Meditative Thinking, Lived Experience and Ethics – Learning about the Nursing Culture

Submitted by Billie M. Severtsen, PhD, RN

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Introduction:

How do student nurses in a basic BSN program become socialized into the values and ethical norms of the nursing profession? The discipline of nursing requires of its practitioners specialized cognitive knowledge, the ability to understand and execute complex psychomotor skills and the incorporation of certain affective values into their professional lives. Cognitive nursing knowledge and nursing skills are typically taught today in theory courses and in practicum laboratories. The cognitive and psychomotor knowledge accumulated in these settings is then put into practice in a clinical facility under the guidance of a preceptor or clinical instructor. In this way, student nurses learn how to apply the knowledge from the classroom or laboratory to the client or patient in the clinical setting. The knowledge transmitted to students in the way described above is outcome centered; that is, it is designed to produce a nurse who understands and uses his or her knowledge base in order to function as a professional nurse in a certain (hopefully correct) way. Virtually all nursing texts use the same outcome oriented formula to present their specific content to students. Power point presentations, lectures, assignments, tests and even class discussions are also largely focused toward assisting students to apply nursing principles in order to achieve certain outcomes in the care of patients or clients.

Schools and colleges of nursing have taught content in the way just described very successfully for many years. These institutions prepare students to sit for, complete and pass the credentialing exam for nurses very well. Teaching and learning in this way is the end product of a specific kind of thinking that is used almost exclusively in contemporary society. Heidegger characterizes such thinking as "calculative". While asserting that calculative thinking is enormously useful and certainly indispensable in today's world, Heidegger adds the following critique:

> Its peculiarity consists in the fact that whenever we plan, research and organize, we always reckon with conditions that are given. We take them into account with the calculated intention of their serving specific purposes. Thus we can count on definite results. This calculation is the mark of all thinking that plans and investigates. Such thinking remains calculation even if it neither works with numbers nor uses an adding machine or computer. Calculative thinking computes. It computes ever new, ever more promising and, at the same time more economical possibilities. Calculative thinking races from one prospect to the next. Calculative thinking never stops, never collects itself. Calculative thinking is not meditative thinking, not thinking which contemplates the meaning which reigns in everything that is. (Heidegger, 1966, p. 46)

Heidegger contrasts calculative thinking with another kind of thinking. Meditative thinking is, in many ways the opposite of calculative thinking. Instead of computing new results and possibilities, meditative thinking is more concerned with reflecting upon the meaning implicit in the experiences encountered in daily life. Indeed, Heidegger urges his readers to examine reflectively our most immediate and personal experiences. He points out that meditative thinking is fundamentally different from calculative thinking. Like the latter, it requires effort, practice and care. But, Heidegger asserts, anyone can learn this kind of thinking because human beings are thinking beings and therefore meditative beings.

> Yet anyone can follow the path of meditative thinking in his own manner and within his own limits. Why? Because man is a *thinking*, that is, a *meditating* being. Thus meditative thinking need by no means be "high flown." It is enough if we dwell on what lies close and meditate on what is closest; upon that which concerns us, each one of us, here and now; on this patch of home ground; now, in the present hour of history. (Heidegger, 1966, p. 47)

What Heidegger seems to suggest is that meditative thinking is concerned with an interpretive function, i.e. a process of reflecting upon ones own experiences over and over again until the meaning and value of those experiences become clear.

Meditative thinking seems to fit better with the need of nursing students to learn about the culture and profession of nursing than calculative thinking. Students of nursing need to be exposed to and understand the values that underlie their profession. Only by learning what these values are and incorporating them into their practice will they be able to function as professional nurses. Additionally, only by understanding the values, both explicit and implied, that inform nursing actions taken by nurse colleagues and witnessed by students, can they differentiate their own professional behavior. Put another way, if student nurses are not clear on why a nurse co-worker behaves or acts in a certain way, the students are more likely to copy the actions of the nurse because "that's what nurses do". However, if students are socialized or taught to examine, reflect and meditate upon the behavior of their colleagues and co-workers, whether that behavior be "good" or "bad", students will be better able to deliberately choose how to respond to what they witness in clinical settings. They might consciously emulate and repeat behavior they see, or they might choose to act in a completely different way.

The place where students are taught about their profession and the values that inform it are the so called “Professional Development” classes. It would seem logical, therefore, that these courses be taught in such a way that allow students to meditatively think about the culture of nursing. However, these courses have long been the bane of nursing students and, additionally, of faculty assigned to teach these courses.

This statement is true, in part at least, because student nurses primarily learn about the nursing culture and profession through the lived experience of the clinical practicums that they are exposed to, not in large lecture theory classes. It is through working alongside nurses, physicians and other health care workers that students see how “things really are.” It is understandable, therefore, why a common reaction of students to a professional development course is to suggest that these courses be designated as electives or be dropped altogether in favor of increasing clinical practicum time. Students reason, quite logically, that they will profit from increased clinical time in the form of increased competence, better communication skills, greater familiarity with the workplace culture and a clearer understanding of the values that underlie the profession.

Several problems exist with learning about the culture of and the values that underlie nursing in the way described above. Most prominent among these issues is the fact that students have no specific chance to carefully reflect upon and interpret the culture of nursing as it unfolds around them in a clinical setting. Certainly students observe and interpret the behavior of others, including other nurses, on their own. Additionally, in clinical courses, there is usually time set aside for the clinical instructor or preceptor to

discuss the culture and demonstrated values of the “clinical world”. But the amount of time allotted to clinical conferences is small and often that time is spent in nursing care case presentations or skill acquisition. For the reasons described above, students in small clinical groups often have little opportunity to interpret, understand and critique the ethical values being demonstrated to them by their coworkers in clinical agencies. Therefore they do not have the opportunity to freely choose which ethical values to incorporate into their own professional practice.

Nursing educators have long recognized this need and, to speak to it, have incorporated “professional development” courses within the basic BSN curriculum. A problem, however, with many professional development courses is that they are taught in a traditional setting - - in a large group, with a textbook, a lecture format, case studies or projects generated by students and testing to measure cognitive gain. The setting and format of courses taught in this way does not meet the need of students to interpret the nursing culture to which they are being constantly exposed outside the “boundaries” of the professional development course.

