An application of Habermas's work on communication and discourse ethics to advocacy.

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AN APPLICATION OF HABERMAS'S WORK ON COMMUNICATION AND DISCOURSE ETHICS TO ADVOCACY.

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CONTENT

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ABBREVIATIONS

'D'	Discourse Ethics
NHS	National Health Service in the UK
NMC	Nursing and Midwifery Council of the UK
'U'	Universalism
UKCC	United Kingdom Central Council for Nursing, Midwifery and Health Visiting. (Replaced by Nursing and Midwifery Council on 1st April 2002).
UK	United Kingdom
USA	United States of America

GLOSSARY

Advocate

The term is defined by Thompson (1995:20) as; 1) 'a person who supports or speaks in favour.'

Communicative Action

The theory of communicative action is described in Habermas (1995). According to Habermas (1995:ix), it is linked to 'moral-philosophical, rather than empirical-psychological considerations.' The goal of people who undertake communicative action is to reach a common understanding and harmony with regard to a situation.

Conventional Level of Moral Development

According to Kohlberg (1981), the conventional level of moral development refers to the individual's adoption of family, groups and society's rules. The rules of the group replace that of the parents as a basis of authority and the belief system that has been internalized by a child can be considered as a conscience.

Critical Theory

The roots of critical theory lie prior to the Second World War, when the Frankfurt School carried out philosophical and social investigations that were critical of the culture, economics and politics of Western societies. The Frankfurt School developed a philosophy called 'Critical Theory' that is discussed in Habermas (1987:381-2) and could be used to criticize ideology. Critical Theory poses questions that relate to the goal of an individual with reference to their society. Where there is a dominant social system, critical theory is concerned with the emancipation of people.

Discourse

Defined by Allen (1990:333) as; 'a connected series of utterances; a text ... talk, converse.'

Discourse Ethics

As described in chapter seven, according to Habermas (1995:65), discourse ethics ('D') can be considered as a framework for the conduct of moral discourse. Habermas identifies discourse ethics as having three principles that will be discussed in part two of the thesis, these are:

1) A principle of universalisation, where there is the intention to set conditions for impartial judgement.

2) The conditions for practical discourse are identified, from which universally valid norms may emerge, that could meet the needs and be accepted by the participants.

3) Those who are involved can only achieve a consensus when there is free participation.

Health Authority

An administrative body in the National Health Service that is involved in the provision and monitoring of patient care.

Ideal Speech Situation

According to Giddens:

> 'An ideal speech situation is one in which there are no external constraints preventing participants from assessing evidence and argument, and in which each participant has an equal and open chance of entering a discussion.'
>
> Giddens (1985:131)

Lifeworld

Habermas offers the following definition:

> 'I can introduce here the concept of the *Lebenswelt* or the Lifeworld, to begin with, as the correlate of processes of reaching understanding. Subjects acting communicatively always come to an understanding in the horizon of a lifeworld. Their lifeworld is more or less formed from diffuse, almost always unproblematic, background convictions.'
>
> Habermas (1984:70),

Nursing and Midwifery Council

Nursing's professional regulatory body that replaced the functions of the United Kingdom Central Council for Nursing, Midwifery and Health Visiting and the four National Nursing Boards on 1st April 2002. The NMC has published a Code of Professional Conduct that came into effect on the 1st June 2002.

Preconventional

Kohlberg (1981) describes the preconventional level of moral development that can be applied to children up to the age of ten, who are too young to develop their own belief systems. The standards used are based on the authority of others for example, parents.

Postconventional

For Kohlberg (1981), a person at the postconventional and principled level of moral development may wish to make a stand with regard to an issue that is based on a personally held conviction.

