee 14 : I did not know whether I should confront this nurse or just leave the matter, because luckily the client did not show any complications. Also, I did not know how my colleague was going to react to me afterwards, it was a tricky situation, really....

The preceding extract *(interview 14)* shows that respect for other people is crucial for the narrator. This seems to emanate from her cultural upbringing which emphasizes respect especially for elders. She comes from a cultural tradition emphasizing respect, especially for elders. This sense of respect seems to be deeply entrenched within her, hence, the terminology she uses when referring to the patient. She calls him a 'client' and likens him with her own father. The extract also highlights the extent to which the narrator is influenced by historical and political issues. For example, the fact that the patient is Black made it even more compelling for her to treat him with respect. Especially, the way that black people have been treated in this country. This is based on my own understanding of how blackness is used in this context. For the narrator, the fact that a fellow black nurse was negligent towards a fellow black patient, sparked feelings of anger. She viewed her colleague's behaviour as an abandonment of responsibility for caring for and respecting another person. Consequently, she perceived this as something that demanded to be challenged. Although she indicates the importance of respecting a fellow black person, she gives a connotation that all people should be respected for who they are. Thus, "people should not be treated like this", she says. The understanding of the narrator's doing of good, is linked to her communal understanding of the way of life. In collectivist societies age is considered as crucial for respect, hence, she says: "old people should be respected."

4.1.2 *Morality as Dedication and Commitment to Service*

Some nurses believed that being moral is akin to being accountability and commitment to patients. This was seen as being central for the accomplishment of beneficence (not to do harm to one's patients). This theme is illustrated in the following extracts:

Interviewee : If you were asked to define a moral nurse, how would you define him/her?

Interviewee 3 : It means showing dedication (*"ukuzinikela")* to your patients and other people...as it is said in the nurse's pledge.

Interviewee 1 : It's all about being committed to caring for your patients... A nurse should always be a patient's advocate.

Both these extracts *(interviews 3; 1)* highlight that for some nurses meeting their obligations means being dedicated and committed to service. Such dedication seems to emanate from the nurses' adherence to the principled approach to ethics as espoused by the Nursing Code. Hence, for them commitment entails advocacy and acknowledgment of the "nurses' pledge."

4.1.3 *Morality as "Thoughtfulness"*

Morality was also envisioned as being the "quality of the mind" by some nurses. To this end, a moral person was seen as someone who does not act without thinking deeply about the situation, taking into account the various possibilities open to oneself. In Zulu, such a person is then said to be *"unomqondo"*, meaning that they apply their mind critically in pursuit of the good. Some nurses defined the "quality of the mind" as the ability not only to think deeply about the situation but also as a competence to think for others, to have others' best interests at heart *(ukucabangela)*. The way the word *"-cabangela"* is used in Zulu also implies an emotional or feeling component, i.e. thinking for or on behalf of the other. This conception of morality is evidenced in the following extracts as underlined text:

Interviewee 1 : To be moral means you have to think deeply, you have to think seriously, it's not easy.

Interviewee 12 : A moral nurse does not act haphazardly, she really thinks before doing something.

Interviewee 16 : Very few nurses are moral, it's difficult, you have to sit down and really think, although most of us would like to be, there is just no time, there is a lot of work to be done. Sometimes, it's only when I get home when I realise that I should have done something in a different way.

The above extracts *(interviews 1; 12; 16)* highlight the complexity of morality, especially the intertwined nature of reason and feeling in moral decision-making. However, traditional approaches to morality and ethics tend to see reason and emotion as independent entities, thereby ignoring the complex relationship between the two.

4.1.4 *Morality as a Consultation Process*

Some nurses perceived the essence of morality as being in the consultative process. In this instance, nurses with little experience are expected to confer with colleagues who have more nursing experience as a means to ensure that their decisions are morally acceptable. Nurses with more nursing experience are viewed as repositories of ethical wisdom. The underlined text in the following extracts illustrate this conception of morality:

Interviewee 9 : For me, to be really, really, moral means always checking out with people with more experience than myself, in such matters.

Interviewee 13 : It's like for instance, a nurse who is prepared to discuss difficult issues with other nurses who have more experience than she has in such matters. It's like, she has guts to consult with other nurses.

In the above extracts *(interviews 9; 13)*, nurses with more nursing experience are consulted to the morality or ethicality of conduct. In this instance, the wisdom reflected through

knowledge accumulated over the years in the nursing profession is perceived as fundamental to ethicality. This understanding of morality reflects the significance of acknowledging one's relative position within the hospital hierarchy. This is linked to the influence of power issues in morality, a theme which I will discuss later.

4.1.5 *Morality as Principled Action*

Morality was also understood as behaving in a principled way. This means behaving according to established rules, principles and procedures. In this instance, the Nursing Code was seen as pivotal in mandating the ethicality of behaviour. These themes are echoed repeatedly by nurses as underlined in the following extracts:

Interviewee 14 : A moral nurse always checks if what she is doing agrees with the rules of nursing.

Interviewee 19 : It (being moral) is knowing when you are doing good and when you are doing wrong.... it means following the rules.

Interviewee 6 : It (to be moral) is doing something that is right, the patient must come first in everything that you do.

What emerges from these extracts *(interviews 14; 19; 6)* is the understanding of the Nursing Code as the foundation for ethical practice. For these nurses, the emphasis is on knowledge of the ethical rules or principles that are thought to guide the nurses' behaviour. The implication in this understanding of morality is that knowledge of moral principles is commensurate to behaving ethically. However, as you will be shown in the discussion section, the application of moral and ethical principles does not translate to ethical conduct.

4.2 *Ethical Conduct as a Balance Between Principles and Specific Circumstances of Each Patient*

For some nurses acting morally and ethically meant adopting principles of the Nursing Code in the way that does not compromise the needs of the patient. For them, the Nursing Code on its own was seen as insufficient in guiding one to be ethical. In addition, patients' needs were perceived as integral in determining whether or not ethicality had been achieved. This conceptualisation of ethical conduct is presented in the following extracts:

Interviewee 9 : It *(ethical conduct)* means being able to do what you have to do, what the rules tell you to do while at the same time being able to see how the person feels about what you are doing. Also, checking to see if the patient is comfortable with your decision and if s/he is not comfortable being able to find out what you as a nurse can do to make him or her comfortable.

Interviewee 17 : It *(being ethical)* is the ability to do what you were taught in your training and looking within yourself, how what you are planning to do makes you feel. It depends on the situation, it also means being flexible.

Interviewee 9 : I consider myself a moral person, I am able to look at the rules which I'm supposed to follow and then think if these really satisfy the patient, I do not just follow rules.

What is echoed by each of the nurses in the preceding extracts *(interviews 9; 17)* is that the practical application of principles in each and every instance requires sensitivity to the context and the individual needs of the patient. These nurses maintained that being ethical demands striking a balance between the code of ethics and patients' needs. They advocated that being a moral nurse necessitates engaging in dialogue with the Nursing Code by weighing it against the needs of the patient. Such reflexivity was seen as a means of negotiating the needs of the hospital as an institution and the needs of patients as the recipients of quality care. Principles in and of themselves, do not guarantee ethical action. Rather, a special kind of knowledge is called for from the nurse, namely, how to act ethically in a particular context. Ethical conduct requires flexibility

and reflexivity.

Extracts cited thus far highlight that nurses' conceptions of ethics in their work context are inextricably linked to their understandings of what it means to be a moral person. Although in the preceding section extracts have been presented to illustrate their conceptions of the moral, these conceptualisations are not fixed and unchanging. Participants were sometimes inconsistent, often shifting from one understanding of the moral to another. This phenomenon sometimes referred to as narrative positioning (Harre & van Langenhove, 1999), is illustrated in the following section

4.3 Simultaneous Existence of Various Perspectives of Morality

Nurses' understandings of morality shifted a number of times within the narratives. These shifts occurred because participants found themselves being influenced by various perspectives of understanding. In many cases, a participant would start a narrative by making it clear what understanding of the world influences his/her thinking but this conception of the world would often shift to accommodate other understandings of reality open to the person. This is in line with Bakhtin's (1981) assertion that it is possible for an individual to be influenced by various perspectives, although these might be contradictory. Oftentimes, participants were not cognisant of these shifts. These were discerned by the researcher upon the reading of the extracts. An illustration of an instance of the simultaneous existence of various perspectives is useful at this point:

Interviewer : What does morality mean for you?

Interviewee 10 : It means being able to do the right thing. The hospital rules are there for you as a nurse to inform you of what is expected of you.

LATER ON IN THE SAME INTERVIEW

Interviewer : Would you consider yourself a moral nurse?

Interviewee 10 : Of course, I am.

Interviewer : What is it about you that makes you think you are a moral nurse?

Interviewee 10 : When I have done something wrong, I am able to sit down and think of how I can make it right. Usually, I try to put myself in the patient's shoes and think that if it were me in the patient's position, how I would feel about this.

Interviewer : Is there anything else that you consider in doing what you think is the right thing?

Interviewee 10 : I think I am naturally a caring person, I grew up in a home where respect was emphasized as you know, in our tradition we believe that "umuntu ngumuntu ngabantu" (a person is a person because of being connected to other people). I always remember that. Another thing, a nurse is always a patient's advocate.

In the preceding extract *(interview 10)*, the nurse's initial understanding of morality is informed by the principles of the Nursing Code. Initially, one gets a sense that it is only the Code that directs this particular nurse whether or not she is being ethical. Later on in the extract, however, other understandings of the moral are accommodated. In response to whether she considers herself a moral person, this nurse refers to perspectives other than the universal principles that inform the current code. Through the concept of "umuntu ngumuntu ngabantu", the tradition of her upbringing continues to speak within her even in the face of a moral dilemma reminding her of her connectedness with other people. The simultaneous existence of various perspectives within the narrator (i.e. principled ethics and connection to others) shows that ethical conduct is not a simplistic application of either.

4.4 The Role of World-views in Moral Reasoning

For many nurses evaluations of moral dilemmas were sometimes tied to their understanding of reality including their views on theories of illness. This theme is illustrated in the following extract involving a female optholomnic nurse who saw a 50-year old partially blind patient. On examining her, she realised that there were no organic bases for the woman's blindness. Before reaching a decision on what to do, the nurse considered what she was taught in her training and her beliefs about Zulu customs. She then decided not to refer the patient for further assessments as expected, but secretly advised her patient to consult a traditional healer.

The extract begins after the nurse had told her story:

Interviewer : In the situation that you've just mentioned, what was the conflict for you?