Having been given the opportunity to teach such a class presented the challenges described above to me as a teacher. I began to wonder if a large theory course devoted to the topic of nursing as a profession and the values and ethics that underlie nursing could be taught in an interpretive way. Could such a course serve as a “safe place” for students to share, process, reflect upon and interpret the culture of nursing? Would students be more likely to self differentiate their actions from the ethical “group think” that often

occurs on nursing units as a result of group discussions in a course separate from the clinical practicum? Most important; would students be able to understand, freely choose and exhibit behaviors consistent with their own ethical values from among the various ethical stance position choices as a result of participating in the course discussions? Additionally, would students learn from the whole interpretive process and enjoy or at least appreciate the process of value clarification? Could a large class of over 60 students function as a community of learners given the usual academic constraints?

The course that emerged in response to this issue is called, "Professional Development:II – Ethical Decision Making". It has, to date, been taught eight times. By using narratives of the lived experiences of nurses in various health care settings and examining these narratives by using meditative thinking, the goals stated above have been met.

In Part one of this chapter, the meditative and calculative modes of thinking will be examined in detail. The process by which students in the class are introduced to this concept will be described. Additionally, the argument will be presented that meditative thinking is an excellent way for students of nursing to learn about the culture they aspire to enter. Part two will consider how narratives or stories of lived experience can be interpreted by a community of learners. The interpreted narratives can then generate new knowledge and insights about the clinical health care world where student nurses dwell. All persons have the capacity to differentiate their own goals and values apart from surrounding pressures; to say "I" when others are demanding "you" or "we". By examining and understanding the values of the culture of nursing in a safe environment

(like a classroom) it can be reasoned that students will have greater capacity for self differentiation. As such, they are more likely to make better ethical and professional decisions. Part three of the chapter will argue that teaching the class in the manner described above helps to demonstrate how students can be treated ethically and also teaches them ethics in terms of thinking/sharing/dialogue, rather than emphasizing ethical rules to follow.

Meditative Thinking and Calculative Thinking: A Comparison:

An essential difference between calculative thinking and meditative thinking is the property of openness. Whereas calculative thinking computes and, in so doing amasses knowledge for a particular or specific purpose, meditative thinking is characterized by openness. It does not actively seek to collect specific knowledge but rather dwells or exists "beyond the distinction between activity and passivity". (Heidegger, 1966, p. 8)

One commentator on Heidegger has further characterized this special kind of openness in the following way:

> Let us regard meditative thinking, then, as a higher kind of activity than is involved in the exercise of any subjective human power. We might think of it, metaphorically, as the activity of walking along a path which leads to Being. Certainly metaphorically, the conversation along the path referred to in the Conversation (on a Country Path) symbolizes such an activity and such a direction. In any case, this higher activity of thinking in relation to the openness involved in it is so important that it needs a special name. Releasement is a defining characteristic of man's true nature involving openness and, through it, direct and immediate reference beyond man to Being. (Anderson (in Heidegger), 1966, p. 25)

Releasement allows persons to choose whether or not to be influenced by what calculative thinking has established as the standard or the norm of behavior. For example,

it allows the meaning in such terms as “professional”, “ethical”, or “caring” to deepen as the meditative reflecting on these terms continues. Heidegger characterized the behavior or comportment which allows persons to remain open to the deeper meaning of things, “openness to the mystery.” He describes releasement and openness to the mystery in the following way:

> Releasement toward things and openness to the mystery belong together. They grant us the possibility of dwelling in the world in a totally different way. They promise us a new ground and foundation upon which we can stand and endure in the world of technology without being imperiled by it. (Heidegger, 1966, p. 55)

Is meditative thinking a good way for student nurses to learn about the culture of nursing – the culture that they work so hard to enter? Certainly important values and norms of that culture can be cognitively grasped by reading any professional nursing textbook. Such texts usually explore topics such as nursing history, social context of nursing, professional associations, philosophies of nursing, critical thinking, ethical and legal aspects, and future challenges to nursing. Each of the chapters of a typical text state in calculative terms the content that nurses have to know to achieve success as professional nurses. At the end of each chapter is a section of “key points” and another section of critical thinking exercises. For example, in one textbook, the chapter on nursing philosophies teaches students that certain values underlie nursing, that values should be chosen freely, be prized and be acted upon to be valid and that students would benefit from identifying and naming their health related values. (Chitty, 2004, p. 191)

Is reading, discussing and perhaps completing an assignment (all examples of calculative thinking) a good way to understand the values of the student and the values of nursing?

Certainly one can argue that it is an efficient way for aspiring nurses to grasp in a cognitive way the important values that inform the profession. Thus, it is a good starting point. Such content serves a specific purpose. True to calculative thinking it represents another thing that student nurses need to know. What content presented in this way does not do is encourage contemplation or reflection upon the meaning that permeates these values.

By contrast, consider the following scenario, taken from an ethical journal article:

> Mrs. Jordan is a fifty-two year old with Stevens-Johnson Syndrome, a rare disease that causes large, blister-like lesions to form on the skin and mucous membranes. In fatal cases blisters form in the lungs and kidneys, causing pneumonia and kidney failure. Doctors have been unable to find a cause or to do much to stop the downward course of her illness. Large, painful, weeping blisters cover her body, soaking her skin and bedding with bloody drainage.
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> Mrs. Jordan's unstable respiratory and cardiac status further complicate matters. Three days ago she stopped breathing. She was coded, resuscitated, and placed on a ventilator. At the time of arrest her blood pressure regulatory mechanisms also stopped working. Doctors ordered intravenous dopamine to maintain a blood pressure high enough to circulate the blood. Each day increasing levels of the drug have been needed to maintain an adequate blood pressure.
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> Several hours before her cardiac arrest, Mrs. Jordan told Janet, the nurse who had been caring for her during most of her stay in intensive care, that she was ready to go. "Even if I stay the same, you should let me go," she said. Janet clearly heard Mrs. Jordan discuss these same thoughts with her family on at least one occasion, and she and another nurse communicated this information to the physician. Moreover, Mrs. Jordan's advance directive states that she wants no life sustaining measures in the event of terminal illness.
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> Today, three days after the code, Mrs. Jordan's two daughters and husband are exhausted, worried and distraught. They told Janet they really wanted to let their mother go since, "She's not going to get any better."