Systems Theory

According to White, systems theory:

> 'envisions strategic actions guided by systemic imperatives. These imperatives operate through the "de-linguistified media" of money and power.'
>
> White (1994:100)

Universalism

Habermas states that:

> 'For a norm to be valid, the consequences and side-effects that its *general* observance can be expected to have for the satisfaction of the particular interests of *each* person affected must be such that *all* affected can accept them freely.'
>
> Habermas (1995:120)

Validity Claims

Validity claims are necessary conditions for discourse and therefore form the basis for the occurrence of proper communication. Proper or undistorted communication can be considered as language used when speakers can defend all of the following four validity claims, as identified by Habermas:

a) 'That the communication should be comprehensible,

b) based on truth and

c) should reflect the rightness,

d) truthfulness of the content.'

Habermas (1995:58)

ABSTRACT

The aim in this thesis is to form a link between Habermas' work on discourse to that of writers on advocacy. There has been a demonstrable need for advocacy in differing societies and this is apparent when one considers the developments that have occurred, for example, concerning the treatment and care of patients and clients in the British Health and Social Services. In this thesis, instances of client and patient care that are less than satisfactory are described and illustrated, as in the Pink case. These demonstrate an identified need for patient and client support. Also, it is acknowledged that the act of becoming a nursing advocate may involve the exposure of the nurse to personal risk.

The thesis considers the views of two British and three United States writers on advocacy. I have come to the conclusion that the USA based perspective, as offered by Sally Gadow (1983), can be considered the most convincing. Gadow has been able to form a philosophical basis for advocacy that can be applied globally. This is founded on the premise that a patient ought to be the person making decisions concerning his or her treatment and care. Gadow takes the view that the role of the nurse advocate ought to involve that of supporting patients, while at the same time offering respect with regard to their wishes.

A description of Habermas' (1995) work on communication and discourse ethics, his framework for an evaluation of competing norms and communication with reference to relevant theory is offered. A link is made between Habermas' work and that of advocacy theorists as Gadow and to my knowledge, this is the first time that such a link has been made.

PART 1 ADVOCACY

CHAPTER 1 INTRODUCTION

1 Preview

There have been many headlines in the UK press concerning cases of alleged poor care of patients in the NHS. For example, The Guardian (27th January 2002) offers a description of an elderly patient, Rose Addis, whom, it is alleged, was left for a long period of time on an inner London hospital trolley, with a lack of attention from staff.

Some of these cases result from a lack of communication between health care staff and patients, or their relatives. Others may relate to a lack of liaison between staff, or their inability to make a stand against colleagues and make their views known. Accounts of such instances in the press describe events that have had a profound effect on both the staff and patients involved. It could be argued that if those who were charged with the responsibility for patient care had assumed an effective

advocacy role, some of the situations described in the press might have been prevented. The aim of this thesis is to form the basis for an understanding of such an advocacy role.

2 Definition of Advocacy

The word 'advocacy' may be interpreted and understood in different ways. Therefore, to arrive at a common understanding of the term, it is important that a definition is offered.

Thompson defines advocacy as:

> 'Support or argument for a cause, policy etc.'
>
> Thompson (1992:13)

Writers on the topic of advocacy within nursing have indicated their differing perspectives. Therefore, having defined 'advocacy' it would be helpful to offer a literature review.

3 Literature Review

Having undertaken a review of the available literature on advocacy, I have come to a view that the British Advocacy perspective, as applied to nursing, is adequately articulated in Gates (1994) and Teasdale (1998). Similarly, the North American advocacy perspective is represented by references to the work of three nurses, Gadow (1983), Kohnke (1982) and Curtin (1979).

In support of the above assertion, it can be seen that Johnstone (1995) makes extensive reference to the above three North American perspectives, as does Mallik (1997), in her review of literature on advocacy and her (1997), paper on 'Perceptions of Practising Nurses.' There are similar references in Mallik's (1998) paper, with regard to the nursing elite in the United Kingdom, also in Mallik and Rafferty's (2000), paper on 'Diffusion of the Concept of Patient Advocacy.'

