Applying kants ethical theory to nursing

Immanuel Kant was born in 1724 in Königsberg, which is today the city of Kaliningrad in the Russian exclave of Kaliningrad Oblast (Watkins, 2002). He was raised in a Pietist household that stressed intense religious devotion, personal humility, and a literal interpretation of the Bible (European Graduate School [EGS], 2010). Kant wrote numerous works in his lifetime but most of Kant's work on ethics is presented in two works, The Foundations of the Metaphysics of Morals written in 1785, and the Critique of Practical Reason written in 1787 (McCormick, 2006).

In order to understand Kant's ethical views, his views on duty, reason, freedom, and good will should be explored. Freedom plays an important role in Kant's ethics. A moral judgment presupposes freedom (McCormick, 2006). Also, freedom is a notion of reason, so without the assumption of freedom, reason cannot proceed. On the other hand, reason can only be satisfied with assumptions that practical observation cannot support. Reason seeks knowledge or understanding that it cannot comprehend (Williams, 2009).

The question of moral action is an issue for rational beings. There is nothing in a rational beings character to waver. It will always match the dictate of reason. Humans are not wholly rational beings. We can either follow our natural instinct or non-rational impulse. Thus, rules of conduct are needed to guide human's actions.

Will is the ability to act according to the law. Outcomes of our actions are beyond our control. The only thing we can control is the will behind the action. Morality of an act must be assessed in terms of the impulse behind it.

Kant says “ good will” as the only thing unconditionally good because it cannot be used for ill purpose.

Kant argued that moral requirements are based on a standard of rationality he dubbed the Categorical imperative. Categorical imperative is defined as the standard of rationality from which all moral requirements are derived (Categorical imperative, 2007). It is an imperative because it is a command. It commands us to exercise our wills in a particular way. It is categorical because it is unconditionally and applies to everyone at all times (Hinman, 2006). CI requires an autonomous will. It is the presence of this self-governing reason in each person that Kant offered decisive grounds for viewing each person as possessed of equal worth and deserving of equal respect.

There are three maxims or categorical imperatives that Kant’s theory are based on. The first categorical imperative is Universalisability which states that, “ Act only according to that maxim whereby you can at the same time will that it should become a universal law.” The second categorical imperative is the Law of Nature which states that, “ Act in such a way that you treat humanity, whether in your own person or in the person of any other, always at the same time as an end and never merely as a means to an end.” The third categorical imperative is known as the Kingdom of Ends states that, “ every rational being must so act as if he were through his maxim always a legislating member in the universal kingdom of ends” (Kant, n. d., ¶ 43).

The first maxim shows Kant’s ethical theory asserts that right actions are those that practical reason would will as universal law. In other words, if the course of action someone plans to take can be willed upon everyone then it is an ethical choice (Davison, 2006). A moral maxim must have universality and could be applied to any rational being.

The second maxim is often seen as introducing the idea of respect for persons, for whatever it is that is essential to humankind (Johnson, 2004). The second maxim expounds on the perfect duty concept in preventing exploitation of others or anyone as a means to an end.

The third maxim combines the others in that it requires that we conform our actions to the maxims of a legislator of laws and that this lawgiver lays down universal laws, binding all rational wills including our own. The idea behind this formulation is that our fundamental moral obligation is to act only on principles which could earn acceptance by a community of fully rational agents.

Kant used the term good will to define the resolve to act purely in accordance to one’s duty. He believed that using reason, a person could work out what one’s duty was. Good will is making moral decisions without considering personal happiness or pain avoidance. Duty must be done whether a person wants to or not(Johnson, n. d.). Duty consists of bare respect for lawfulness. x

Explanation of Watson’s Theory of Caring

Watson’s first major publication, Nursing: The Philosophy and Science of Caring, began as a class notes for a course she was developing (Tomey & Alligood, 2002). This publication was developed in 1979, and revised in 1985 and 1988. According to Watson, the book emerged from her “ attempt to bring meaning and focus to nursing as an emerging discipline and distinct health profession with its own unique values, knowledge and practices, with its own ethic and mission to society (Watson, 2007, ¶ 1). Watson used the term “ carative factors” to describe the framework for the core of nursing values. These carative factors complemented conventional medical “ curative factors” by adding the theory of human caring to the medical focus of cure (Watson). Watson’s major assumptions of the science of caring in nursing are the following:

Caring can be effectively demonstrated and practiced only interpersonally.

Caring consists of carative factors that result in the satisfaction of certain human needs.

Effective caring promotes health and individual or family growth.

Caring responses accept person not only as he or she is now but as what he or she may become.