> Janet approached the physician during morning rounds. "Dr. Johnson," she said, "This woman is terminal. Nothing seems to help. Her blood pressure is increasingly labile, even with the dopamine. The family wants to stop treatment. You are aware of what she said before the code. Her advance directive says no life sustaining measures. Why are we prolonging her agony?"
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> "I disagree," he replied. "This is a difficult disease to anticipate. We just don't know yet what is going to happen. We must stay the course." And with that he proceeded to the waiting room and conveyed his opinion to the family.
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> Frustrated and exhausted, the family returned to the unit after talking with the doctor. They were adamant about not wanting further treatment and were convinced that their mother would not want it either. They even talked about switching doctors and fighting the system. However, when several nurses offered to help them with the process, the family declined, saying they were simply too tired to try.
>
> After the conversation with the family, Janet went back to care for Mrs. Jordan. She got a new bag of IV fluid, labeled it as if she had added dopamine to the bag (but did not) and hung it to run continuously.
>
> Over the next several hours Mrs. Jordan's blood pressure fell and she rapidly deteriorated. Janet called the doctor to report the patient's failing condition. "I guess you were right," he told Janet. "She's not going to make it. Do not resuscitate her if she codes. I'll be in later." Twenty minutes later Mrs. Jordan died.
>
> Did Janet fulfill her obligations to the patient, to the family or to her profession? (Hastings Center Report, 1997, 27 (5), p. 23)

This story represents an opportunity for students to be open to the deeper meaning of the story. In the narrative, the nurse attempts to embody the professional values understood and deeply prized by nurses. She honors the autonomy of the patient and her family by attempting to communicate the clear desire of Mrs. Jordan to the physician. She gives compassionate care to both patient and family. She is a true advocate. Janet and the other

nurses on the unit are in the best position to listen to, understand and convey the wishes of patient and family. Yet, as stated in the commentary of this case study:

> There should also be procedures that protect the conscience of caregivers and staff. If we recognize that there will be differences in moral judgments about what is or is not appropriate for a case, then people should not be forced to act against conscience or make solitary, rash decisions. There should be appropriate mechanisms for health care workers to "sign off" a case where there is a conflict of conscience. An institutional system should be such that anyone involved in the case can easily bring forward his or her ethical concerns for discussion. (Hasting Center Report, 1997, 27 (5), p. 24)

In the absence of the safeguards, cited in the above commentary, Janet performs an action that is clearly illegal and immoral.

As students reflect upon this story, they are initially struck by the superficial context of the narrative. Questions like, "Was this a rigid or power hungry doctor?" or "I'll make sure that I never work in a place that would treat nurses like Janet was treated." are soon replaced by deeper reflection. As students experience releasement, they begin to identify with the powerlessness of the nurse in this situation. The hierarchy of power in health care institutions can make it very difficult to live out the values that the students have learned and that they wish to inform their practice. As the students reflect still further they begin to understand the various ways that the situation with Mrs. Jordan and her nurse could be played out. Could Janet, the nurse, have communicated better with the doctor? Should there be institutional safeguards such as a patient advocate office for situations like this? Should a nurse, or any concerned person, be able to access the

hospital's ethics committee easily? Could a group of nurses, acting together and in an assertive manner, proactively avoid a situation like the one that happened to Mrs. Jordan?

As new meanings evolve out of the story, students are finally able to deeply understand the values that they are expected to choose, prize and act upon. They begin to see that it is often very difficult to live out these values at all times, but through reflection in a group upon a story such as this, they can begin to formulate new ways of perceiving the narrative and its meaning for them. Thus, to again paraphrase Heidegger, (the students) are granted "the possibility of dwelling in the world in a totally different way." (p.55)

Narratives used as an aid in self differentiation:

Differentiation is the capacity of an individual to define himself or herself. Friedman, one of the pioneers of systems theory has characterized it in the following way:

> Differentiation means the capacity of a (family) member to define his or her own life's goals and values apart from surrounding togetherness pressures, to say "I" when others are demanding "you" or "we". It includes the capacity to maintain a (relative) nonanxious presence in the midst of anxious systems, to take maximum responsibility for one's own destiny and emotional being. It can be measured somewhat by the breadth of one's repertoire of responses when confronted with crisis. The concept should not be confused with narcissism, however. Differentiation means the capacity to be an "I" while remaining connected. (Friedman, 1985, p.27)

Given the above definition of self differentiation, it is axiomatic that one must understand the values and norms that undergird any system (such as the culture of one's profession) in order to choose one's response to those values. Put another way, for student nurses to

incorporate the values that form the core of professional nursing, they must first learn those values, observe or witness how the values inform the practice of nursing, choose to emulate the values and finally to act in accordance with the value choices they have made. They must also understand how important it is to freely choose each value. In other words, students must learn to differentiate themselves from the ways in which they see other nurses and even other student nurses acting. Unless they examine, understand and freely choose to embrace, prize and act in accordance with the values that they see modeled for them, they will not have the capacity to make thoughtful and ethical decisions for their practice, the patients that they care for, or for their profession. Self differentiation also prepares the "ground" of the organization for healthy change. As Friedman states: "It is the maintaining of self differentiation while remaining a part of the (group) that optimizes the opportunities for fundamental change." (p. 29) Additionally, persons who learn to self differentiate themselves while remaining part of the system avoid the twin traps of solitary, disconnected independence on the one hand and cloning or "group think" on the other hand.

A fundamental question to ask then, is can self differentiation be accomplished (relative to the culture of nursing) in a classroom setting? Examining narratives in the way described in part one of this chapter can also serve as a modality or a way for students to practice self differentiation. A useful way to begin this process is to ask students to consider the material or information in a narrative and to think about the story in a way that avoids the ideas of "should" or "must". To return to the paradigm narrative cited earlier, most students clearly identify that nurse Janet acted illegally by hanging an IV

bag, labeling it incorrectly and not adding the ordered dopamine to the IV. But the conversation about the behavior of the nurse and the values behind her actions can be further elaborated. Did Janet embody professional values? To say that she did not because she acted illegally is true but also a somewhat simplistic answer to a complex situation. What knowledge can students gain by thinking about this situation devoid of "should" or "must". Must nurses always follow the orders of physicians even when they clearly disagree with those orders? Should a nurse cease from advocating for what a patient and family clearly desire because of an institutional hierarchy? What happens in situations where nurses feel powerless or trapped from doing what they feel is right? As one commentator states:

> This institutional focus reveals where the real moral failure occurred – with the institution. The decision and burden of aiding Mrs. Jordan in her death should not have been the private, secret choice of Janet, who perhaps felt powerless to do what she thought was right. (Hasting Center Report, 1997, 27 (5), p.24)

Examination and discussion of the narrative in the manner described above often serves as the impetus for students sharing their own stories. These narratives range from student's experiences in clinical settings as students, students as friends or family members of patients or even students sharing their own experiences as health car consumers. Each narrative is deconstructed in the same way. First, the story is shared with the group. Next, questions are encouraged to clarify exactly what happened and what values are being embodied in the actions of the participants. Next, the students are encouraged to share how they feel about the actions of the nurse or other health care worker in the story. As the instructor, I steer the group discussion away from any value

judgment about what a professional nurse “should” or “must” do. Instead, students are encouraged to think about what they would do in a similar situation. Through this process they learn and have an opportunity to think about what self differentiation behavior looks like in the context of the narrative. Students learn to start thinking about what they would do as professionals instead of simply judging whether the nurse in the story acted appropriately or not. As an example of the process just described, a student shared a story about caring for a patient in an acute care setting. The patient, who was diagnosed with pneumonia, as well as a variety of chronic cardiac problems, had an order for intramuscular penicillin to be administered. The order had been written by a physician who had known and cared for this patient for many years. Before the student prepared the medication, she checked the patient’s chart for evidence of allergies. She found that the patient had reported an allergy to penicillin upon admission. She immediately notified her clinical instructor who, in turn, notified the head nurse. The student was anxious to discuss with the physician why he had ordered penicillin for a patient who had an allergy to that medication. The head nurse told both the student and the clinical instructor that she would notify the doctor and would subsequently “take care of the problem.” The student, although disappointed that she was not being encouraged to talk to the doctor herself, thought that the matter was settled. She was surprised to find noted on the patient’s chart later that morning that the penicillin had been administered by the head nurse. She was even more surprised and upset to witness the doctor angrily confronting the clinical instructor and threatening to forbid any students from working with his patients in the future “if they don’t trust me enough to follow my orders.”

When this narrative is "unpacked," students tend to focus on the "good guys" – the student and the clinical instructor and the "bad guys" – the head nurse and the physician. If the discussion continues to frame the narrative in terms of good guys and bad guys, it turns into a discussion of what the various participants in the narrative should do. Viewed from this perspective, students tend to think about either going along with the head nurse's actions (after all, the patient didn't die) and remaining part of the group of nurses on that unit or challenging the doctor and his decision making and therefore becoming emotionally and relationally separated from the other nurses.

However, if students are instead encouraged to think about this story in self differentiated ways, it becomes a narrative about understanding why each person acted in the way that they did and then choosing how they (the student) might respond in a similar situation. It is very likely that the doctor, who had treated the patient for years, was aware that an allergy to certain antibiotics did exist. If he ordered a specific type of penicillin which the patient had tolerated well before, it is understandable why he did not grasp the student nurse's reluctance to administer the medication. The patient, having experienced a drug reaction sometime in the past, would certainly report an "allergy to penicillin" if that was his understanding of his previous experience. The head nurse, who deals with the pressures of a busy unit to manage, is anxious to implement and monitor the medical protocol for this patient as soon as possible. She is also expressing a value that many nurses, particularly nurses educated prior to 1960, hold – namely the value of silent obedience to the orders and protocol designated by the doctor. Both the student nurse and the clinical instructor are more interested in finding out why such an apparently unsafe

order is written by the doctor. Their expressed value is fidelity or beneficence to the patient. They are interested in protecting him from harm and consequently not administering a drug that would compromise his well being. From a presumed understanding of why each participant acted as they did, the students can come to a choice of what values they themselves might demonstrate in a similar situation. Is it better, in a situation like this, to be obedient to the point of not questioning a potentially dangerous order, or is it more professional to question the doctor in a respectful, but assertive way? Moreover, should there be a protocol or agreement within the unit and the institution that supports nurses in their role as professionals and provides an atmosphere where nurses and doctors can work collaboratively without a rigid power gradient interfering with optimum patient care.

Regarding the last point about changing the atmosphere in an institution, when students begin to think about fundamentally changing the ways that people relate to one another in a hospital for example, they are thinking about modeling new behaviors and therefore, how to exercise non anxious leadership. Nurses, as a group have been characterized as passive-aggressive. This purported trait is usually tied to the lack of power that nurses have historically had within health care institutions. If this claim is true, a way to break the cycle of passive-aggressive "group think" is to encourage self differentiated leadership. This kind of leadership starts with understanding situations and making deliberate and non anxious choices while still remaining connected to one's peers and coworkers.

Teaching and Learning about Ethics through Thinking/Sharing/ and Dialogue:

Ethics concerns itself with the study of morality, i.e. issues of right and wrong. It is, therefore, organically connected to values – both one's own personal values as well as the values that inform a profession. Students usually learn about ethics in terms of ethical rules to follow. Typically they are taught ethics vocabulary; e.g. definitions of common ethical terms, various kinds of ethical issues or dilemmas, ethical principles that guide nursing practice and the ethical rights of health care consumers. The basic vocabulary material is followed by an examination of the two classic rule based ethical systems – Deontology, which focuses on duty or means, and Teleology (Utilitarianism), which focuses on outcome or consequences. An examination of virtue ethics and the various subsets of that system usually rounds out the student's exposure to ethical content in a theory class. (Volbrecht, 2002, p.16)

There are several problems with this approach to teaching ethics. One challenge that presents itself is that students are not used to thinking about their clinical practicum experiences in ethical terms. They perceive clinical experiences in terms of science and therefore, by definition, in a calculative way. Both medicine and nursing are heavily weighted with applied science. Science tends to be value neutral whereas ethics is about morality and moral behavior. Students also view themselves, for the most part, as relatively powerless (in an ethical sense) in clinical situations. They view physicians, who diagnose and implement medical protocols as powerful and they likewise view patients and their families who make the decisions that allow health care to be implemented as

strong players in any ethical issue that might occur. But they view themselves as somewhat irrelevant in these scenarios. Add to this the typical student's unfamiliarity with ethical vocabulary and terms and their inability, at least initially, to use ethical argument and the result is often a student who learns the ethical content superficially at best and who rarely, if ever, utilizes this important concept in his or her nursing practice.