A discussion concerning the nature of the relationship between the nurse and patient occurs in Morse (1991) and Ramos

(1992). The main sources for all these authors are the commentators referred to above, i.e. Gates, Teasdale, Gadow, Kohnke and Curtin. Similarly, the professional implications for nurses of assuming a role as patients' advocate are explored by Grace (2001), Willard (1996), Copp (1986) and also in Snowball (1996), whose papers refer to the identified North American perspectives.

The problems with regard to the nurse undertaking an advocate's role are detailed in Martin (1998), Bird (1994), Hewitt (2002), Allmark and Klarzynski (1992), and Woodrow (1997). Their references suggest that the majority of the literature on advocacy, with regard to nursing, originates either from Britain or North America. They often refer to Gates, Teasdale, Gadow, Kohnke and Curtin.

I will now consider advocacy with reference to the above perspectives. The five chosen authors offer differing accounts of advocacy that reflect the differing social philosophies of the United States and United Kingdom.

For Mallik (1997), the United States perspective reflects this society's acknowledgement of the importance of human rights, with reference to the rise in the Civil Rights Movement and its citizens awareness of the potential implications of the development of medical technology and distrust of experts. According to her, the United States perspective is also linked to the rise of consumerism, where the citizen as a consumer who has paid for his or her care through an insurance plan, expects that an adequate level of service should be provided.

The United Kingdom's perspective differs somewhat, in that the National Health Service Act (1947), was based on the assumptions that the 'citizens have a right to basic health care', and 'the State has a duty to provide health care for all.' The United Kingdom's National Health Service Act (1947) perspective, that 'citizens have a right to basic health care,' could be considered as similar to the philosophy held by the United States, which acknowledges the need for a state health care safety net for its citizens. However the main difference arises in the duty of the United Kingdom, as a state, 'to provide health care for all,' as described in the National Health Service

Act (1947), a function largely fulfilled in the United States by personal insurance.

This is illustrated when one considers the different methods of funding of healthcare in the two countries. According to the 'Healthcare Market Review,' with reference to the United Kingdom:

> 'In 2000, total expenditure on the main healthcare services of the NHS was estimated at £41.25bn, or 73.1% of the total UK healthcare services market.'
>
> UK Healthcare Market Review (2000:1)

The Review goes on to state that:

> 'The private healthcare sector ... was estimated to account for 25.3% of the total UK healthcare market in 2000.'
>
> UK Healthcare Market Review (2000:1)

As a contrast, according to the National Center for Health Statistics (2003), in 2000 the United States of America had a Public to Private ratio of 35.8%:64.2%, therefore the majority of healthcare is provided by the Private Sector.

The funding of healthcare in the United Kingdom and United States has had an influence on the ways in which advocacy has developed. In the United States, advocacy rests on the notion of the primacy of patients' rights. The rights of patients are similarly considered as important in the United Kingdom. Where a client or patient has difficulty in articulating his or her claim to rights as for example in the Learning Disability or Mental Health sectors, group and advocacy alliance schemes have formed. These have the remit of promoting the interests of patients and clients, as described by Gates (1994). The underlying aim of these groups is the respect of an individual and their claim to rights. These bodies should therefore ensure that all patients or clients, as individuals, are able to articulate effectively their rights claims. At this point in the thesis it would be useful to consider what can be assigned as a nursing role.

4 Perceptions of a Nursing Role

When considering advocacy, a nurse's perception of his or her role is an important factor. The link of science to art is discussed in Midgley (1980:86), who states that 'practising any science properly is an art.' With reference to the 'art' of nursing, the role

often requires subjective interpretation. Some nurses believe that they should concentrate on the patient care that is perceived as the basis of nursing. An example of this would be helping a patient with personal hygiene to prevent the occurrence of complications such as pressure sores. Alternatively, many nurses hold a contrasting perspective that is based on the idea that nurses should extend their role to embrace tasks traditionally undertaken by doctors. For example, performing a patient's intravenous cannulation and drug prescription. It therefore follows that accepting and undertaking such extended roles should allow nurses to build their professional confidence. One could claim that advocacy should be considered as an important factor in nursing, regardless of whether the nursing role is extended or otherwise. Beardshaw (1981) offers support for this view that nurses ought to undertake advocacy as part of their role.