A caring environment is one that offers the development of potential while allowing the person to choose the best action for himself or herself at a given point in time.

Caring is more “ healthogenic” than is curing. A science of caring is complementary to the science of curing.

The practice of caring is central to nursing (Watson, 1979, p. 8)

Watson based her theory for nursing practice on 10 carative factors (Watson, 1979, p. 9). The first three factors served as the “ philosophical foundation for the science of caring” (Watson, 1979, p. 10).

The formation of a humanistic- altruistic system of values.

Humanistic and altruistic values are learned early in life but can be greatly influenced by others and life experiences. This factor is defined as satisfaction through giving and extension of the sense of self (Watson, 1979).

The instillation of faith-hope.

This factor facilitates the promotion of holistic nursing care by developing effective nurse-patient relationship.

The cultivation of sensitivity to one’s self and to others.

The recognition of feelings leads to self actualizations through self acceptance for both the nurse and the patient. When the nurse is able to acknowledge their feelings, they are more sensitive to the feelings and needs of their patients.

The development of a helping-trust relationship

The development of a helping-trust relationship between the patient and the nurse is crucial for the expression of both positive and negative feelings. This helping-trusting relationship develops rapport and caring. It involves

congruence, empathy, nonpossessive warmth, and effective communication (Watson, 1979).

The promotion and acceptance of the expression of positive and negative feelings.

The expression of feelings is a risk taking experience for both the nurse and the patient. The nurse and the patient must be prepared for each moment of expression.

The systematic use of the scientific problem-solving method for decision making

Use of the nursing process brings a scientific approach to decision making.

The promotion of interpersonal teaching-learning.

This factor allows the patient to be well informed about their care in order to participate in their plan of care and healthcare decisions. The nurse is the facilitator with the use of teaching-learning techniques appropriate for the patient.

The provision for a supportive, protective and /or corrective mental, physical, socio-cultural and spiritual environment.

The nurse must be aware of the external and internal factors that may affect the well being of the patient. The nurse also must provide comfort, privacy and safety as a part of this carative factor (Watson, 1979).

Assistance with the gratification of human needs.

The nurse must recognize the biophysical, psychological, and intrapersonal needs of the patient. The patient must satisfy lower order needs before attempting to attain higher order needs. Watson suggested that the nurse also must provide comfort, privacy and safety as a part of this carative factor (Current Nursing, 2009).

The allowance for existential-phenomenological forces.

This factor helps the nurse view the patient holistically while attending to the patient's needs. Watson considers this factor to be difficult to understand but is included to provide thought provoking experience leading to a better understanding of the self and others (Watson, 1979).

Nursing: Human Science and Human Care- A Theory of Nursing was published in 1985. The purpose of the book was to address some of the problems that still existed in nursing (Tomey & Alligood, 2002). Her most recent book, Caring Science as Sacred Science (2005), " seeks to bridge paradigms as well as point toward transformative models for the 21st century" (Watson Caring Science Institute, 2009).

As Watson continued to evolve her theory, she introduced the concept of clinical caritas process (Watson, 2005). The caritas process has greater spiritual dimension and overt show of love compared to the original carative factors (University of Colorado Denver, 2007).

Embrace altruistic values and practice loving kindness with self and others.

Instill faith and hope and honor others.

Be sensitive to self and others by nurturing individual beliefs and practices.

Develop helping – trusting- caring relationships.

Promote and accept positive and negative feelings as you authentically listen to another's story.

Use creative scientific problem-solving methods for caring decision making.

Share teaching and learning that addresses the individual needs and comprehension styles.

Create a healing environment for the physical and spiritual self which respects human dignity.

Assist with basic physical, emotional, and spiritual human needs.

Open to mystery and allow miracles to enter (Watson Caring Science Institute, 2007).

Watson (1999) characterized a transpersonal caring relationship as a special kind of human care relationship that depended on the nurse's moral commitment in protecting human dignity, nurse's caring consciousness to preserve the embodied spirit, and to potentially heal because of this connection (Watson, 2007). Transpersonal relationship is a deeper connection of the mind, body and spirit, and the intentional caring for the whole being of the patient. The relationship is unique because the nurse and the patient bring their individuality to the moment, and if a different nurse or patient is injected to the moment, a different experience would exist.

According to Watson (1999), a caring occasion is the moment when the nurse and the patient come together with their uniqueness and an occasion for caring is created. During the moment that the nurse and the patient are together, each would decide how to react and to take advantage of the moment to heal and to share. The whole caring-healing-loving consciousness is contained within a single caring moment (Watson, 2007).