The use of meditative thinking combined with both paradigm narratives and the students own lived experience stories provides a useful way to address the problems referred to above. Certainly a starting point for gaining knowledge about ethics is to understand ethics vocabulary and the focus of the various ethical systems of thought. In the course, this content is made available to students and presented as a set of tools that will enable them to start to think about ethics. As this introductory material is presented, many examples are used to illustrate the points being made. As discussed earlier, students are encouraged to think deeply about the examples and be open to seeing the nuances in each situation. As students reflect together on the examples, they begin to see that there is usually not one right answer or rule to follow, but that each example presents a scenario that can be viewed in a variety of ways. For example, one example involves two nurses who work on an unit where many seriously ill patients, who often are immunocompromised, are being cared for. (Aiken, 2004, p. 175) The unit is short staffed because of a respiratory virus infecting many workers. The two nurses realize that they are exhibiting the initial signs of the viral illness. Should they continue to work with the patients or should they return home to care for themselves (leaving the unit even more short staffed.)

An example like this is familiar to students and it is easy for them to imagine themselves in a similar position. As students discuss the example, the discussion is again steered away from a rule based orientation to the scenario. Instead of discussing what the correct choice is for these nurses to make, students are encouraged to think about and share what they themselves would do in such a situation. They are also encouraged to provide a rationale as to why they would act in the way they have just described. To use the same example cited above: A student might share that he or she would stay at work, perhaps take some over the counter medication and continue to care for patients. The student is then asked to provide rationale for his or her choice of action. If the rationale is that it is better to stay and care for patients because the absence of nurses leaves the unit even more short staffed and there is on a possibility that any patient will contract the virus, the instructor could point out that the student's response indicates a valuing of consequence or outcome over strict duty or motive. Upon further reflection, students might be encouraged to think more deeply about contrasting ethical frameworks. Is valuing a teleological approach to ethical problems over a deontological approach always best? Is valuing one rule based approach over another a reflection of the student's own core values or can ethical approaches differ, depending on the context of the ethical issue and situation? Finally, in the discussion, students are asked to hypothetically put themselves in the situation. What pressures might be put upon them to choose one action over another? How important would it be for them to "go along" with what the head nurse or supervisor feels that they should do? How congruent would the choice they ultimately make be with their own personal value system? How does that choice agree with or differ from what they were taught in school? How would they articulate their choice to their

supervisor? To a physician whose patient they were caring for? To their patients and the families of those patients?

From a discussion like this students are able to identify the deeper ethical meaning in the example. They also can identify the values associated with each choice that the players in the situation might make. When students reach the point of understanding the value choices that people can potentially make in any situation, they are in a position to again think about this specific example in a self differentiated way. Which value would they choose and why? This exercise reinforces the idea that a hallmark of professional behavior (including the behavior of professional nurses) is to say, "This is what I choose to do" as their professional value response.

After the introductory material related to ethics is thoroughly discussed, utilizing numerous examples, as was cited above, students are introduced to several assignments that allow them to continue their reflective thinking about ethics. All these assignments ask the students to think in a meditative way about the story. In addition, they all ask the students to choose how they, themselves, would act in the story. This, of course is another way to encourage self differentiation.

The first assignment asks the students to read another ethical case study from the Hastings Center Report: (HCR, 1998. p. 28) The case study is entitled, "An Alert and Incompetent Self; The Irrelevance of Advance Directives." It tells the story of an elderly patient with progressive respiratory failure and psychosis. She suffers a "major blood

episode" and, consequently, ends up in a long term ventilator support unit, intubated, with a tracheostomy and a feeding tube. Permanent brain damage can not be ruled in or ruled out. The patient is confused at times, but content, and most importantly alert. She seems to enjoy watching TV and interacting with staff and visitors. She has a five year old living will that states that she does not want to be kept alive by artificial means if she has "no reasonable expectation for recovery from extreme physical or mental disability." She has no family, but two close friends and her primary care doctor request that she be removed from the ventilator based on her living will decisions and her current condition. None of these people requesting removal from the ventilator are legally designated proxies. However, they have known the patient for over 50 years. The critical care doctor and staff disagree with the request and strongly object to the proposed action, believing the patient to be improving and also citing her reply of "no" to their queries of does she want to be removed from life support. After bringing this case to the ethics committee, the decision is made to support the critical care team. However the primary care doctor is told that if he wishes to transfer the patient to another hospital where a doctor can be found to diagnose that the patient is incompetent to speak for herself, his wishes and those of the two friends can be carried out without objection from the first hospital. The primary care doctor does find such a facility and a cooperative doctor, the patient is transferred, she is diagnosed with permanent brain damage by a neurologist, the ventilator is removed, and the patient dies one week later.

Students are asked to reflect on this case study in several ways. First, they are asked to identify the ethical issue or issues. Immediately the situation becomes complex. It is not

just a matter of should the patient be removed from life support. The actions of each of the three doctors, the two friends, the patient and the critical care staff need to be examined and understood. Next students are asked to cite which ethical principles are most relevant to the story. The usual list of ethical principles includes beneficence, non-maleficence, fidelity, veracity, and justice. Commonly understood legal rights coming from the U.S. Constitution include the right to autonomy and the right to life. (Volbrecht, 2002, p. 4) The situation that the students are asked to analyze is so complex that each principle or right can be interpreted as having either great relevance or little relevance to the story. For instance, was justice to the patient served? On the one hand, yes, because her living will request and the wishes of her two close friends were honored. On the other hand, no, because she, herself, stated that she wanted to remain on life support and at least one doctor felt that her condition was improving. Students analyzing the situation realize that a rationale for either honoring or dishonoring each principle can be made. Therefore, it becomes impossible for the students to choose the "right" answer because there is no objectively "right" answer. Consequently, students are forced to start to think of this scenario in terms of what value choice they would make if they were one of the participants in the story and why that value choice seems right to them. Next they are asked to consider what their duty to the patient is. Following this question, another one asks them to consider the best outcome or consequence for the patient. In this way, the deontological and teleological perspectives of the case are addressed. Again, these questions point out the complexity of the story. Is one's duty to preserve life at all cost? Is it to honor the autonomous wishes of the patient – and if so, what really are those wishes? Is the best outcome to remove the patient from the ventilator, thus honoring the

wishes of the people who know her the best? This later solution would certainly conserve scarce resources. Or, does allowing the patient to be removed from life support when she says, “no”, diminish the value that we as a society put on life itself? Students are next asked to state who the stakeholders in the situation are. Answers vary widely; from a narrow interpretation of the stakeholders being the two friends, the primary care doctor and the critical care doctor and staff to a very broad interpretation that stakeholders include all human beings who might find themselves in a similar circumstance. Finally, students are asked what a client advocate should do in a situation like this. Responses range from doing nothing and letting the story come to its inevitable end, to asking legal authorities to evaluated the situation using a guardian ad litum. Although the assignment is a written one, students are asked in a class session to share what they would do as client advocates and to provide rationale for their choice. This exercise again, reinforces the idea of meditative thinking, that is, thinking about a familiar situation again and again, dwelling upon it, to use a Heideggerian term, in order to uncover the hidden meaning in it. As Heidegger observes:

> There is then, in all technical processes, a meaning, not invented or made by us, which lays claim to what man does and leaves undone. We do not know the significance of . . .technology. The meaning pervading technology hides itself. But, if we explicitly and continuously heed the fact that such hidden meaning touches us everywhere in the world of technology, We stand at once within the realm of that which hides itself from us, and hides itself just in approaching us. That which shows itself and at the same time withdraws is the essential trait of what we call the mystery. I call the comportment which enables us to keep open to the meaning hidden in technology, openness to the mystery. (Heidegger, 1966 p, 55)

By sharing what they would do in this situation as client advocates, students also have an opportunity to explore their process of self differentiation. The nurses in this case study are essentially invisible. They are passive observers of the drama that unfolds around them. In this assignment, students are not allowed to remain passive. Hence, they are forced to think about their behavior and to contrast it with what they see modeled to them in the case study.

In the relative safety of the classroom, the issues related to this scenario can be fully explored. By fostering an environment where every opinion is backed up with rationale and where there is an understanding that the overall goal is not consensus about what is the correct ethical stance, but rather an understanding and respecting of diverse opinions and ideas, students can begin to think deeply about the ethical dimensions of their practice. As they share their insights with others and listen to what others have to say, new understandings of the case study can emerge. Students are often able to expand their repertoire of professional value responses to the ethical dilemma because of the class discussions and their expended knowledge of the issue.

For example, in the “Alert and Incompetent” case study, students usually move from a judgment stance about whether or not it was appropriate to move the patient to a second hospital to thinking and sharing about how the worst case scenario of the patient in this story can be avoided. How did the patient get to the point of being ventilator dependent given her living will? Why were conversations with the two friends and the primary care doctor delayed until after long term ventilator support was initiated? If the critical care

nurses truly believed the patient to be improving, why did they stand passively by while she was transferred to the second hospital, when the purpose and outcome of the transfer was clear to all? By sharing their thoughts with others, listening to what others have to say and creating an ethical dialogue around this case study, students are able to practice becoming more resilient in their thinking; i.e. not always having the same solution to every problem, but being able to consider a repertoire of professional responses.

Another assignment designed to foster the idea of ethics as thinking/sharing/dialogue is one which asks students to share their own story of an ethical dilemma. Students are asked to tell a real story in which they were involved with the health care system as a consumer of health care, an employee of a health care agency, or a student nurse. The story should be one where the student is able to identify an ethical dilemma within the narrative. Students are asked to apply the basic concepts of virtue ethics to the situation they have described. By framing the story within a virtue ethics framework, students are able to move from thinking about ethics as rules to follow toward thinking about ethics as personal comportment of the nurse within a specific context. Virtue ethics, with its hallmarks of virtuous players (conscientious people trying to do the right thing), emphasis on clear, honest, non-hierarchical communication, and its directive to work proactively to prevent worst case scenarios, provides a way to look at ethical issues that is much more sensitive to context. (Volbrecht, 2002, p. 96) It also provides a way to directly and specifically involve nurses and their actions, since it tends to objectively recognize the ethical responsibility of each player in the situation. After students have written their story and analyzed it within a virtue ethics framework (in the written

assignment), they are asked to share it by reading the story and analysis in class. As with the first assignment, sharing the story with classmates and meditatively thinking upon it to uncover its meaning has proven to be a fruitful experience.

As an example, one student shared a story of being assigned to care for a patient recovering from extensive colon surgery (including a permanent colostomy) secondary to a diagnosis of colon cancer. The patient was recovering uneventfully from a medical point of view. However, her psychological adaptation to her changed body image and her loss of control, due to her colostomy and a diagnosis of cancer, produced a patient who was angry, non compliant and very difficult to work with. The student writing the story had heard other nurses on the unit refer to this patient as, “the patient from hell.” Upon being assigned the patient in question to work with, the student was told by her team leader that, “This assignment will be good for you. Challenging patients are good ones for students to learn on.”

Eager to care for the patient in the most optimum way, the student quickly found herself stuck between two opposing camps - - one being the patient who, although cooperative and respectful to the student, continued to insist that all the other nurses were “terrible” and that she wanted only the student to care for her, and the other being the unit nurses who maintained their conviction that the patient was deliberately being “bad” and that she needed to be disciplined in some way to foster her recovery. Consequently, the student found herself in a classic emotional triangle formed by the patient, the unit nurses

and herself. Friedman notes that emotional triangles can be formed by any three persons or issues. He states:

> The basic law of emotional triangles is that when any two parts of a system become uncomfortable with each other, they will "triangle in" or focus on a third person, or issue, as a way of stabilizing their own relationship with one another. A person may be said to be "triangulated " if he or she gets caught in the middle of such an unresolved issue. Conversely, when individuals try to change the relationship of two others (two people or a person and his or her symptom or belief), they "triangle" themselves into that relationship (and often stabilize the very situation they are trying to change.) (Friedman, 1985, p. 35)

In this situation, the student was the triangled person, as she was caught in the center of an unresolved issue between the patient and the unit nurses. In addition, another triangle was formed between the unit nurses, the clinical instructor and the student. By the team leaders remark that, "students need challenging patient," it is possible to hypothesize that the student is being set up to not only care for the patient, but also is being asked (in a covert way) to bring change to the relationship between the patient and the unit nurses. Understandably, the student felt very uncomfortable in the situation. She realized that this was not just a simple assignment where all she needed to do was give excellent care to a difficult patient. Yet, the message that the student received was exactly that – give this patient excellent care and you will be making many people, including patient, unit nurses, and clinical instructor, feel much better about this entire episode.