An integral part of a nursing role, when acting as patient's advocate, is an acceptance that the patient ought to be given an opportunity to make decisions concerning his or her treatment and life. The nurse should acknowledge that the patient ought to

be able to seek explanation and advice about their treatment. Faulder (1985) offers support for this by suggesting that a patient should be the person involved in key decision-making with reference to his or her life and treatment. This ought to be acknowledged by a nurse when undertaking a patient advocate role and the nurse should not therefore take on the responsibility of making such decisions for a patient.

One should however acknowledge that patients, who wish to have support with regard to their decision-making, might express their preference that a nurse should be involved in the decision-making process. A nurse could offer an explanation of terms and concepts in a form that the patient should be able to understand, therefore facilitating appropriate decision-making by a patient. This can be considered as a contrast to a patient or client-having decisions made for him or her by a nurse, which would amount to a form of paternalism. The above examples of nursing action demonstrate some of the implications for nurses, who wish to take on a role as patients' advocate. One should therefore consider the implications that such a role can have for nurses.

The nurse should acknowledge that boundaries exist and possess a level of self-awareness with regard to the personal and professional aspects of his or her life. The personal feelings of a nurse may at times differ from the perception of a professional duty towards patients, with whom the nurse should have an ability to empathize. The nurse should be aware that focusing on professional duty as part of a professional role might demand a suppression of his or her feelings. This may be psychologically detrimental for a nurse and therefore have a potential to adversely affect patient care. It should be acknowledged that a person, who wishes to undertake an advocacy role, could encounter accompanying risks. It is therefore important that such a person be aware of such risks.

5 The Presence of Risk

The thesis will seek to identify and explore risks that may be involved when a person wishes to take on a role as advocate and these have to be taken into account when a person considers whether or not to take on such a role. The person who is contemplating an advocate's role should be offered a level of training and support with reference to the role and risks that are

involved. A certain level of understanding by a person wishing to act in such a role should lead to him or her being in possession of an ability to take appropriate action in given situations. This should lead to a minimization of risk to the advocate, his or her colleagues and patients.

To understand the role of an advocate, one should possess a level of knowledge with regard to advocacy, as linked to a form of ethical discourse. To facilitate this, the latter part of the thesis will describe the work of Habermas (1995), with regard to the conditions required for ethical discourse and this will be applied to advocacy.

6 The Link to Habermas

Habermas (1995) has constructed a framework that can be used to identify the conditions that are required for an ethical discourse and he has created a schema in which statements can be tested for their validity and effectiveness. I will offer a description of the Pink case study as a clinical example, where advocacy became an issue. Habermas' (1995) principles with

regard to discourse ethics are applied to the Pink case with the aim of demonstrating how such an application may help to offer a rational basis for the policies and actions of those involved. In the same part of the thesis, I have made an application of Habermas' (1995) work on discourse ethics, to Gadow's (1983) perspective of the role of a nurse as advocate. I have also used another case study as a means of illustrating some of the points that are raised later in the thesis.

7 Preview to Chapter Two

In chapter two I will employ a thematic approach to a discussion of advocacy and will refer to the work of five authors, as previously identified, who have written extensively on advocacy. The first two British authors, Gates (1994) and Teasdale (1998) offer views of advocacy that largely reflect the United Kingdom's perspective, which includes the group and collective advocacy perspectives. The last three American authors, Gadow (1983), Kohnke (1982) and Curtin (1979), as suggested previously, reflect the widely held view in the US society that advocacy should be based on the rights of the patient or client. These authors hold that the role of the nurse is to inform and support

the client in any decision that has to be made and they consider self and citizen advocacy as being typically the most relevant.