Interviewee 5 : The conflict was in not really knowing what I should do, should I refer this woman for further assessments or should I advise her to consult a traditional healer. The conflict was also the fact that we as black people have our beliefs and customs while at the same time, in our training we are taught what to do which is different to our beliefs. But, we at the same time, know that there are customs which we should follow, so the conflict for me was in really not knowing what to do.

Interviewer : What did you eventually do?

Interviewee 5 : I secretly told her to consult a traditional healer whom I knew and she eventually confessed that she had been to a traditional healer before.

Interviewer : How did your decision make you feel emotionally?

Interviewee 5 : It was a very difficult decision for me but I consoled myself that I had done the right thing because I knew that there are things that can't be cured at the hospital. I have worked in rural areas before, people there believe strongly in traditional customs. We also saw many instances where traditional healing was beneficial.

The preceding extract *(interview 5)* illustrates the role of world-views and in particular, the conflict between the traditional and Western theories of illness, in ethical decision-making. The narrator experienced the situation as a dilemma because she was caught between these two world-views. Although much of her behaviour was influenced by her traditional customs and beliefs, she had also been exposed to nursing training which is largely informed by the biomedical model of illness. While she works within the dominant medical model, she also subscribes to traditional conceptions of the person and the world. Her story shows a connection to traditional customs and beliefs of the Nguni. However, inasmuch as she believes in traditional theories of illness and treatment, her conduct should take cognisance of the fact that as a professional nurse she is expected to observe the standards of principled Western ethics. While such approaches to ethics do not accommodate one's personal values in decision-making, her own assumptions about life came into play. Although the current Nursing Code directs nurses to recognise patients' *"appropriate beliefs and traditions"*, the question of what comprises appropriate beliefs and who

defines them, is not acknowledged. As a result, this particular nurse experienced the situation as a dilemma. She resolves this dilemma by "secretly" referring the patient to a traditional healer.

The narrator also experienced the situation as a dilemma because her own values and assumptions about life came into play and influenced her decision. The fact that the narrator held contradictory perspectives resulted in tensions within her psyche: "the conflict was that...as black people we have our beliefs and customs while at the same time in our training we are told what to do, which is different to our beliefs". The conflict in this case arises from the non-recognition of traditional beliefs and customs within the medical establishment.

Although the narrator in the preceding extract *(interview 5)* subscribed to a traditional model of illness, it does not follow that all black people share this word-view. The following extract *(interview 12)* should be read against the background of the preceding one. It illustrates the narrator's positive disposition towards Western principled ethics, and the negative portrayal of traditional healing. The extract comes from an interview with a newly employed female nurse who was in charge of a children's ward. She was confronted by a woman whose child had been hospitalised for a while. The woman wanted to take her child home but the nurse refused because the ward doctor had not given authorisation for the child to be discharged. Although the narrator's colleagues pressured her to discharge the child, the narrator was adamant that she would not do that. Furthermore, the narrator felt that she was going to be in trouble when the doctor realized that she had discharged the child without his permission.

The extract begins after the nurse had related her story:

Interviewer : In the situation that you have just mentioned, what did you eventually decide to do?

Interviewee 12 : This was tricky because if I had decided to discharge the child and then something happened to it, I could have been blamed. So, I forbade the woman from taking the child.

Interviewer : Is there anything else that came to your mind before reaching your decision?

Interviewee 12 : I thought the woman possibly wanted to take the child to traditional healers, her condition could have become worse and the woman would have brought her back to us in a severe

state. I felt that if the woman wanted to take her child to traditional healers she should have done that first before bringing her to us. These people expect to see improvement in a person's condition within two days and then they go home to use traditional herbs and hospital medications and end up not knowing what works and what doesn't.

Interviewer : How did your decision affect your relationship with the child's mother?

Interviewee 12 : She was angry at me and hurt, saying that she is entitled to take her child whenever she wants to. I did feel a bit sorry for her because I am also a parent. But it was also my duty as a nurse to tell the correct thing to do...

Although the narrator's decision was influenced by biomedical ethics, her attitudes towards traditional healing also feature strongly. She comes across as someone who has little faith in alternative forms of healing, hence, her assertion that the child's condition could have deteriorated if she were to be exposed to traditional healers. She maintains that people who use traditional healers have unrealistic expectations: "these people expect to see improvement in a person's condition within two days and then go home to use traditional herbs..." By referring to people who embrace traditional healing as "these people", she sets them apart as a separate group. However, a slight shift in the narrator's narrative position is evidenced, where she responds to the child's mother not only as a professional but a mother as well, "I did feel a bit sorry for her because I am also a parent". This suggests that one's values do come into play when reasoning about moral and ethical issues. Supposedly uncomfortable with this connection between herself and the woman, the narrator quickly retracts and proclaims her position as an expert, "but it was also my duty as a nurse to tell her the correct thing to do." The narrator's behaviour in this instance, is modelled after Western ethics with its quest for objectivity, where one's values are frowned upon.

People's world-views shape the way they view the world and their attitudes towards it. However, the extracts cited in this section also highlighted that the fact that people come from a common background does not mean that they necessarily, share a similar world-view. Furthermore, people's world-views are not fixed across time and space. Rather, they are fluid and

marked by inconsistencies and changes according to context.

4.5 The Role of the "Other" or "Internal Audiences" in Moral Decision-making

For some nurses at the point of making a moral decision, the "other" came to the fore and served as an "internal audience" against whom the morality or ethicality of their decisions were judged. These internal audiences took the form of internalised voices or perspectives from parents, family members, hospital or clinic authorities. In conceptualising ethical dilemmas, voices from these "others" served as a frame of reference against which the ethicality or morality of one's behaviour was evaluated. In many cases these voices had been appropriated as nurses' own. These nurses engaged dialogically with the nursing code rather than regarding it as *"authoritative discourse"*. This dialogue entails considering the codes of ethics in the context of engaging with perspectives of the moral. This theme is illustrated in the extract about a staff nurse who was nursing an elderly diabetic woman who had a huge septic sore on her leg. On numerous occasions the woman had been advised to keep her sore clean. On her follow up visits, she would come back with her sore in a deteriorated condition. She would explain that she found it difficult to clean her sore regularly as she was from a rural area and stayed alone. On one occasion, the staff nurse found it difficult to contain her anger at the woman. When asked what made the situation a dilemma for her, she responded as follows:

Interviewee 18 : On the one hand, I could understand the woman's situation, she really had no one to take care of her. It's not like she did not try to clean herself... On the other hand, I felt like I was fighting a losing battle, because she would always come back, smelling more awful than before... I really lost my cool on one occasion.

Interviewer : What did you do?

Interviewee 18 : When it was about to be her turn to be treated, I went on an extended tea break. When I came back, I was hysterical, I shouted at her and accused her of being negligent. I even considered sending her home without giving her any antiseptic!

Interviewer : Did you ...?

Interviewee 18 : When I saw her crying, <u>I thought of how my mother would react if she heard how I had behaved, I felt bad and began to dress the woman's wound.</u>

Interviewer : Is there anything else that you considered before you reached a decision to attend to the woman?

Interviewee : You see, my mother was well known as she used to be a matron at this clinic. She has high regard for my nursing skills, she really would have been disappointed if she heard....

The above extract *(interview 18)*, illustrates the influence of an internal audience on a person's decision-making process. The staff nurse's doing of the good was inspired by her thoughts about her mother. In contemplating ill-treating her patient, her mother came to the fore as an "internal audience" against which the intended behaviour was evaluated. This "internalized audience," usually consisting of significant others in our lives, is akin to a second party of some sort, always at the background influencing our moral or ethical conduct. In making the decision, the nurse considered her relationship with her own mother, the fact that she has high regard for her nursing skills, rather than relying on the principles of the nursing code alone.

4.6 Influences Informing Reasoning about Ethical Issues

Some nurses cited various social and cultural institutions as influences in their moral or ethical reasoning. Institutions alluded to were family, community, religion and hospital or clinic setting. Family values, particularly how one was brought up, were seen as playing a major role in one's morality. Community values and various religious systems were also conceived as crucial in shaping a way in which one reasoned about ethical issues, as were the circumstances related to the location of the hospital or clinic in which the nurses worked. Each of these is discussed in more detail below.

4.6.1 *The Influence of One's Upbringing, Particularly, One's Family*

For many nurses the values embraced in their families were pivotal in how they conceptualised moral or ethical issues. In this context, the family was defined in broader terms, encompassing not only the nuclear but also the extended and ancestral families as well. The influence of family is evidenced in the following extracts:

Interviewer : In thinking about your decision, is there anything that you considered?

Interviewee 4 : The reason I felt uncomfortable about my decision is the fact that it is the opposite of what my late grandparents had taught me to do. I was taught to have great respect for another person. My grandfather used to say that a person is incomplete without another. For me, that meant I have to respect each and every person as they are a part of me. Therefore, the way I was treating this patient was really contrary to the notion of respect which I was taught at home.

Interviewee 7 : It (being ethical) really depends on what you were taught when growing up, if you were taught to respect traditions and customs when you get older you are likely not to forget that. The things that were instilled in me when I was a child, have a great influence on my life. For example, I was taught about the power of ancestors in protecting people from all evils. Therefore, whenever I sense that bad luck is happening to me too often, I consult a diviner who helps me find out the appropriate rituals that I need to do in order to re-connect with my ancestors.

Interviewee 10 : I grew up trying to do what my parents wanted me to do, it was n't easy. I still find that a lot of the things I do, it's mainly what they taught me. I was taught to have *"ubuntu"* (being humane), for example, things like greeting each person that I pass on the street, addressing every male who is my father's age as "father". There are times however, when I do what I personally believe is right, although this is sometimes in conflict with what my parents taught me.

Interviewee 3 : I thought that if my parents were to hear about what I had done, they would be hurt emotionally, "bangaphatheka kabi emoyeni". I was taught to place the needs of others before mine and whenever I do not do that, I feel guilty. Because of my work load I sometimes find myself behaving selfishly, putting my needs before those of my patients.

The above extracts (*interviews 4; 7; 10; 3)* illustrate that for most participants, values upheld such as respect for others, consideration of others' needs and systemic understandings of reality were a direct influence of family background. This held true even in cases where some

believed to have done things which were conceivably immoral or unethical.

4.6.2 *The Influence of Religion*

For some nurses religious systems were cited as having an influence on morality. For the purposes of the study the term religion is used in a loose sense to refer to any systems of ideas or beliefs such as a Christianity and traditional ancestral beliefs. The significance of religion is illustrated in the following extract about a nurse who referred a patient to a traditional healer.