As students thought about the shared story and, as they began to dialogue with each other about what the student should do in a situation such as this, they begin to uncover some

of the psychological “laws” or “rules” that apply to emotional triangles. It should be noted that, instead of receiving a list of the rules that govern emotional triangles, the students, in the classroom, uncover this information in the guided discussion about the narrative that the student has shared. They begin to understand how the student was trapped by her assignment and how they themselves might be (or perhaps already had been) set up to intervene and become trapped in a similar situation. As persons generally committed to a value system that demonstrates altruism, nurses are particularly vulnerable to being caught in emotional triangles as they attempt to “do the right thing.”

To deconstruct the student’s story it is necessary to understand how emotional triangles occur and the consequences or outcomes that are the results of triangulation. Friedman has postulated seven such “laws”. Each will be elaborated and then applied, using the student’s story as an example.

> “1. The relationship of any two members of an emotional triangle is kept in balance by the way a third party relates to each of them or to their relationship. When a given relationship is stuck, therefore, there is probably a third person or issue that is part of the homeostasis.” (Friedman, 1985, p. 36)

The relationship of the patient and the unit nurses are kept in a homeostatic or balanced state by the way that the student nurse related to each party. She cares for the patient in a competent and holistic way, thus allowing the patient to maintain her stance that the nurses are uncaring, punishing and unsympathetic to her illness. Conversely, because the

student takes care of the unrepentant "bad" patient, the unit nurses can continue to regard the patient as "the patient from hell."

"2. If one is the third party in an emotional triangle it is generally not possible to bring change (for more than a week) to the relationship of the other two parts by trying to change their relationship directly." (Friedman, 1985, p. 37)

The student nurse is asked to deliver good care to the "bad" patient. By implication, she is being asked to change the dynamic between the unit nurses and the patient. Probably no one realizes that the current perceptions of the patient by the nurses or of the nurses by the patient will probably not be altered at all by what the student nurse says or does. Neither patient, nor nurses are deliberately trying to trap the student. However, by their reluctance to address their relationship issues with each other, they are attempting to shift the responsibility for their relationship problems onto the student. This helps to explain why the student feels so uncomfortable with her assignment. She realizes that what she is being asked to do, in a subliminal or covert way, is not her responsibility.

"3. Attempts to change the relationship of the two sides of an emotional triangle not only are generally ineffective, but also, homeostatic forces often convert these efforts to the opposite intent. Trying harder to bring two people closer . . . will generally maintain or increase the distance between them." (Friedman, 1985, p. 37)

The student gives excellent, holistic care to the patient, thinking that this will convince the patient that the nurses (after all, the student is a student nurse) are trying to and are capable of helping her. She also assumes that the unit nurses will understand and be more empathetic to the patient situation and her non compliant behavior because of the interpretation of that behavior by the student. The story that she read in the classroom and the subsequent discussion that followed revealed her surprise that her good efforts had exactly the opposite effect. The nurses still characterized the patient as impossible to work with and the patient still found the nurses to be mean and unsympathetic.

"4. To the extent a third party to an emotional triangle tries unsuccessfully to change the relationship of the other two, the more likely it is that the third party will wind up with the stress for the other two." (Friedman, 1985, p. 27)

The student brought this story to class in response to the assignment that asked her to think about an ethical issue that had happened to her. Throughout the reading of her story and in the subsequent discussion, she frequently expressed her feelings of discomfort and stress with the situation that she found herself in. She knew that there was something ethically "wrong" in the scenario even though she herself was giving good care to the patient. Several times during the discussion, the student stated that she felt terrible being in the situation even though she couldn't precisely identify the reason for that feeling. Usually students and nurses feel good about being able to give good nursing care. In this case, however, the student is carrying the stress for the failed relationship between the

patient and the unit nurses. Consequently, the student experiences negative feeling about the whole episode without understanding why she feels this way.

"5. The various triangles in an emotional system interlock so that efforts to bring changes to any one of them is often resisted by homeostatic forces in the others or in the system itself." (Friedman, 1985, p. 38)

As students discuss this story it becomes clear that a whole set of interlocking triangles are present. The patient, student and unit nurses are one triangle. Another is the nurses, the clinical instructor and the student. Another is the physician, the nurses and the patient and still another is the student, her fellow students and the unit nurses. When the student is assigned to care for this patient and as she tries to change the dynamic between the patient and the unit nurses, change also occurs in the other triangles mentioned above in an effort to maintain homeostasis in the system as a whole. For example, the student may not fully trust the clinical instructor in the future because she may feel like the instructor somehow "set her up" for this situation. Or the unit nurses may try to convince the physician that the patient is not deserving of holistic, excellent care, because she doesn't cooperate with the nurses.

"6. One side of an emotional triangle tends to be more conflicted than the others. In healthier (systems), conflict will tend to swing round the compass, so to speak, showing up in different persons or different relationships at different times. In

relationship systems that are not as healthy, the conflict tends to be located on one particular side of a triangle." (Friedman, 1985, p. 38)

Because the student nurse is not an integral part of the nursing staff on the hospital unit, she is less likely to be involved in the myriad triangles that typically occur in a health care workplace. The nurses who work on any nursing unit may be regularly caught up in such emotional triangles, but they are often unaware of the specific triangle dynamic that can be found in their work setting. They may attribute their discomfort with triangulating circumstances to such things as "burnout" or "job stress." For students, however, who are eager to change the health care world, one patient at a time, by their professional practice, the realization that conflicts between nurses and patients often do occur is disheartening and somewhat frightening. They usually understand that they, as students, are in some sense protected from the interpersonal stress of the unit. But they often also come to expect that the stress that they witness among unit nurses will be an inevitable part of their workplace experience when they graduate. Understanding the dynamics of triangulation can assist their anxiety about assuming the role of registered nurse.