I will argue that Gadow's (1983) advocacy perspective is able to offer the most sound and convincing rationale for the role of a nurse as advocate, as her work on 'existentialist advocacy' and the 'lived' and 'object' body can be applied internationally to the majority of situations that may require advocacy. In my view, this provides sufficient justification for preferring Gadow's (1983) perspective.

Having offered an outline of the main content of the thesis, I will now follow this with an account of the different forms of advocacy, starting with self-advocacy.

CHAPTER 2 FORMS OF ADVOCACY

1 Self-advocacy

In this chapter I will identify and explore the different forms of advocacy and will begin with 'self-advocacy.' The five authors that I have identified, namely; Gates (1994), Teasdale (1998), Gadow (1983), Kohnke (1982) and Curtin (1979) all refer to 'self-advocacy' either in explicit or implicit terms. It is therefore important to offer an account of this term. In the UK and USA, patients' rights are considered as important and these are linked to self-advocacy. Both societies emphasize the right of an individual to make informed decisions that are appropriate to his or her needs and welfare. I will begin with an account of self-advocacy and the British perspective.

2 Self-advocacy and the British Perspective

Gates (1994) and Teasdale (1998) acknowledge the occurrence of self-advocacy, when people are encouraged to speak for themselves rather than rely on an advocate to speak for them. Teasdale (1998) links this form of advocacy to those who have

learning disabilities and recommends that the advocate should encourage a patient or client with a learning disability to speak for themselves, rather than trying to make decisions on their behalf.

Following this principle, for Teasdale (1998) self-advocacy often involves the setting up of groups with the aim of representing their members. An example of these groups typically includes people with learning disabilities who are aided by other people, such as the 'Advocacy Alliance', described by Sang and O'Brien (1984:9-26). This allows for identification of common problems and the required support can be made available to enable the group members to put forward a collective point of view. The groups normally consider their members' welfare with reference to organisational policy that has responsibility of providing a certain level of services and care. Teasdale (1998:21) also makes a suggestion that the philosophy of self-advocacy could be applied to groups other than those with members who have learning disabilities, for example, people with mental health problems. Therefore, the principle of people forming support

groups whose function is to represent the members' interests can be applied in other fields of health care.

Teasdale (1998:37) expresses his preference for self-advocacy on the grounds that it promotes the autonomy of a client and reduces risk to the advocate. He discusses the point made by Dawson and Palmer (1991), that self-advocacy involves people expressing their concerns and wishes, while being able to make choices and to take responsibility themselves. This can be illustrated with reference to self-advocacy and empowerment, as discussed in the next section.

3 Self-advocacy and Empowerment

Teasdale (1998) considers how clients can be helped to self-advocate. An autonomous client ought to be able to make decisions with regard to his or her welfare and the advocate's role should reflect the empowerment of the client to achieve this aim. Teasdale (1998) observes that there are degrees of autonomy and that the client's autonomy may be restricted due to illness, whether physical or psychological. He suggests that

the client should be able to learn about their illness and make the necessary choices when they are able to do so and their wishes should be respected. I will now give an account of a practical example of self-advocacy, as offered by Corcoran (1994).

3a Corcoran's Example.

Corcoran (1994) offers a clinical illustration of self-advocacy when she describes a case study relating to a woman who experienced menopause and faced decisions concerning her proposed treatment with oestrogen therapy. There were three choices;

a) To take oestrogen alone,

b) to take it as a combination therapy or,

c) not to take any hormones.

The patient was given an explanation concerning the proposed treatment. This was accomplished by the nurse referring to the gynaecologist, as required, for expertise. Opportunities were

made for the patient to voice doubts and the patient was then able to come to an appropriate decision. The decision made by the patient was facilitated by the communication of information offered by a nurse who used the consultant gynaecologist's knowledge as required and this enhanced the patient's autonomy. Corcoran's patient-centred emphasis with regard to decision-making can be linked to self-advocacy as previously described. Having considered the British perspective, I will now explore self-advocacy and the North American perspective.