Interviewee 5 : A woman had been coming to our clinic for a while for her daughter's treatment. Her daughter had severe acne and this started to make me feel bad as I could see no improvement in her. My daughter also once looked like this until I went to a diviner ("isangoma"), who advised me to offer a sacrifice to my ancestors. I spoke to this woman and gave her the contact details of the diviner. She called me sometime later and told me that after she had done the necessary rituals, her daughter was cured. These things do happen...

The preceding extract illustrates that the nurse's understanding of the moral in this instance was informed by her belief in ancestral spirits. In spite of her training, she is ready to acknowledge the deficiencies of Western approaches to medicine and is willing to recommend holistic approaches to treatment. Further influences of religion are evidenced in the following extract involving Christianity.

Interviewer : Is there anything that you consider in reasoning about moral issues?

Interviewee 7 : I always consider my Saviour. It is impossible to be a nurse without believing in God. Our work is difficult, we all need God especially, when we are in difficulties. He is the way. It is impossible to love other people such as your patients if you do not have God within you. We do not love each other automatically, but God comes within and enriches us with the capacity to love others.

Interviewee 13 : Whenever I am tempted to do something that is wrong, I try to think of my morning

prayers. These guide me in my daily activities. I believe in the power of God. He has worked miracles for me, especially in work situations where I did not know what to do.

As indicated in the preceding extracts *(interviews 5; 7; 13)*, various participants cited the religions which they upheld as having a great influence in their perceptions of the doing of good. The values and traditions embraced in these religious systems were instrumental in ethical decision-making. In some cases, participants would hold different religious views, each belief system being used to justify a particular course of action. These religious views often shifted with the context, affirming Bakhtin's (1981) argument for the simultaneous existence of contradictory perspectives within one individual.

4.6.3 *The Influence of the Hospital or Clinic Setting*

Some nurses maintained that the hospital or clinic environment in itself determined the way they conceptualised the doing of good. There were different views about how this happens. On the one hand, were nurses who believed that the hospital or clinic is a Western institution and as such should epitomise the principled approach to ethics. For these nurses, engaging in dialogue with the Code was inconceivable. On the other hand, were nurses who held the hospital or clinic as an extension of the community in which it is located. For them incorporating the values of the community in defining ethical conduct was essential. The contrast between these two positions is illustrated in the following extracts.

Interviewer : What do you consider in reasoning about moral or ethical issues?

Interviewee 3 : It depends on where I am. If I am here *(hospital)*, I have to observe what the Nursing Code tells me to do. There is no question about that...

Interviewer : If you are not here *(hospital)*?

Interviewee 3 : *(laughs)* Well, I do what I believe is right. I do not have to answer to anyone... I do what feels right for me.

Interviewer : Would there be an instance where you do what feels right for you here?

Interviewee 3 : You know, when you are here, you automatically think like you are expected to...

While some nurses saw a discontinuity between the values of the hospital and those of the community, others held a different view. The latter group saw themselves and the institution as an extension of the community:

Interviewer : Is there anything else that you consider in reasoning about ethical issues?

Interviewee 7 : Since we work within the community, almost the whole community knows who we are, therefore, sometimes we really have to be careful of what we say and do. That is why I refuse to participate in any abortion processes especially if I know the family of the person requesting abortion. The community is against abortion and I do not like to do anything which is against the values of this community.

For the nurse in the preceding extract *(interview 7)* the hospital is not a separate entity, but forms part of the community. Thus, in thinking about how to respond to a moral situation, the narrator considers how her behaviour will be viewed by the members of the community. In this instance, she does not only bear in mind what the rules of the hospital tell her to do but how that is going to be embraced within the broader community.

4.7 Power Issues in Ethics

The nurses' relative positioning within the hospital hierarchy had an influence on their conception of morality. Nurses in lower ranks tended to adhere to the Code unquestioningly. They were reluctant to explore other perspectives or possibilities, given the context of their problem or dilemma. They saw the Code as the only determinant of ethicality. However, when in doubt they would consult with their senior more experienced colleagues. Professional nurses on the other hand, tended to be flexible and reflexive in their understanding of nursing ethics. They were more vocal about the need to contextualise the Code, taking into consideration more understandings of ethicality. Power dimensions in nursing ethics are shown in the excerpt below in which the professional nurse justifies her views.

Interviewee 14 : At approximately 17h00, I was called in one of the wards and there were approximately

> 50 nursing assistants waiting for me. After greeting them, I wanted to know why they had called me. One of them said 'we called you because we heard that you reported to other professional nurses that we told you that they do not do their work properly...' I said to them: calm down because as you are talking you obviously do not know what you are talking about because firstly, the meeting where I spoke was for professional nurses, secondly, I was talking about professional nurses, about things which have nothing to do with your category, I do not know if any of you are professional nurses. I do not know if any of you administer blood transfusions, I do not know where you all fit in as you are not professional nurses, "angazi ukuthi nixhumaphi ningebona o-sister".

The preceding extract *(interview 14)*, shows how the narrator uses her rank as a power tool in communicating with her colleagues. The narrator seems to derive her power from her rank, highlighting inequalities between herself and the nursing assistants. The narrator comes across as overly conscious of her rank and subsequently uses power accorded by it to demean those below her. In conversing with nursing assistants she keeps reminding them of their position within the hospital hierarchy. She does this by being cynical and bragging about the difference in roles between professional and assistant nurses. By reading the above extract, it becomes possible to discern the tone of the narrator. This conveys a sense of self-importance and omnipotence.

The role of power issues in ethics was also evidence in the next extract *(interview 4)* about a professional nurse who was confronted by a woman who wanted her 16-year old girl to be given contraceptives because she believed that girls her daughter's age had boyfriends. In this case although the nurse is a professional her position in relation to the community places her in a junior position to that of the mother. The setting (rural area) in which the hospital was located made the nurse feel powerless and disrespect the autonomy of the teenager, thus behaving unethically.

The extract begins after the nurse had told her story:

Interviewer : What was the conflict for you in this situation?

Interviewee 4 : This was a conflict for me because the mother believed that her daughter was not sexually active but still wanted her to be given contraception. The teenager was angry at

being forced to do what she did not want.

Interviewer : What did you do, eventually?

Interviewee 4 : Although we are not supposed to give contraception to people who are not sexually active, I ended up giving it to the teenager because her mother really wanted this. I feared that if the teenager became pregnant in the near future, the mother would blame me. Also, I thought that I do not live with the teenager, I do not know what she does when she gets home and you really can't believe what children say about themselves.

Interviewer : Is there anything else that you considered before reaching your decision?

Interviewee 4 : There are may things that came to my mind. Firstly, I thought about how the teenager would feel about what I was doing to her. Secondly, I thought about the possibility of the teenager getting married in the future as I'm starting her on contraception now, when she does not even know if she is capable of having children. I also thought about the possibility of her battling to have children in the future, and her thinking I destroyed her future by interfering with her child bearing abilities.... Thinking about these things hurt me deeply but there was nothing else I could do, the mother wanted me to do this.

In the preceding extract *(interview 4)* the mother used power rooted in the cultural tradition, to force her point of view on the nurse, thus leading the nurse to contradict principled ethics. She became caught between the principles of the hospital and doing what the mother wanted. Her considerations in reaching a solution to this conflict give an idea of her insecurity in her professional role at that stage. Her slight acknowledgment of 'rules' reflects an awareness of principled ethics, a cognisance of what she as a nurse ought to do. Accordingly, her dilemma originated from embracing contradictory perspectives on adults and children. Her resolution is influenced in part by her perceptions of how adults should be treated in relation to children. To this end, the teenager's mother is portrayed as powerful and worthy of respect. In contrast, the teenager, whose status is that of a child, remains 'voice-less' and is consequently unheard. These understanding of adults and children are evidenced in predominantly collectivist cultures, where people's social positions determine how they should be treated. In this context, the power or the social status of the person is at stake in the resolution of the dilemma. Nevertheless, the narrator's acknowledgment of the teenager's anger and her distress about the impact of her decision on the

teenager, highlights the possibility that she recognised that the teenager is also an individual who has a right to consent on what has to be done to her. The notion of rights and individual consent is based on a Western conceptualisation of self. The fact that the narrator thinks about the possible ramifications of her decision signify a tension within her. Thus, holding different understandings of children and adults which are informed by individualistic and collectivist perspectives created turmoil within the narrator. Although, she finally gave in to her collective understanding of the person, one gets a sense that her decision tormented her.

4.8 Conclusion

The aim of this chapter has been to present the main themes that emerged from the study. In the findings extracts were used to illustrate nurses' conceptions of morality. These perceptions of morality were informed by both the individualistic and collectivist understandings of what it means to be a moral nurse within clinic or hospital setting. Various conceptions of morality emerged. These were: the notion of morality as empathy towards patient; morality as the quality of thoughtfulness; ethical conduct as dedication and commitment to service; morality as principled action; and ethical conduct as a balance between universal principles and caring. These understandings of morality shifted a number of times as a consequence of being influenced by various perspectives. Nurses' evaluations were influenced by their understandings of reality including their views on theories of illness. Various influences including, power issues and the role of internal audiences in moral decision-making, were illuminated. The results presented in this chapter are discussed in the following chapter.

CHAPTER FIVE

DISCUSSION

The aim of this chapter is to discuss results presented in the previous chapter. The concept of a world-view will be discussed first, with particular attention to how it informs nurses' understanding of morality and ethics. Conceptions of morality will be explored next. These will be discussed in relation to the components of a world-view such as; notions of personhood, theories of illness, and understandings of reality. The significance of these influences on morality and ethicality and their implications for the Code, are also explored. In the previous chapter institutions such as family, community, clinic or hospital setting and religion were identified as crucial in reasoning about moral issues, particularly, when engaging with people from largely collectivist cultures. The bearing of these institutions on morality and their implications for the Code, is also examined. Power issues which are viewed as central in the understanding of ethics, are also discussed in relation to the Nursing Code. An attempt is also made to explore what the theoretical implications of the study are.

5.1 World-views and Morality

Results presented in the previous chapter highlight the fundamental role of different conceptions of morality in ethical decision-making. For example, this was evident with certain understandings of the theory of illness. Numerous nurses endorsed a systemic African view of health and illness. This perspective takes into account the cultural dimensions that influence people's conceptions of illness (Castillo, 1997; Ogbonnaya, 1994). This view does not treat symptoms as presenting problems in isolation, but also considers the spiritual dimensions and subscribes to multiple causality. Since the systemic view of illness is not accommodated in bioethics, nurses felt compelled to secretly refer their patients to traditional healers. While the Code is supposed to respect different world views, this does not happen in practice.