Explanation of Benner's Novice to Expert theory

Benner has numerous influences in her body of work. She acknowledges that Virginia Henderson influenced her in her nursing thinking (Tomey & Alligood, 2002). She also worked as a research assistant for Richard Lazarus in University of California, Berkeley. He mentored her in the field of stress and coping. Hubert Dreyfus was a philosophy professor at Berkeley during the time Benner was getting her doctorate degree. He introduced her to phenomenology. Hubert Dreyfus, together with Stuart Dreyfus, developed the Dreyfus Model of Skill Acquisition which Benner applied in her work From Novice to Expert (Benner, 1984).

Benner's work as the author and the project director of a federally funded grant, Achievement Methods of Intraprofessional Consensus, Assessment, and Evaluation (AMICAE) led to the publication of From Novice to Expert (Tomey & Alligood, 2002). Benner and Wrubel further explained the background to this study in The Primacy of Caring: Stress and Coping in Health and Illness (Benner & Wrubel, 1989).

In the AMICAE project, 1200 nurse participants completed questionnaires and interviews, with 51 participants observed by trained researchers. Paired

interviews were conducted with preceptors and preceptees, and nurse clinicians with newly graduated nurses and senior nursing students. These interviews “ aimed at discovering if there were distinguishable, characteristic differences in the novice’s and expert’s description of the same clinical incident” (Benner, 1984, p. 14). The interviews also “ described characteristics of nurse performance at different stages of skill acquisition” (Benner, p. 15). This study led to the use of Dreyfus’ five levels of competency, namely novice, advanced beginner, competent, proficient, and expert, to describe skill acquisition in the nursing practice. Each stage builds on the previous one as the nurse gains clinical experience.

By analyzing the transcript from the interviews, 31 competencies emerged from the nurse’s detailed description of patient care. Each of these domains was described with the related competencies from the exemplars describing nursing practice (Tomey & Alligood, 2002). From these competencies, 7 domains were derived according to similarity of function and intent:

The helping role

The teaching-coaching function

The diagnostic and patient-monitoring function

Effective management of rapidly changing situations

Administering and monitoring therapeutic interventions and regimens

Monitoring and ensuring the quality of healthcare practices

Organizational work-role competencies (Benner, 1984)

By using the model in nursing practice, Benner noted that “ experience-based skill acquisition is safer and quicker when it rests upon a sound educational base” (Benner, p. xix).

Benner defined skill and skill acquisition as the actual use of skilled nursing intervention and clinical judgment skills in actual clinical situations (Benner, 1984). This accumulation of nursing skill and knowledge is relevant only when these skills and knowledge are used to improve patient outcomes and improve patient care.

Benner added to her research from the first study to a six year study of 130 hospital nurses, the majority from the critical care areas. She presented the results of the study on her book Expertise in Nursing Practice: Caring, Clinical Judgment, and Ethics (Benner, Tanner, & Chesla, 1996). Benner states, “ In the study we found that examining the nature of the nurse’s agency, by which we mean the sense and possibilities for acting in particular clinical situations, gave new insights about how perception and action are both shaped by a practice community.”(Benner et al., p. xii). Phase two of this study also produced nine domains of critical care nursing practice. They are:

Diagnosing and managing life-sustaining physiological functions in unstable patients

The skilled know-how of managing a crisis

Providing comfort measures for the critically ill

Caring for the patient’s families

Preventing hazards in a technological environment

Facing death: end of life care and decision making

Communicating and negotiating multiple perspectives

Monitoring quality and managing breakdown

The skilled know-how of clinical leadership and the coaching and mentoring of others (Benner, Hooper-Kyriakidis, & Stannard, 1999).

With a sound educational base, nurses develop skills and patient understanding through clinical experiences. Benner proposed that the “ know-how” or gaining of knowledge and skill can be acquired without the “ know-to” or learning the theory (Benner, 1984). Significant clinical experience is a prerequisite to attaining the higher stages of skill acquisition (Dracup & Bryan-Brown, 2004). x

Application of Benner’s work in nursing practice

Benner’s work, especially the five stages of skill acquisition, has been applied in administration, education, practice, and research (McEwen & Wills, 2007). Benner’s seven domains of nursing roles have been used by Schools of nursing in their school philosophy (Liberty University Department of Nursing, 2009), and also in many hospital institutions (Nuccio et al., 1996, Alberti, 1991). Benner’s novice to expert skill acquisition was used in establishing expectations for both staff and administration in the implementation of laptops in the home care setting (Larrabee, 1999). In another application of Benner’s levels of skill acquisition, the University of

Maryland, Baltimore School of Nursing used Benner's concept to establish protocols for the development of patient care simulation for students (Larew, Lessans, Spunt, Foster, & Covington, 2006). Benner's model was also used to guide nurses in taking care of handicapped children in the school setting (Pesata, 1994). Benner's skill acquisition framework has also been used in research (Cusson & Strange, 2008; Lyneham, Parkinson, & Denholm, 2008; Fuller & Conner, 1997; Maynard, 1996).