4 The North American Perspective

I will now look at three North American views of self-advocacy, as described by Curtin, Kohnke and Gadow.

4a Curtin on Self-advocacy

Curtin (1979) offers support for self-advocacy when she suggests that sufficient information ought to be provided by the nurse to enable a patient to exercise a choice concerning the available treatment options. According to Curtin (1979), the nurses' individualistic view of their patients forms the basis of a

holistic understanding of the needs of their patients. Nurses need to understand the whole of the patient's background in order to appreciate the effect of a physical or psychological problem on a patient's integrity and this is considered as a prerequisite for advocacy. There has to be an acknowledgement that there is a responsibility on the part of a professional, regarding the provision of information to his or her patient concerning the options and choices that are available. This should enable a nurse to enhance the autonomy of a patient with regard to his or her decision-making. I will now turn to Kohnke's (1982) perspective.

4b Kohnke on Self-advocacy

From my reading of Kohnke (1982), her definition of nursing refers to the importance of the patients' autonomy and right to self-determination. For her, the nursing role should reflect this philosophy; therefore the nurse should act to support the autonomy of the patient and in this way, her definition of advocacy is linked to self-advocacy.

Kohnke offers support for self-advocacy when she states that:

> 'The role of advocate is to inform the client and then to support him in whatever decision he makes.'
>
> Kohnke (1982:2)

According to this definition, the nurse should ensure that the patient is adequately informed and supported in their decision-making.

For Kohnke (1982), an advocate should be able to ensure that a patient is fully informed with regard to his or her illness and required treatment or care. This implies that the advocate should possess a certain level of knowledge concerning a patient and their illness, in order for the advocate to offer the patient adequate information. Alternatively, that the advocate should be able to access knowledge, as required.

According to Kohnke (1982), the client has a right to make decisions concerning his or her treatment and care. The amount of information offered and the client's consequent level of knowledge may influence these. For a client who has received

adequate information about his or her condition, ought to be in a favourable position to make decisions about treatment and care. However, a person who has received inadequate information concerning their options may, through a lack of knowledge, make an inappropriate decision. With reference to such a case, the advocate should perceive (and by default accept), a sense of responsibility.

With reference to the rights of a patient or client, Kohnke (1982) suggests that advocacy should be considered in a related context, as for example, when the patient requires adequate information and support that should allow the patient to make appropriate decisions concerning his or her treatment and care. Kohnke (1982) acknowledges the need for the provision of a certain level of information for the patient who has a right to accept or reject this information. This could lead to unforeseen consequences, for example, the advocate may be aware that his or her patient's decision may not be considered as the right one, but ought to be accepted as this is considered as a patient's right.

Kohnke (1982:17) accepts that the client may "wish to know" and conversely "not to know", therefore the role of advocate can become a balancing act where the role of advocate can be considered as far from clear and potentially open to ambiguity. This implies that the advocate should possess a level of knowledge concerning the role and its side effects, the nurse who undertakes such a role in relation to his or her patient should be aware of this. One can now consider Gadow's (1983) perspective of self-advocacy.

4c Gadow on Self-advocacy

Gadow (1983) further develops the idea of self-advocacy when she suggests that the advocate should help the patient acquire the necessary information and facilitate a patient's analysis of this with reference to their values and beliefs. Gadow (1980b) considers that it is important that the advocate ensure the patient has the relevant information by requesting, as required, that a doctor should to speak to the patient regarding his or her diagnosis and treatment. In this way, the advocate should use his or her professional knowledge to enable a patient to gain the required information. By helping a patient to determine their personal values, the advocate should be able to gain a deeper

understanding of the basis of a patient's decision and the appropriate level of information offered to a patient by an advocate should enhance the patient's understanding. For this to occur, there has to be an element of trust between the advocate and patient. It would seem pertinent at this stage to describe Gadow's (1983) definition of nursing and her account of existential advocacy, as described next.