A large proportion of nurses seem to see the biomedical approach and traditional healing as informing each other in conceptualizing health and illness. For these nurses, the biomedical perspective caters more for the physical side while the traditional addresses the spiritual. The synthesis between biomedical and traditional healing approaches is in line with Bakhtin's (1981) theory of dialogism. This theoretical framework rejects either-or explanations and argues for a synthesis between various perspectives. Similarly, a systemic African view announces that a person should be treated holistically, taking into account all perspectives open to the individual (Myers, 1993; Verhoef & Michel, 1997). Thus, the nurses' reflexive and flexible engagement with the Code signified an endorsement of a synthesis between various perspectives in an attempt to treat patients holistically.

Results have shown the centrality of world-views on nurses' conceptions of morality and ethics. It has been argued throughout this study that the Nursing Code is grounded on ethical principles which are based on an individualistic conception of the world. The individualistic hegemony inherent in the Nursing Code is at the expense of more comprehensive conceptions of morality (Dien, 1997; Geertz, 1973). For example, the notion of individuals' rights which are fundamental in bioethics advocates an individualistic and deontological understanding of reality. From this understanding of reality, moral reasoning is divorced from the context. The continuing debate surrounding such issues as the Abortion Act of 1996 indicate the importance of looking at the person-in-context when reasoning about moral issues. In spite of the individual's freedom of choice espoused by the principle of autonomy, the Act is still met with resistance in many African communities. This is because these communities embrace a holistic approach to life, where people are connected to others, the higher beings (e.g., ancestors), and eventually, to God (Ikuenobe, 1998; Myers, 1993). As such, abortion signifies the weakening of ties which are central to life. The Code as it stands fails to take cognisance of the fact that other perspectives distinct to individualism construe morality and ethics ontologically. The current study suggests that the conception of the doing of good in bioethics needs to be broadened to embrace context sensitive understandings of reality. Such conceptions are informed by particular views of the world.

Although nurses in this study were guided by the Nursing Code which is individualistic in orientation, they came from a population which is largely collectivistic. To this end, their understanding of morality and ethics was influenced by a multiplicity of world-views. In reasoning about moral and ethical dilemmas, most nurses had to negotiate with their divergent perspectives until they formed a perspective of their own. For example, they would observe what the Code authorized them to do, judge that against the needs and values of the patient, explore their own values and then make an enlightened decision. This engagement with as many perspectives as possible is in line with Bakhtin's (1981) theory and was an attempt to treat patients holistically. The nurses' deliberation with other points of view in their understanding of the doing of good highlights the importance of not only focusing on the individual but also on the communal context, within which moral reasoning takes place (Jensen, 1997).

5.2 Understandings of Morality

Five main themes emerged in the nurses' conceptions of morality. Accordingly, these conceptions also have significance for the nurses' notions of personhood. Most nurses understood morality as empathy or respect for patients. Equally upheld was the notion of morality as the "quality" of the mind. While some nurses viewed morality as principled behaviour, others perceived it as a consultative process. These themes are discussed next.

5.2.1 *Morality as Empathy / Consideration / Respect for Another*

The conception of morality as empathy, consideration or respect for another is linked to Gilligan's (1977; 1982) relational ethic of care, also referred to as 'feminist ethics'. This perspective acknowledges that morality entails sensitivity to another's needs and considering their feelings. For example, most nurses believed that to be a moral nurse requires the ability to feel the suffering felt by their patients. Some nurses believed that to be moral entailed being attuned to their patients' needs. Gilligan's relational ethic of care is often discussed in contrast to Kohlberg's (1981) ethic of justice which focuses on the determination of rights and claims of individuals. The ethic of care proclaims a standard of morality measured by intuitive reactions to concrete situations rather than the ability to stand outside a situation and rationalize one's position in terms

of universal moral principles (Dreyfus & Dreyfus, 1987) and hypothetical dilemmas. The conception of morality as empathy also implies that deciding on ethical behaviour is not made solely on the basis of abstract principles as espoused in codes of ethics, but also in terms of the discomfort it may cause for other people. From this perspective, the quest for personal goodness is conceived of as a relational task based on the interdependence resulting from the mutual immersion and participation in the suffering of the other. The value of such an approach to morality is in authorizing the experience of empathy. In this study, this was linked to the experience of caring for patients and consideration towards their needs. This was most evident in instances where nurses believed that being moral meant not doing something that would hurt their patients. Furthermore, most nurses believed that to be moral also meant "putting themselves in their patient's shoes" and then doing something that is good from patients' points of view.

The acknowledgement of empathy in the context of nursing highlights the interdependent and relational nature of the relationship between nurses and their patients. It is a recognition that the view of an independent self-sufficient person as espoused in the traditional codes of ethics, is insufficient. Rather, the "essence" of being a nurse emanates from a relationship with a patient. It is only in terms of the patient that a nurse gains his / her existence as a nurse. This sense of interdependence between nurses and patients is linked to webs of relationships that exist between people (Brown & Gilligan, 1991; Sampson, 1988). This was most evident in instances where nurses believed that being moral stemmed from the notion of loving one another *(ukuzwana)* and caring for one another *(ukunakekelana)*. This love for another and caring was seen as a defining feature of what it means to be a person in the world, the notion of *"ubuntu"* (being humane). Underlying this conception of morality is the notion of drawing-in of patients in attempts to be fully involved with them in their plight. This refers to the process of entering the world of the other and experiencing it as if it were one's own. For example, some nurses equated morality with the ability to think and feel other people's feelings, the notion of *"ukucabangelana"*. The way the word *"-cabangela"* is used in Zulu also implies an emotional and a feeling component. Accordingly, the notion of "drawing-in" signifies the webs of relations that exist between nurses and patients. In line with Gilligan's (1977; 1982) ethic of caring, the Code should acknowledge

that nurses' empathy should be based, not on role expectations or formal rules such as beneficence, but on feelings of caring that flourish in the experience of being in relationships with others (Miller, 1994). By affirming the experience of empathy, Gilligan's perspective sanctions the ethical status of those people who tend to use such experiences in moral judgment.

Although Gilligan's (1982) acknowledgment of empathy was confined to the experiences of women in particular, the conception of morality as empathy is also consistent with a collectivist world-view. For instance, interdependence is a central feature of collectivism. As such people from these societies are characterized by great concern for others (Fijneman *et al.*, 1996; Menkiti, 1994). In spite of Gilligan's valuable contributions to the study of morality, her theory is culturally circumscribed to the American population, particularly women. Bearing in mind her valuable insights that understandings of morality are linked to conceptions of self (Gilligan, 1982) as well as declarations that understandings of self are culturally variable (Markus & Kitayama, 1991) leads to the expectation that interpersonal moral codes emphasizing an individualistic view of the self will differ qualitatively from those emphasizing a more interdependent view of the self (Miller, 1994). This qualitative difference stems from the fact that the type of interpersonal moral approach highlighted in Gilligan's (1982) American population represents an individually oriented moral code (Miller, 1994). In contrast, the type of perspective emphasized among collectivist societies embodies a duty-based interpersonal moral code (Bersoff & Miller, 1993). Therefore, the notion of empathy from a collectivist framework signifies a more infused compassion for another, enhancing social embeddedness (Fijneman *et al.*, 1996). Great concern for others is at the heart of collectivist communities.

The conception of morality as empathy or consideration for another implies that the nurse responds to a situation not only on the basis of principles espoused within the Nursing Code, but also on the basis of his or her feelings for the patient. This was most evident in instances where nurses believed that being moral meant the ability to feel the suffering felt by their patients. The notion of feeling for another implies a process where one person gains entry into another's lived experience. This theme was echoed by many nurses in the study where they conceptualized

morality as akin "to being in the patient's shoes", the notion of *"ukuzwelana"*. Such emotions are a consequence of nurses' connectedness to their patients. The centrality of feelings is largely ignored in traditional theories of morality but is acknowledged in collectivist paradigms.

5.2.2 *Morality as Dedication or Commitment to Service*

For some nurses being moral implies responsibility towards patients by respecting their independence and freedom to make choices about issues affecting their lives. This understanding of morality encompasses as sense of obligation on the nurse's part. Nurses who conceptualised morality in this way, used the Code and the nurses' pledge as frames of reference. For example, when encountered with a situation such as how to help an African woman faced with an unwanted pregnancy, a nurse would inform her of the latest Abortion Act and remind her that she has a right to decide what needs to be done to her own body. In this instance, a nurse would be evoking the principle of autonomy as espoused in the Code. On judging their level of dedication nurses' adherence to the principles of the Code were used as a framework. This is also endorsed by the fact that professional codes of ethics often contain statements which begin with, "the professional has a responsibility to..." (Bandman & Bandman, 1990; Mellish, 1981; Rumbold, 1999; SANC, 2000), thus conveying something about what nursing as a profession assumes its foundation to be. The notion of commitment also signifies a pledge incumbent upon those who care for the sick (Benjamin & Curtis, 1992). In this study, the conception of morality as dedication and commitment to service is based on the principle of beneficence, the doing of good (Rumbold, 1999). In enforcing commitment and dedication, nurses are expected to ascertain the endeavours that will most benefit the patient. As a consequence of their vulnerable positions, patients may depend on nurses for both caring and protection from abuse. By implication, nurses are thus assigned the role of being honourable to the needs of their patients. However, because of the advantaged position afforded by their knowledge, some nurses tend to abuse this power and pursue their needs instead of their patients' (Bandman & Bandman, 1990).

While there are nurses whose sense of dedication follows from empathy with patients, there are those who perceived their sense of commitment as emanating from what the Code

prescribes them to do. There are significant differences between the two. Nurses whose sense of dedication stems from their heartfelt empathy, are more likely to feel connected to their patients. For these nurses, their dedication tends to be natural and not mechanical. On the other hand, for nurses whose sense of dedication emanates solely from adherence to the Code, their dedication is seen as merely a condition of their nursing role. For these, their conceptualisation of the moral reflects a world-view characterized by an orthodox perception of the Code. In this instance, the Code becomes the only authority for ethical decision-making. Such reasoning is in line with what Bakhtin (1981) termed, "authoritative discourse", symbolized by uncritical affirmation of others' discourse or perspectives. For example, the Code states that "disregard (on the nurse's part) for the South African Nursing Council rules of professional conduct is regarded as unethical" (SANC, 2000, p. 16). This directive does not lend itself to adaptation to suit patients' particular needs. Since the Code is based on an individualistic orientation to reality, there are instances where it could be arguably justifiable to ignore it, especially when working within collectivist contexts. For example, providing services unrestricted by considerations of race, colour or religion, as the Code suggests, would be problematic. This would entail not taking into account patients' socio-cultural considerations in their treatment. However, the Code as it stands is based on principles which have been treated as if they are the only standard of judgement available to us. Failure to adhere to the Code is classified as one of the "conduct(s) which adversely affects the image of the profession" (SANC, 2000, p.16). Since the Code is based on a particular ideological understanding of the world, endorsing it without addressing these ideological assumptions is arguably inappropriate at best. The authoritative nature of the Code calls for unconditional acceptance. Perhaps the prescriptive nature of the Code hinders a dialogic engagement with it for some nurses. A dialogic endeavour with the Code would entail taking into consideration the indigenous views of the moral and the ethical.