"7. We can only change a relationship to which we belong. Therefore, the way to bring change to the relationship of two others (and no one said it is easy) is to try to maintain a well defined relationship with each, and to avoid the responsibility for their relationship with one another. To the extent we can maintain a "nonanxious presence" in a triangle, such a stance has the potential to modify the anxiety in the others. The problem

is to be both nonanxious and present. Anyone can keep his anxiety down by distancing, but that usually preserves the triangle." (Friedman, 1985, p.39)

This "rule" of emotional triangles is perhaps the most important one because it clearly shows how to avoid the triangulation process in the first place. Friedman makes the point (which was reiterated in the classroom discussion of the student's story) that maintaining a well defined relationship to others without accepting responsibility for their relationship with a third entity is not easy in every case. However, it is crucial. It is also a good way to conceptualize thinking about ethical comportment. Ethics is all about doing the right thing within the context of a relationship with someone else. Implied in that statement is the idea that there are some relationships where doing the ethical thing is not part of our responsibility as nurses. The essential learning about this concept is to think about and understand clearly where one's relationship responsibilities lie, to cultivate and maintain those relationships in a well defined manner and to attempt to maintain a "nonanxious presence" in a triangle situation where no relationship responsibility exists. What the student learned from sharing her story and the subsequent discussion was that her only responsibility was to care for the patient. Certainly part of good nursing care is to assess, communicate and plan care collaboratively with the patient, implement care and document her findings. If other nurses can learn from the example the student set, or if the patient can gain some insight, from general communication with the student, about her relationship problems with the other nurses, that is well and good. But it is not the student's job to either reform the "patient from hell" or to change the patient's perception of the "terrible nurses." Once the student and her classmates understood that idea, their

anxiety was markedly lessened. They gained an understanding, in the classroom setting, of not only how to approach the typical "difficult patient" but also some awareness of the entire emotional triangle process.

Conclusion:

This paper has attempted to describe the process used, in a large professional development class setting, to introduce and socialize students to the values and ethical norms of the culture and profession of nursing. Instead of using calculative thinking processes such as power point presentations or examinations to explore the content of nursing as a culture, a more meditative or reflective thinking approach was utilized. The material that served as the "ground" for meditative contemplation were the narratives or stories shared in the classroom setting. These were reflected upon, discussed by the class participants and finally interpreted for their inner meaning by the community of scholars.

Early on, in the course, students were introduced to the idea that meditative thinking means remaining open to the releasement to the mystery of the meaning found in the stories brought to the class. Heidegger encourages people to give priority to this kind of thinking, since, he asserts, it is the most authentic thing we can do. It is, in Heidegger's words, "mans essential nature" to think in this manner. He speaks of, "a great danger" – greater than another World War – if people forget how to meditatively think.

> What great danger then might move upon us? Then there might go hand in hand with the greatest ingenuity in calculative planning and inventing

> indifference toward meditative thinking, total thoughtlessness. And then? Then man would have denied and thrown away his special nature – that he is a meditative being. Therefore, the issue is the saving of man's essential nature. Therefore, the issue is keeping meditative thinking alive. (Heidegger, 1966, p.56)

What is found when a story or narrative is meditated upon? Heidegger maintains that the nature of truth is essentially hidden and that any particular fragment of truth becomes revealed through steadfastness to the meditative process. This steadfastness was given the name "indwelling" by the philosopher, who characterized it in the following way:

> Indwelling
>
> Never one truth alone;
> To receive intact
> The coming forth of truth's nature
> In return for boundless steadfastness:
> Imbued the thinking heart
> In the humble patience
> Of unique high minded
> And noble memories.
>
> (Heidegger, 1966, p. 82)

This, then, was the task of the students in the class. Rather than focus on the rules that govern ethical comportment, an attempt was made to present the class content as a series of discussions among a specific community of scholars. The task of this community was to remain steadfast to the meditative thinking process as the various narratives were interpreted. As students practiced "indwelling," they were able to resist the simplistic "right answer" for the more nuanced "coming forth of truth's nature."

Students also explored the concept of self differentiation in the class. They learned, through stories, how powerful self differentiation is, both in the area of ethical discourse and also as a model for leadership. The idea of being able to lead through self differentiation is particularly attractive to student nurses, who often feel themselves to be on the powerless end of the power gradient so often found in health care institutions. Friedman cites three distinct components that characterize self differentiated leadership. First, the nurse leader must remain connected.

> The concept is basically organic: for any part of an organism to have a continuous or lasting effect, it obviously must stay connected. This is not nearly as easy as it may seem. Remaining connected becomes increasingly difficult in direct proportion to the leader's success at defining his or her own being (the second compartment). It is far easier for a head to remain attached if it is content to merge its "self" with the body. Any leader can stay in touch if he or she does not try to stand out. The trick, as we shall see shortly, is to be able to differentiate self and still remain in touch despite the body's efforts to counter such differentiation. (Friedman, 1985, p. 229

Secondly, the nurse leader must be able to "take nonreactive, clearly conceived and clearly defined positions." (Friedman, 1985, p. 229) He postulates that the health and even the very survival of organizations (such as the nurses on a particular unit) depends on the capacity of its leader to, "Define self and continue to stay in touch." (Friedman)

A third leadership component is the ability of the nurse leader to deal with the unintentional sabotage that inevitably surfaces among the more poorly differentiated members of the organization. Friedman characterizes this sabotage in the following way.

> The more poorly differentiated members . . . will be quickest to feel the

> pull-out when the head (of the organization) tries to emerge from the undifferentiated state of the organism. What they feel will be at the deepest cellular level, because they have fused with their leader. It is almost as though they experience part of their own self being ripped away. Their response is unthinking, automatic, and always serious. It by-passes the "conscious" and is more biological than the "unconscious." It is like a twitch. It is instantaneous and . . . tends to be that which succeeded in triangulating the leader in the past, a reflexive effort to reestablish the old homeostasis. (Friedman, 1985, p. 230)

The solution to this dilemma is, according to Friedman, "the leader's capacity to maintain a position and still stay in touch" that stabilizes and allows the organism to grow. "Crucial here is the leader's capacity to distinguish process from content, and the ability to be playful, that is, not serious or anxiously helpful." (Friedman, p. 230)

One of the greatest gifts that we can give to others is their understanding that their ethical comportment is related to how well they know themselves. Therefore it is important, for nurses, that they bring themselves to others in ways that allow those others to know themselves. This profound learning was addressed again and again in the classroom discussions and in the assignments completed by the students. Rather than "feeding" the students cognitive material related to the values and ethical norms of professional nursing, they were encouraged to know themselves through meditative thinking. Self differentiation was introduced as a concept that assists students to bring themselves to others in ways that help the others to know themselves. It is hoped that the experience of attending this professional development class will motivate the students in the class to practice meditative thinking, self differentiated nursing behavior and ethical comportment as professional nurses.

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