Clinical Nursing Situation

All names used in this narrative have been changed to protect anonymity. Aaron was 28 years old when he was admitted in the community hospital due to meningitis. He stayed in the hospital due to complications like sepsis and bacteremia. He lost a tremendous amount of weight, and eventually his muscles atrophied, and his joints became contracted. His parents were unable to cope with the situation so they stopped visiting him in the hospital.

Aaron was transferred to the County hospital where I worked. I first met Aaron when he was admitted to the intensive care unit. He came in with sepsis and pneumonia which required him to be connected to the mechanical ventilator for support. His 80 pound thin frame was evident especially since he was six foot tall. The only command he could follow was to look at you.

For the whole week, I was assigned to him. I learned to change the channels to any sports related shows. I would tell him about sports games I watched or read about. He would just look at me waiting to hear more. I learned to suction him without triggering him to have bronchospasm. By the end of the

week, I saw the hospital’s palliative care physician come in to check on the patient. The physicians, after much discussion with Aaron’s parents, decided to disconnect Aaron on the weekend from the mechanical ventilator and to start comfort measures as soon as he was removed from the ventilator.

The next day, I was the nurse in charge of the whole unit. I was not initially assigned to Aaron but had to take over his care when the nurse originally assigned to him could not handle the emotional situation. As I walked in the room, I saw Aaron struggling. He was breathing loudly in the 40s. It sounded like a saw going through a hollow tree. He was using his accessory muscles to breathe. His heart rate was double where his baseline heart rate was. He was diaphoretic. This was not a comfortable death.

I increased the morphine rate to 10 milligrams per hour as ordered. I wet a washcloth with cold water and started wiping Aaron’s forehead. He looked at me but instead of the sad look, he had a painful look and tears in his eyes. I turned on the television to the music channel where it was playing soft music. All these measures did not help Aaron’s respiratory distress. Aaron’s attending physician walked in. He suggested giving a bolus of and starting propofol drip to ease Aaron’s respiratory distress. I gave the bolus and started the propofol drip.

Aaron was breathing in the 10s and his heart rate was back to where his baseline was. Dr Herms sat down beside Aaron and held his hand. I continued to wipe his forehead, and to talk to Aaron. A few minutes after starting the propofol drip, Aaron’s breathing stopped and he passed away.

Application of Kant’s Ethical Theory

In order to adhere to the categorical imperatives and as a result make ethical choices, one must distance oneself from their emotions. It is a matter of stepping out of ourselves and thinking of the effects our decisions have on others.

In applying the first CI by Kant, " Act only according to that maxim whereby you can at the same time will that it should become a universal law"(Immanuel Kant, 2009, ¶ 44), we must first formulate a maxim for the reason of the action. Second part is to use that action as a universal law governing all rational agents. The third part is whether to consider the maxim as conceivable in a world governed by laws. The last part is whether you as an agent will act on the maxim. If you could do all steps, the action is morally permissible. In this case, a high dose of sedative and narcotic is given to help with Aaron's respiratory distress. This action is permissible for end of life measures and is conceivable in today's world. Thus, the administration of high dose of narcotics and sedatives for respiratory distress is morally permissible.

The second CI states that " Act in such a way that you treat humanity, whether in your own person or in the person of any other, always at the same time as an end and never merely as a means to an end" (Immanuel Kant, 2009, ¶ 44). Aaron being a rational being demands respect. As a human being, Aaron has the right to die peacefully and with less suffering. Any symptoms of his struggle and suffering should be addressed in order to achieve his due end.

As the nurse who volunteered to take over a coworker’s assignment, I had the free will to choose to help or not. Since I know Aaron, I understand the situation and agree with the plan of care. I was bound by my duty to help Aaron die with little or no pain. The health care providers assigned to Aaron’s case had the right motive to allow him to have a peaceful humane death. x

Application of Watson’s Theory of Caring

Embrace altruistic values and practice loving kindness with self and others.

This system of values is what makes the nursing profession human. Each nurse brings to the profession their own set of altruistic and humanistic values that each have learned in their lifetime. In this case, my value for a life is strong. My desire for each person to die with dignity and with someone by their side is important. So even if I was busy that day being in charge, I dropped everything in order to assist the physician to give the necessary medications, and just simply to be there for Aaron until he passed away.

Instill faith and hope and honor others.