5.2.3 *Morality as Thoughtfulness*

One of the major conceptualisations of what it means to be moral was the notion of morality as "thoughtfulness". Most nurses understood morality as the "quality of the mind." To this end, a moral nurse was perceived as someone who thinks deeply about the situation, taking into account

the various possibilities open to oneself. Although this conception of the moral is not solely collectivist, it differs form a general understanding of thinking. From a collectivist perspective, "thoughtfulness" has a feeling dimension. To be thoughtful from a collectivist framework, entails not only thinking deeply *(ukujula ngomqondo)*, but also the ability to think for others *(ukucabangela)* or to have others' best interests at heart. This mandates an action which requires consideration for other people's concerns in pursuit of social harmony. The notion of morality as thoughtfulness demands that people be sympathetic to other people's desires. If there were no human interests and needs to be fulfilled, the notion of morality from a collectivist perspective, would have been meaningless (Ikuenobe, 1998). Competence to apply one's mind thoughtfully in the pursuit of the good, is one of the narratives about what it means to be a moral person within collectivist societies.

Behaving morally was conceived by some nurses as a complex task. Moral issues were perceived as compelling one to think deeply, taking into account the various possibilities open to oneself. This was evident in instances where nurses understood morality as entailing avoiding to act thoughtlessly but exploring as many viewpoints as possible. Perspectives cited as crucial in thinking about ethical matters included the patient's value systems, a nurse's beliefs and assumptions, hospital regulations and influences of the community wherein the hospital is situated. A moral nurse was perceived as someone who is able to entertain all these viewpoints in thinking about moral issues. Such a conceptualization of morality is in line with Bakhtin's (1981) theorizing about "internally persuasive discourse". This entails critically examining all perspectives open to the person, in the formation of one's own. Some nurses cited the intertwined nature of reason and feeling in moral decision-making as compelling them to "think deeply" about issues. The Abortion Act of 1996 is one issue cited by many nurses as requiring a high level of "thoughtfulness" (Taitz, 2000). This Act requires nurses to think deeply because their own values such as religion and respect for life come into play. This law gives women the right to have abortions while at the same time giving nurses the right to refuse to perform them. For some nurses the issue is not as clear cut as presupposed by the Act. Rather, in coming to a decision to choose whether or not to participate in a abortion process, most nurses have to explore as many

points of views as possible. In making a decision about whether or not to participate in performing an abortion, most nurses considered how the community would react towards them if they were to hear of their involvement in this process. For some nurses, the knowledge of the mother of the youngster coming for the abortion was instrumental in their decision-making. This implies that people's reasoning about lived experiences rests on rarely examined notions about the world (Jensen, 1997). Perspectives other than the Code are also used in reasoning about such issues. This dialogic encounter with the Code is one way of addressing the perspectives which have been largely ignored in mainstream ethics. It also implies that the Nursing Code should not be viewed uncritically.

5.2.4 *Morality as a Consultation Process*

A conception of morality as a consultation process is linked to the understanding of morality as thoughtfulness. Nurses with more nursing experience were consulted to determine whether or not one behaved in ways that were consonant to morality. By virtue of their nursing experience, nurses who had more years in the profession were thought to reflect wisdom in ethical matters. This conception of older folk as bearing wisdom in ethical matters is consistent with a collectivist world-view (Ikuenobe, 1998; Verhoef & Michel, 1997). Although the use of supervision in principled ethics encapsulates this dimension, the use of elders within the collectivists framework is arguably more comprehensive. From a collectivist perspective, elders within the African community are seen as repositories for morality (Verhoef & Michel, 1997). In this context, elders are expected to resort to their experience to settle disputes about what constitutes morality. By the same token, experienced nurses are considered to be the best people to impart knowledge gained through past experience about what comprises the doing of good. Consultation signifies an acknowledgment of one's relative position within the hospital hierarchy. This has implications for power issues and requires an affirmation on the nurse seeking consultation of the central role of ranking within nursing. Nevertheless, it is also regarded as "good practice" to consult or seek peer supervision in principled ethics. The significance of people's positions on moral issues is also in line with a collectivist world view. From this perspective individuals are positioned uniquely within the community on the basis of age, rank and experience (Verhoef & Michel, 1997).

However, in spite of the fundamental role of positioning within the nursing profession, a large proportion of nurses tend not to utilize opportunities to enrich their nursing experience (Barriball, While & Norman, 1992; Hutton, 1987) and hence some countries (e.g. North America) have opted to make continuing nursing educational programmes mandatory, to ensure that all nurses are kept up-to-date (Mackereth, 1989).

The notion of morality as a consultation process, implies that the Code on its own is insufficient in guiding a nurse to reason about moral issues. Nurses with more experience are consulted to supplement what the Code authorizes them to do. These nurses do not use only the Code in guiding their juniors but also draw on the wealth of their personal experiences. This is another example of engaging in dialogue with the Code as opposed to embracing it uncritically. It should be borne in mind that engaging in dialogue with the Code does not imply abandoning it altogether, but suggests enriching it with other more comprehensive perspectives.

5.2.5 *Morality as Principled Action*

The conception of morality as a principled approach means behaving according to established rules, principles and procedures. For instance, some nurses construed a moral nurse as someone who always checks if what he/she is doing agrees with the rules of nursing. Although there are nurses who use the principles of the Code in a flexible manner, there are those who adopt them rigidly. While the former adapts principles to suit particular needs of patients, for the latter behaving ethically entails following the principles of the Nursing Code unquestioningly. In this instance, the principles of autonomy and beneficence espoused within the Code are seen as pivotal for conducting oneself morally (Allmark, 1992; Beauchamp & Walters, 1982; Christakis, 1992; Faden & Beauchamp, 1986). This understanding of morality considers moral principles as a foundation for behaving ethically. This conception of morality implies that the knowledge of principles translates to being ethical (Gibson, 1993). From this understanding, the Nursing Code is seen as an indispensable document authorizing nurses to behave ethically. Such a conceptualization of the Code is an instance of an authoritative discourse, which calls for unconditional obedience thus constituting a monologue, as opposed to a dialogue.

The understanding of morality as principled action is one way of understanding morality and needs to be broadened. It has been argued throughout this study that morality is a complex phenomenon requiring one to entertain as many perspectives as possible in the formation of one's own. For example, indigenous understandings of the doing of good need to be incorporated in ethical theories (Kashima, 2000). Therefore the conception of morality as principled action upholds the individualistic outlook of reality at the expense of other more comprehensive systems. Approaches such as the systemic African conception of morality (Ikuenobe, 1998), hermeneutics and dialogism (Mkhize & Frizelle, 2000) are better means available in exploring people's lived experiences. The notion of morality as principled action, signifies an individualistic notion of reality. In this world-view, to be moral means abiding by the universalistic principles of the Code. However, this is no indication that principles have no place within a collectivist paradigm. Rather, it is an assertion that principles cannot be used in isolation but they are there to service the practical-lived aspects of people's experiences. Therefore, there should be harmony between principles and issues that give meaning to life such as belongingness and relatedness.

What emerges form these conceptions of morality is the centrality of world-views in the understanding of the doing of good. Systemic conceptions of illness, the notion of person-in - context, and the interdependence between self, family and community all informed how nurses conceptualized moral and ethical issues. Although there are many understandings of what it means to be a good person in the world, ethical theories have upheld conceptions rooted in the individualistic orientation of reality. This has been done at the expense of more comprehensive views of the world, such as context sensitive approaches to life. Although nurses are expected to follow their Code, some of them are able to engage with it in a critical manner. This issue is discussed next.

5.3 Ethical Conduct as Reflexivity

This conception of morality requires engaging in dialogue with as many perspectives of morality as possible in an attempt to achieve an informed understanding of the moral. For example, nurses in this study would examine the presenting issue through adhering to a principled approach to

ethics, which entails behaving according to established rules and procedures. This perspective would be juxtaposed with an indigenous understanding of morality entailing socio-cultural understandings of the moral. This synthesis between contradictory viewpoints is in line with Bakhtin's (1981) theory of dialogism which argues for the possibility of a polyphony of perspectives within an individual. In this case, the Nursing Code on its own is perceived as insufficient in guiding a nurse to behave ethically because it is based on the individuality principle, autonomy, and individuals working in isolation from communities. For instance, most nurses maintained that being ethical necessitated not only doing what the rules of the profession authorizes one to do but also checking out if that conforms with the patient's value system. In so doing, the principles espoused in the Code are implemented with flexibility by ascertaining whether or not the needs of the patient are compromised. This perspective allows for indigenous understandings of morality to be incorporated in ethics as opposed to relying only on the principles of the Code. This approach to morality is analogous to Bakhtin's (1981) theorizing where he argued for a simultaneous existence of opposing perspectives in analyzing human lived-experiences. Such a model argues for a co-existence of both 'individualism' and 'connectedness', as these understandings to life can be evidenced in one person. For instance, most nurses in this study affirmed that being a moral nurse required not only to do what one was taught in training but also taking into account the patient's understanding of the nature of causality. In engaging in dialogue with the Code, moral principles which nurses were taught are compared with the patient's theories of illness. The nurses' dialogical engagement with the Nursing Code reflects an attempt to move beyond the individualistic-collectivistic dichotomy. A reflexive conception of nursing ethics is thus in line with hermeneutic-dialogical approaches. By allowing for a synthesis of various perspectives, hermeneutic-dialogical approaches make it possible for the integration of indigenous views which have been historically ignored in mainstream ethics.

The notion of reflexivity in ethicality has a number of implications for personhood. It assumes that an individual can be influenced by both individualistic and collectivist orientations. The individual is viewed as capable of entering into an inner dialogue with both perspectives (Bakhtin, 1981). Through the process of multi-voicedness, the person speaking within a collective

perspective may simultaneously be communicating with an individualistic voice (Hermas & Kempen, 1995). This implies that a nurse may be responding to the situation as a consequence of his / her personal analysis of the situation and by also taking into account the guidelines of the Code. This analysis may be influenced by different perspectives open to the nurse with the ultimate formation of the nurse's own.

To engage reflexively with the Nursing Code also implies taking into account other world-views in the understanding of morality. Incorporating patients' needs in the understanding of morality involves acknowledging other understandings of health and illness. In the case of patients from collective societies, this may include taking cognisance of traditional models of illness. From this perspective, health means a balance between all elements of the universe (Edwards, 1999; Ikuenobe, 1998). Accordingly, the weakening of ties between ancestors, humans and the whole of the universe signifies illness (Ogbonnaya, 1994). In this way, cultural systems are seen as providing a meaning to people's everyday experiences (Castillo, 1997). Engaging reflexively with the Nursing Code entails taking into account the indigenous understandings of patients' experiences and incorporating them in their healing.

Although nurses' conceptions of morality have been presented in a linear format thus far, in reality they shifted from one perception to another. For instance, at one point a principled conception of ethics would be salient, entailing adhering to established rules and regulations of nursing, yet later on an a systemic African view of illness will be evidenced. This corresponds to Bakhtin's (1981) theorizing where he argued for the possibility of a simultaneous existence of multiple, sometimes even contradictory voices within a single personality. Therefore, each nurse in the study espoused numerous divergent conceptions of morality which were influenced by different understandings of the world. These shifted from one situation to another, and were thus marked by inconsistencies. The exposure to various voices can create tension within the individual. This implies that not only should codes of ethics endorse individualistic factors but there should be a recognition that those sometimes exist simultaneously with other understandings of what it means to be a good person. This is in line with Bakhtin's (1981) assertion that it is

possible for an individual to hold contradictory perspectives, although these are often in conflict with each other. Therefore, instead of basing the Code on an individualistic conception of autonomy in every instance, in order to be truly fair, autonomy needs to be conceptualized against the needs of the patient in each particular situation. Furthermore, there should be an awareness that such conceptualizations shift from one situation to another. For some nurses, engaging in dialogue with the Code was a means of negotiating the conflict which they experienced with this process. Nurses' inconsistencies in their conceptions of morality and ethical conduct were largely influenced by how they positioned themselves in relation to the Code. Results indicated that nurses tended to adopt understandings of the moral influenced by a collectivist world- view if they perceived themselves as having the power to engage flexibly with the Code. This power was derived on the basis of age, rank and/or level of nursing experience. However, in instances where the nurses perceived themselves as disempowered to be flexible with the Code, due to lower ranking and/or fewer years in nursing, individualistic conceptions were adopted. Inconsistencies in conceptions of the doing of good resulted because nurse's perceptions of power tended to shift with each situation. For example, while a nurse with more nursing experience might derive his or her power from his/her length of service, if he/she is in a lower rank that perception of power becomes unstable and this would impact on his or her conception of the moral depending on the variable she derives her power from and the situation he or she finds herself in. These inconsistencies have an impact on how nurses behave. This theme is elaborated on next.

5.4 Positions in Perceptions of Morality

Harre and Langenhove (1999) perceive positioning as a constellation of personal qualities that impact on interpersonal action. In the context of this study, these are qualities such as age, rank and the extent of nursing experience. The notion of positioning within nursing implies that nurses are not equal, but are placed hierarchically on the basis of rank and nursing experience. This hierarchical positioning is a great source of power and has a bearing on one's conceptions of ethical issues. Furthermore, power goes hand in hand with respect (Verhoef & Michel, 1997). As a consequence of higher rank and more nursing experience nurses in these positions gain respect from their subordinates and colleagues. Higher ranking is viewed positively by many nurses

(Barribal, While & Norman, 1992). The results presented in this study have shown that nurses' relative positioning within the hospital hierarchy influence their understanding of morality and ethicality. For instance, nurses who perceived themselves as powerless tended to treat the Code as "authoritative discourse", a divinity to be obeyed unquestioningly, while those who perceived themselves as powerful tended to engage more dialogically with the Code. This is reiterated by Harre and Langenhove (1999) where they argue that if someone is positioned as powerful, that person may legitimately assign orders and demand conformity from others where this position is acknowledged. This implies that one's position affords one with privileges which are dictated by the moral sense of the system. The young ones tend to lose out since they are often subordinated to the authority of those in higher positions (Paris, 1995). For example, children are perceived as voice-less and adults have to make decisions on their behalf. This reiterated in principled ethics as well where children under 18 years, on the basis of their age are seen as incapable of informed consents. Morality in nursing thus reflects the dynamics of a status hierarchy, where one's differentiated role within the hospital system determines how one conceptualizes issues.

The role of positions in morality is consonant with the African conception of morality, where one's status reflects what the community expects of one morally (Mbiti, 1970; Verhoef & Michel, 1997). Individuals are situated uniquely within the community hierarchy in relation to age, kinship, character, wealth or gender (Menkiti, 1984; Verhoef & Michel, 1997). Within these hierarchies are duties imposed by the moral sense of the community. This corresponds to the conception of self as a social representation where the individual is seen as embodying the needs and values of the community. From this framework, one's relative position in socio-political contexts, influences one's conception of significant experiences (Oyserman & Markus, 1998). Since social relationships underpin morality in this context, one's position must be used to the benefit of the whole community to ensure harmony. People in privileged positions are expected to dispense their duties in a way that enhances interrelatedness with others. It is believed that a person's conduct would encompass the values of the larger group in the quest for harmony (Paris, 1995). Otherwise, people in privileged positions lose the respect due to them. It is hoped that those nurses who engage dialogically with the Code will also utilize the principles of the nurses'

pledge to serve the needs of the greater nursing community. This would guard against the abuse of power.

5.5 "Internal Audiences" in Moral Decision-making

For some nurses, voices from significant "others" served as frames of reference at the time of making a moral decision. Instead of relying only on the Nursing Code for guidance, some nurses used these "internalized audiences" as well. These were used as some form of a moral audience for evaluating the ethicality of one's behaviour. For instance, when one nurse considered treating her patients badly, thoughts of how her parents would react served as an internal audience against which such behaviour was evaluated. In making a decision, this particular nurse considered her relationship with her parents rather than relying on the principles of the Code alone. The utility of moral audiences in decision-making gains support form various theorists such as Day (1991). He argued that moral behaviours are a function of the audience to which they are enacted. This suggests that moral actions always occur in relationship to these internalized "others" and that people's actions are always performed and interpreted with significant others at the background. The notion of an "internal audience" also implies that the consistency of moral action has much to do with the consistency of the audience to whom such actions are performed. The use of "internal audiences" at the time of making a decision is another instance of engaging in dialogue with the Code. Results have shown that for some nurses instead of relying only on the principles of the Code, internal audiences are referred to at the time of making a moral decision. For example, instead of adopting individualistic conceptions of justice some nurses used understandings of justice informed by voices from significant others. This is no indication that individualistic principles have no place in morality but the use of internalized audiences is an attempt to advance alternative views from which the doing of good is acknowledged.

5.6 Significant Influences in Morality

In conceptualizing ethical dilemmas, most nurses cited various social and cultural institutions as influences in reasoning about moral or ethical issues. Institutions referred to were family, community, religion and the hospital setting. Nurses' conceptualization of moral issues were

largely shaped by values acquired from their families, particularly how one was brought up. Communities, various religious systems and the location of the hospital were also cited as significant in influencing how a nurse thought about moral and ethical issues. In many instances these influences were appropriated as nurses' own. In authorizing these influences, nurses were engaging in a dialogue with the Nursing Code, as opposed to treating it as "authoritative discourse". This is significant because traditionally, other perspectives such as the collectivist, comprised forms of excluded experience in mainstream ethics. The identification of excluded experiences on morality, such as the notion of respect for another, is one way of reclaiming neglected perspectives (Miller, 1984), affirming their dignity and providing a source of moral empowerment. Upholding the significance of these influences on morality is also a way of acknowledging the fact that morality is made of more comprehensive understandings of reality.

Although the inclusion of families and communities is undoubtedly significant in conceptualizing ethical issues, it is not without problems. Attempts to incorporate cultural issues in conceptions of informed consent have shown that the perspectives of the communities are not homogenous as there are marked differences within cultural groups (Gasa, 1999). As such, conceptualizing ethical issues from an entirely collectivist framework may overlook the fact that even from these societies there are people who adopt an individualistic view of the world. The significant impact of historically 'excluded perspectives' in ethics, is considered next.

5.6.1 *Family Influences*

For most participants thoughts about moral issues signified an indispensable role played by their family background. In this instance, values passed down by family members seemed to resonate within the nurses' psyche on reasoning about ethical matters. This is consonant with the African ethos which declares an interdependent notion of personhood (Mbiti, 1970; Verhoef & Michel, 1997). The standard of maturity is the ability to harmonize one's relationships with family and community members (Christopher, 1996). For an individual with a collectivistic orientation, it is meaningful to be influenced by family values because failure to live up to the expectations of one's family is perceived as a moral transgression (Verhoef & Michel, 1997). Thus, the inner voice of

one's family could be seen as offering some guidance on the individual and may counteract against any guilt feelings should the individual choose to disregard these. For instance, in contemplating whether or not to ill-treat her patient, one nurse's thoughts about her mother were used as a framework against which the intended behaviour was evaluated. For this particular nurse, instead of relying only on the Code, her mother's values of respect for others, were always in the background influencing her moral or ethical conduct. However, the views of the family may not necessarily be consonant with what the individual wants to do. For example, problems occur when family consent is at odds with the consent of the individual (Richter *et al.*, 1999) . Perhaps, in such cases the fact that the individual consults with the family and engages in dialogue with them ought to be considered as crucial rather than the end result.

The notion of family influences on morality has implications for principles such as autonomy. For the Code to be appropriate, there needs to be a recognition of cultural influences on individual functioning. This should not be taken to imply that all nurses from collectivist backgrounds are influenced by this perspective. Rather, it is an assertion that for some nurses, the family plays a crucial role in authorizing their responses to moral issues. Indeed, if one takes into account that cultures are not static over time, the extent to which family background influences each person will differ from one individual to another.

5.6.2 *The Role of Religion in Morality*

For some nurses religious systems were perceived as having a bearing on their reasoning about moral issues. The term religion is used loosely here, to refer to any ideas such as Christianity and traditional or ancestral beliefs. The influence of religion on morality is characteristic of an African ethos where morality and ethics are perceived as integrated with religion (Verhoef & Michel, 1997). Morality and religion from a collectivist orientation are characterized by complex interdependence (Mbiti, 1970). There is no distinction between these disciplines as they are not understood as entities in themselves but as influential systems that cannot be separated (Verhoef & Michel, 1997). As a consequence of the holistic conception of life, everything, including God, ancestors and the living is perceived as connected and interrelated (Ikuenobe, 1998).