This factor facilitates the promotion of holistic nursing care and describes the nurse’s role in the development of effective nurse-patient interrelationship. Since I took care of the patient for a week, I learned small nuances about the patient to know what his needs are. I had learned what sports teams he liked, and what kind of songs he listened to. These may seem small things, but when you look at a person, you see everything about them. As nurses, we aim to foster that faith of our patients in us that we are going to do what is best for them.

Be sensitive to self and others by nurturing individual beliefs and practices.

The recognition of feelings leads to self actualization through self acceptance. It is hard to know if Aaron has accepted his fate (since he was nonverbal), but personally, I was able to accept that everything was done for this patient. We had done everything that we could, and at that point we had to assist him to his peaceful death.

Develop helping-trusting-caring relationships.

The development of a helping-trusting-caring relationship involves empathy, warmth, and effective communication. With the time that I worked with Aaron, I told him the treatment, and activities we planned to do. I recognized that even if he wasn’t able to vocalize his needs, he still had feelings and needs.

Promote and accept positive and negative feelings as you authentically listen to another’s story.

The positive and negative expression of feelings was more on the parents’ side. I never saw his parents come to visit in the morning but I have heard that the physicians and social workers were in regular contact with the family. During the course of the end of life measures, there were discussions between the medical and nursing staff on how to make things easier for Aaron. Although Aaron was not able to verbally express his feelings, his nonverbal cues like facial grimacing, tearing up, and labored breathing was enough to communicate his needs.

Use creative scientific problem-solving methods for caring decision making.

After we extubated Aaron, he went into respiratory distress, in spite of the morphine drip and other medications given. After recognizing that the treatment was not effective, the palliative care doctor consulted another attending physician. A decision was made to give propofol. During the time of discussion, other nursing measures were instituted like music, touch, and cold compress to the head. The scientific problem solving method used involved assessment, plan, treatment, and evaluation of treatment given.

Share teaching and learning that addresses the individual needs and comprehension styles.

Although no active teaching-learning experience was done, Aaron was still informed of the treatment, medication, and plan of care. The teaching-learning process was more dynamic between the nursing and medical staff about end of life measures. All the teaching-learning process was still directed towards the care of Aaron.

Create a healing environment for the physical and spiritual self which respects human dignity.

I was focused on the adequate pain relief, supportive caring environment for Aaron. He was never left alone. All the healthcare providers were communicating with Aaron what was being done.

Assist with basic physical, emotional, and spiritual human needs.

Biophysical, psychophysical, psychosocial and intrapersonal needs of the patient were attempted to be met. According to the Aaron’s family, he was neither religious nor spiritual so that was respected.

Open to mystery and allow miracles to enter

As Aaron’s health care providers, we allowed ourselves to be instruments for his care. The miracle is the passing away of suffering and start of after life for Aaron.

The transpersonal relationship between Aaron and I occurred from the moment I was assigned to him, and attempted to get to know his history and needs. We each brought our uniqueness to the relationship. My acceptance of Aaron’s situation and my commitment to take care of him helped foster a healing environment for Aaron. The caring moment occurred whenever I would seek to find out what his needs are, and attempting to fulfill his physical, social, psychological, and spiritual needs.

Application of Benner’s Novice to Expert Theory

In applying Benner’s work in the clinical exemplar, the prerequisite in providing appropriate nursing care is through knowing the patient. In this case, getting to know Aaron was harder since he was nonverbal and his family was not there to answer questions regarding Aaron. Benner called these patients the silent patient (Benner, 2002). I worked in the critical care unit for five years. This time gave me the opportunity to acquire skills in being attentive to patient’s needs especially those who are sedated or paralyzed, and acquire knowledge and expectations in the progression of disease and end of life measures.

In applying Benner’s seven domains of competencies, I was able to use majority of the functions. I was in the helping role in managing Aaron’s pain

and discomfort. The teaching-coaching function allowed me to coach Aaron in slowing down his breathing. I was able to monitor Aaron’s progression, and this allowed me to effectively manage his changing situation. I was able to administer therapeutic interventions to ease Aaron’s pain. Through it all, I was working with the health care team.

In Benner’s nine domains of critical care nursing practice, I will focus on my function as providing end of life care for Aaron. Benner described dying as “ central to human identity, and it forms a part of everyone’s history (Benner, Kerchner, Corless, & Davies, 2003, p. 558). She further states that “ palliative care should address symptom management comprehensively and flexibly so that the person’s comfort and dignity are preserved” (Benner et al., p. 558).

As part of the healthcare team who provided care to Aaron’s last hour, I made sure Aaron had a comfortable dignified death by providing the best care I have learned through all my years of clinical experience. x

Conclusion