The nurses' acknowledgment of the influence of religion on morality is another instance of engaging dialogically with the Code. On one hand were nurses who believed that being moral is inseparable from being a Christian. On the other hand were nurses who believed that it is impossible to be ethical without being connected spiritually with one's ancestors. These religious systems were seen as pivotal in authorizing a person to behave ethically. For example, an immoral nurse was defined by others as a person whose ties with ancestors or God have been severed. In this way, the doing of good is seen as tied in with religion. This is also an affirmation that the Code on its own is insufficient in helping a nurse reason about moral issues because it does not take into account other understandings of morality. Religious systems are perceived as influential in informing nurses about the doing of good. However, the religious values are sometimes in conflict with the requirements of health. For example, the Jehovah's Witnesses' stance on blood transfusions.

5.7 Conclusion

The results of the study have been discussed under the main themes that emerged. It has been shown that nurses' conceptions of the moral are influenced by their understandings of reality. These conceptions were marked by contradictions and inconsistencies which shifted with each nurses' positioning within the narrative. Perceptions of power were also perceived as having a bearing on nurses' understanding of the doing of good. Various influences, including the role of the family, religion and "internalized others" were seen as instrumental in authorizing a person to behave ethically. In many instances the Nursing Code on its own was seen as insufficient in guiding a nurse to act morally. There was a call for the Nursing Code to embrace other more comprehensive perspectives of morality.

CHAPTER SIX

CONCLUSION

The purpose of the study was to explore cultural notions of morality and personhood and the implications thereof for the practice of ethics within the nursing profession. The study also investigated how nurses made sense of the ethical procedures within the hospital context, especially as these are applied to patients from a largely collectivist background. Using an in-depth semi-structured interview schedule, interviews were held with participants drawn from a local hospital. These were guided by the *voice-centred-relational method* developed by Gilligan (1981) and later adapted by Mautner & Doucet (1998). Hermeneutic and dialogical approaches provided the theoretical context for the study.

The results of this study have shown that nurses are often caught between two opposing viewpoints. On the one hand are hospital procedures, which are informed by universalist approaches to the person and the moral. From these are derived ethical principles emphasizing individual autonomy and choice. On the other hand, the majority of the patients subscribe to a communal view of personhood. From this perspective, to be moral is inseparable from quality of being, and entails knowing one's position and responsibilities within the family and community. Being caught between these two contradictory understandings of morality created turmoil and disillusion among nurses. It contributed to the complexity of the moral dilemmas that they faced.

The individualistic paradigm that informs ethical theories and the practice of nursing in South Africa is too limited. From a nursing perspective, it is crucial to recognise that the Nursing Code is based on theoretical assumptions about what constitute reality which are not universally shared. Furthermore, by being based on assumptions which are claimed to be universal, the Code is uncritical of its own cultural presumptions and value-laden positions. It marginalised the perspectives on life of an already historically disadvantaged, large majority of the population. For

this reason, it is important to broaden understandings to include interpretivist, meaning-based approaches that take into account indigenous narratives of what it means to be a person developing within certain social and cultural contexts. By addressing the individualistic-collectivistic dichotomy, hermeneutical-dialogical approaches provide renewed insights in ethical issues. They facilitate a richer, responsive and experientially relevant conceptualisation of moral issues.

6.1 Implications of the Study

The significance of hermeneutic-dialogical understanding to ethics bear the following implications:

a) research on ethics must address the interplay of subjective, situational and contextual influences on morality;

b) codes of ethics should acknowledge contextual considerations and the dialogical nature of morality;

c) indigenous understandings of personhood, such as the notion of person-in-community, need to be included in clinical training and practice.

6.2 Recommendations

In the light of conclusions reached and the implications for the study, it is recommended that ethical and moral deliberations should dialogue with alternative, marginalised viewpoints in order to be culturally responsive. Attempts are being made to include communities in ethical decision-making (Gasa, 1999; Richter *et al.*, 1999). However, these seem to be confined to the area of HIV research. This study recommends that every profession which adopts a principled approach to ethics needs to re-examine its ideology to encompass contextual understandings of reality. To this end, it is recommended that ethics be conceptualised as a practical moral engagement, as opposed to a detached application of knowledge.

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APPENDIX A

THE INTERVIEW SCHEDULE - THE ENGLISH VERSION

There is a belief that the practice of nursing is a moral enterprise and thus as a nurse you are always exposed to situations wherein you have to make decisions, and sometimes you may be unsure of what to do.

* Can you tell me about a situation within your nursing profession, where you were faced with a moral conflict and had to make a decision, but were unsure of what to do. Could you describe the situation from beginning to end?

Probes (used with flexibility)

1. What was the conflict for you in that situation? Why did you perceive it as a conflict? How did it impact on you as a person?
2. When you were in the situation that you mentioned, what kinds of things did you consider in thinking about what to do? Why? Is there anything else that you considered apart from the things that you have already mentioned?
3. What did you eventually decide to do? How did your decision affect your relationship with your patient / colleagues / treatment given?
4. Considering the option you chose, do you think it was the right thing to do? Why / Why not?
5. Bearing in mind the decision you took, how did it impact on you as a person? How did it impact on your upbringing/ principles/ religion?
6. What was at stake for you in this dilemma? What was at stake for other people involved? In general what was at stake?
7. How did you feel about it? How did you feel about it for others involved?
8. Is there another way of seeing the problem (other than the way you have already described)
9. When you think back over the conflict you described, do you think you learnt anything from it?
10. How would you describe a moral nurse?
11. What does morality mean for you? What makes something a moral/ethical problem for you?
12. **Considering what you were taught to do in your training when faced with moral dilemmas and what you do in practical situations, is it the same or are there any differences?**

Thank you for taking part in this research. Please feel free to add anything that you think I did not cover. Also, you are free to ask any questions concerning the issues that we've discussed today.

(Adapted from Brown & Gilligan 1991; Mauthner & Doucet, 1998).

APPENDIX B

THE INTERVIEW SCHEDULE - THE ZULU VERSION

Kunenkolelo ethi umsebenzi wobunesi uphathelene kakhulu nobumnene noma nobulungiswa okwenza ukuthi njengonesi uhlale njalo ubhekene nezimo ezinzima ezidinga uthathe izinqumo ezinokwenza nonembeza, ngenxa yalokho-ke uzithole ngezinye izikhathi ungenaso isiqiniseko sento okumele uyenze.

* Ngizocela ungixoxele isimo esinzima owake wabhekana naso emsebenzini wakho wobunesi, lapho wazithola usebunzimeni, kufanele uthathe khona isinqumo, kodwa ungazi ukuthi yisiphi isinqumo ozosithatha. Isimo-ke lesi sasiphathelene nokuthi kunokwenzeka ekuthatheni isinqumo wenze into ehambisana nonembeza wakho noma engalungile engahambisani nonembeza. Lapho wabe sewufana nomuntu odonseka macala womabili, ungazi ukuthi yini into okumele uyenze. Ngicela ungixoxele udaba lwakho lonke, ukuthi kwaqalaphi, kwenzekani kwaye kwafikaphi.

Imibuzo (isetshenziswa ngokulandela isimo sengxoxo)

1. Kulesisimo owawubhekene naso, yini eyabe iyinkinga kuwena ngokukanemebeza? Yini eyenza lesisimo usibone njengesimo esiyinkinga?
2. Ngesikhathi ubhekene nalesisimo, yiziphi izinto ezakufikela emicabangweni yakho? Ingabe kukhona okunye okwakufikela emqondweni ngale kwalokho osungitshele kona?
3. Isiphi isinqumo owagcina usithathile? Ingabe isinqumo sakho sabenza babanjani ubudlelwano bakho nesiguli noma owawusebenza nabo?
4. Uma ubheka isinqumo owagcina usithathile, ucabanga ukuthi kwaba yisinqumo esilungile? Yini eyenza ucabange kanjalo?
5. Sisekuso isinqumo owagcina usithathile, yingabe sakuphatha kanjani ngokwemizwa yakho? Yingabe sasinakho ukuxhumana nezinkolelo zakho kumbe indlela owakhuliswa ngayo?
6. Yingabe yini eyayi baluleke kakhulu kulesisimo owawubhekene naso?
7. Waphatheka kanjani ngabantu ababebandakanyeka kulesisimo?
8. Uma ucabanga omunye umuntu wayengayibona kanjani lenkinga yakho? Wayengayibona ngendlela eyahlukile?
9. Uma ucabanga ngalesimo owawubhekene naso, ingabe ikhona into esakufundisa yona, wena njengomuntu?
10. Ungamchaza uthini unesi onobulungiswa noma ononembeza?
11. Yini eyenza isimo siphathelane nokukanembeza kuwe?
12. **Uma ubheka indlela owafundiswa ngayo usafundela ubunesi, nendlela okumele wenze ngayo uma ubhekene nezimo ezinzima eziphathelene nokukanembeza, nendlela owenza ngayo emsebenzini wakho wobunesi, ingabe kukhona ukwefana noma kukhona lapho kwehluka khona? Ake uchaze.**

Ngiyabonga ngesikhathi ongiphe sona. Ngicela ukhululeke ubuze nanoma yini engakucacelenga kumbe noma yini othanda ukungibuza yona.

APPENDIX C

MATRIX DISPLAY USED TO SUMMARIZE DATA

Participant Age Sex Rank	**Reading 1:** **<u>The plot:</u>** * Paying consideration to the unfolding of the story. * Concentrating on metaphors, contradictions, recurrent images and changes in the narrative position.	**Reading 2:** * Reading for the voice of the "I". * Focus on the participant's sense of self. * Focus on "I" in relation to "we" and the tensions within.	**Reading 3:** * Reading for relationships * Focus on how the participant experienced herself (or himself) in relation to others. i.e. how she (or he) perceived herself (or himself) and behaved in relation to these others.	**Reading 4:** * Placement of people in social and cultural structures. * Focus on the participant's experience of hospital rank, family, authorities, politics etc. whether these forces were perceived as enabling or constraining.	**Summary** * Highlighting major themes across the four readings.

APPENDIX D

AN EXAMPLE OF A CONSENT FORM

UNIVERSITY OF NATAL

Psychology Department

Private Bag X01, Scottsville, 3209
Telephone 033-2605853 Fax 033-2605809

Date

Dear Sir / Madam

You will no doubt be aware of the University of Natal's active involvement in research. To this end, I am conducting a research on nurses' moral dilemmas as part of my degree requirements. This research is of significance as nurses tend to be faced with complex ethical or moral issues in their daily working lives. To assist me in understanding how nurses make ethical decisions, I need participants to take part in this research. This consists of an in-depth interview which takes approximately 20 minutes.

Should you wish to take part in this research, please note that participation is voluntary and that appointments for interviews will be held at a time to suit you. Furthermore, the research is anonymous and confidential. Should you feel uncomfortable in any way during the interview, please exercise your right to withdraw at any point.

The results of this study will be presented in a summarized version with all identifying details concealed. I am sure that your contribution will assist towards a better understanding of moral and ethical issues.

Please sign below to indicate that you consent to participate in the study:

I _____*(name)*_____ have not been forced in any way to participate in this research. I understand that I can choose to withdraw at any point, should I wish to do so.

Many thanks for your participation.

Yours Sincerely

Ms S. Q. Gambu

APPENDIX E

A SAMPLE OF AN INTERVIEW TRANSCRIPT - ENGLISH VERSION

CASE 5[1]

QG: Begins with a full explanation of what is expected prior the interview. Gives participant a few minutes to think, then question 1 is posed.

QG: As I have already explained to you, I would like you to tell me of a situation within your nursing profession where you were faced with a moral conflict and had to make a decision but were unsure of what to do. Could you describe a situation from beginning to end?

X: There was this woman who was approximately XX years old. She was blind. I conducted all the necessary assessment to check what was the cause of her blindness. I tried all that I can, but could not identify the cause of her blindness. I thought about referring her on to another hospital for further assessments. She explained the cause of her blindness as being witchcraft. She said there were major problems within her extended family, she believed that her blindness was a consequence of bewitchment form other family members. She said that some of her siblings have amputated limbs as a consequence of witchcraft. However, as a nurse I was supposed to refer her on for further assessments but I did not. Instead I thought of secretly referring her to a traditional healer.

QG: If this woman already suspected that the cause of her problems was witchcraft, why did she come to hospital?

X:There used to be no optholomnic nurse before in this hospital. Sometimes, even when people have been told over and over again that they will never be able to see, they never loose hope. They believe that by going to someone new, they might be told a different story.

QG: In the situation that you have just mentioned, what was the conflict for you?

X: The conflict was in not really knowing what I should do, should I refer this woman for further assessments or should I advise her to consult a traditional healer. The conflict was also the fact that we as black people have our beliefs and customs while at the same time, in our training we are taught what to do which is different to our beliefs. But we at same time know that there are customs which we should follow, so, the conflict was in not really knowing what to do.

QG: What did you eventually do?

---

[1] In the interest of confidentiality, this interview has been shortened and some identifying details have been deleted.

X: I secretly told her to consult a traditional healer whom I knew and she eventually confessed that she had been to a traditional healer before.

QG: How did your decision make you feel emotionally?

X: It was a very difficult decision for me but I consoled myself that I had done the right thing because I knew that there are things that can't be cured at the hospital. I have worked in rural areas before, people there believe strongly in traditional customs. We also saw many instances where traditional healing was beneficial.

QG: How did your decision affect your relationship with the woman?

X: I think she was quite pleased that there are nurses who do not look down on alternative forms of healing.

QG: What kinds of things did you consider in thinking about what to do?

X: I thought about how my parents had brought me up. At home, I was always reminded of the importance of respecting our traditions and customs. My parents used to say that, no matter how educated I become, I should always respect our traditions.

APPENDIX F
ANALYSIS OF APPENDIX E

| Case 5

Female

32 yrs | **Reading 1:**
<u>The plot:</u> A female optholomnic nurse sees a XX yr partially blind woman. On testing her she realises there are no organic bases for her blindness. The woman confesses that her blindness is a consequence of witchcraft and gives convincing reasons as to why this is so. Before reaching her decision the nurse considers what she was taught to do in her training yrs and her beliefs about Zulu customs and decides not to refer the woman for further assessments as expected, respecting her autonomy in this instance.
* At some point the nurse wonders if she did the right thing as she questions the validity of the woman's story but ends up acknowledging the limits of western medicine when applied to traditional African people.

<u>Response:</u> I was struck by the nurse genuineness and her sense of respect for her pts and thus my own beliefs were brought into play. | **Reading 2:**

* Self "I" comes across as respectful in relation to her pts.

* The self "I" is also defined as a nurse who considers the consequences of her decisions on the well-being of her pts.

* Self "I" is seen as showing a connectedness with Zulu traditional people, hence uses "we" when referring to their beliefs, signifying oneness with them *"thina bantu abamnyama sinezinkolelo zethu..., ..kukhona izinto zethu zesiZulu okufanele sizilandele"* and juxtaposes this against what her training informs her to do *"..kanti futhi sinezinto esizifundiswe kwi-training..."*

* The self is characterised as humane towards patients and approachable. | **Reading 3:**

<u>Relationships with pts:</u> These are characterised by respect and understanding, she accords them the power to make their own decisions about how they should be treated if the situations permits her to do so.

<u>Relationships with colleagues:</u> Sees that her colleagues like herself are not perfect human beings, hence is supportive of them, tells her pts when they come to her to complain about how other nurses ill-treat them that sometimes nurse do make mistakes ... *"ngesinye isikhathi omunye kade esembonile omunye u-sister, abuye azokhalela mina ebese ngizama ukuthi hhayi izinsuku azifani nathi ngelinye ilanga sibuye sithukuthele.."*. | **Reading 4:**

Family: acknowledges the importance of good family values in teaching about respecting traditional diversities amongst people.

Authorities: respects them and is able to stand for what she thinks is the right thing to do.

School(ing): considers the importance of referring to what one was taught and assessing if the situation will benefit from that or not.

Indiv's background: acknowledges individual differences amongst nurses based on the influence of the environment that one was exposed to; the effects of one's professional experience and the influence of one's upbringing . | **Summary**

* As a nurse one can't ignore the influence of one's beliefs, one's principles and one's background in thinking about moral issues.

* A moral nurse refrains from doing something that would hurt her pts. She always tries to think about the repercussions that her decision would have on the lives of her pts. |

APPENDIX G

A ZULU VERSION OF APPENDIX E

CASE 5[2]

QG: Begins with a full explanation of what is expected prior the interview. Gives participant a few minutes to think, then question 1 is posed.

QG: Njengoba besengike ngachaza ngizocela ukuba ucabange isimo esake senzeka emsebenzini la wawubhekene khona nesimo esinzima la kwakufanele ukhethe khona phakathi kokubili ukuthi ngizokwenza into elungile ehambisana nonembeza wami noma ngizokwenza into engahambisani nonembeza wami. Kulesosimo wazithola sewudonseka macala womabili ungazi ukuthi yini okwabe kufanele uyenze. Ngizocela udaba lwakho uluqale ekuqaleni uze ufike ekugcineni.

X: Kwakunomama owafika la owaye no plus minus XX years engaboni emehlweni ngase ngiya check(a)-ke yonke into ukuthi ngabe yini i-cause yokungaboni kwakhe. Ngathi sengixakekile ngingayitholi i-cause ngase ngicabanga ukuthi kungcono ngim-refer(ye) kwesinye isibhedlela for further assessments. Wase eyangichazela ukuthi ene uyasazi yena isizathu sokuthi eh yini engaboni. Wathi ukuthi ekhaya kunezinkinga uthi kwaxatshwana. So, ku-sort of i-punishment abayitholayo bona, abanye bayavaleka emehlweni, abanye balimale imilenze, banqunywe imilenze yomibili. Kodwa ke mina kwakufanele ngim-refer(ye) yena wathi ungabe usangiyisa ngoba i-reason ngiyayazi. Ngase nga-accept(er) lokho yize ngazi ukuthi kwakufanele ngimdlulisele phambili

QG: Uma ngabe lomama wayeyazi i-cause yokugula yini ayelindele ukuyithola lapha e-clinic?

X: Kwesinye isikhathi umuntu uyaye athi ene... Njengala e-clinic ibingekho i-optholomolic nurse, so, abantu ngisho sebetsheliwe kwezinye izindawo ukuthi angeke usaphinde ubone bazitshela ukuthi ngoba kukhona umuntu omusha mhlawumbe uzongitshela into engcono. Usenayo i-hope ukuthi mhlawumbe kukhona ozongitshela into engcono bese kubangcono ngibone

QG: Kulesisimo owawubheke naso yini eyabe iyinkinga ngokukanembeza yini le eyayikudonsela macala womabili?

X: I- conflict yayisekutheni ngabe ngingazi okwakufanele ngikwenze. Ngiyamdlulisela phambili yini for further assessments, noma ngiyambonisa ukuthi aye kubantu abelapha ngokwesiZulu. I-conflict futhi yayisekutheni thina bantu abamnyama sinezinkolelo zethu kanti futhi sinezinto esizifundisiwe sikwi training ukuthi kufuneka uma uhlangana nento enje wenze kanje at the same time nathi siyazi ukuthi kukhona izinto zethu zesizulu okufanele sizilandele, so, i conflict yayisekutheni ngithatha

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[2] Lengxoxo ifingqiwe ukuze kuvikeleke owayeyixoxile. Kanjalo namagama athile afihliwe.

kuphi?

QG: Wagcina wenzenjani?

X: Ngamtshela ngasese ukuthi aye kwabelapha ngokwesiZulu. Naye wagcina eshilo ukuthi wayeseke waya kwababonayo ngaphambilini.

QG: Isinqumo owagcina usithathile, ingabe sakuphatha kanjani ngokwemizwa yakho na?

X: Kwabanzima kakhulu kodwa ngaziduduza ngokuthi ngabe negnze into e-right ngoba ngiyazi ukuthi kunezinto ezingelapheki esibhedlela. Sengike ngasebenza ezindaweni lapho abantu bekholelwa kakhulu ezintweni zesintu.Sasizibona izinto eziningi ezabe zingelapheki esibhedlela.

QG: Isinqumo owagcina usithathile, ingabe sabenza babanjani ubudlelwane phakathi kwakho nalomama?

X: Wayejabule kakhulu ngoba wabona ukuthi basekhona o-nesi abangazibukeli phansi izinto eziphathelene nesintu.

QG: Yini eyakufikela emicabangweni yakho ngaphambi kokuba uthathe isinqumo sokuthi awumdluliseli phambili lomama?

X: Ngacabanga indlela engakhuliswa ngayo ekhaya mayelana nokuhlonipha amasiko nezinto nje zesintu. Abazali bami babehlale bengikhumbuza ukuthi ngisho ngingafunda kangakanani kumele ngiwahloniphe amasiko.