5 Gadow's Existential Advocacy Perspective

For Gadow (1983:40), 'nursing is concerned – or ought to be – with the whole person of the patient.' According to Gadow's (1983:42) perspective, nursing is seen as a philosophical ideal, rather than an 'empirical construct' and is 'distinguished by its philosophy of care and not its care functions.' According to Gadow (1980) the development of a philosophy of nursing should reflect an enhancement and development of the nursing role that should include basic nursing tasks, with an accompanying acquisition of the necessary skills.

Gadow (1983:45) proposes that nursing is suited to the concept of 'existential advocacy' and considers that this term is

interchangeable with the term 'advocacy.' According to Gadow's definition:

> 'The concept of existential advocacy ... is based upon the principle that freedom of self-determination is the most fundamental and valuable human right, and therefore is a greater good than any which healthcare can provide.'
>
> Gadow (1983:45)

The concept of existential advocacy can be readily applied to a patient care setting as part of a nursing philosophy. The aim of existential advocacy is the integration of the patient's self and body.

Gadow (1980) offers a discussion of a patient's position in terms of communication and the formation of inter-personal relationships between nurses and their patients, with reference to the values that are held by a patient. Gadow (1980) makes the claim that nurses are in frequent and prolonged contact with their patients. Therefore they can be considered as occupying a favourable position that enables them to combine their knowledge and experience, enabling them to perceive a patient as a whole person. The focus of nursing, as according to Gadow (1983), ought to be directed primarily towards the patient.

Nurses who are afforded adequate education and resources can often reach their full potential, in that they are able to take the view that patient-care ought to be considered from a holistic perspective, while acknowledging that a patient or client normally possesses a level of self-determination. This is considered as the ideal prerequisite for existential advocacy, as from this base one can then make a deduction that nurses are well placed to help a patient with their decision-making, with an informed reference to their treatment and well being. In this sense, nurses can be considered as occupying a strong position with regard to offering patients informed support.

Gadow (1983:45) offers her view of existential advocacy in positive and negative terms, as described next. I will now turn to her account of Positive Existential Advocacy.

5a Positive Existential Advocacy

With reference to positive existential advocacy, Gadow states:

> 'In positive terms, this meaning of advocacy has far greater implications for the professional, which extend beyond the narrow realm of proscriptions into the realm of ideals. The ideal which existential advocacy expresses is this: that individuals be assisted by nursing to authentically exercise their freedom of self-determination. By authentic is meant

> a way of reaching decisions which are truly one's own – decisions that express that all one believes important about oneself and the world, the entire complexity of one's values.'
>
> Gadow (1983:45)

For Gadow (1983) the nursing role with regard to positive existential advocacy should involve assisting patients in their decision-making, taking into account their individual circumstances and needs. For Gadow (1980), this principle ought to be upheld, even though this may have a detrimental effect on the health of the patient. In positive terms the meaning of advocacy has implications for nurses as it goes far beyond the planning of basic nursing care. Again, advocacy could be applied to an example of a patient who wishes to die, with the advocate offering support for the patient's decision.

According to Gadow's (1980) view, the term advocacy implies that the advocate should respect the right of a client to make decisions concerning his or her treatment and welfare. Existential advocacy acknowledges the individuality of patients as people and this is based on the premise that people possess their own complex values. The person who enters a new situation may be required to recreate his or her own values as,

for example, in relation to admission to hospital. For instance, from a health-related existential advocacy point of view, health is normally considered as an important human value (although of less importance than self-determination). Human values can be considered as subjective, for some people health may be less important than, as for example, the acquisition of wealth. It is proposed that a philosophical foundation is developed from where the patient and nurse can enter into a relationship that can be freely determined by those who are involved. As a contrast to positive existential advocacy, Gadow (1983) offers an account of negative existential advocacy.

5b Negative Existential Advocacy

Gadow offers an account of negative existential advocacy:

> 'In negative terms, this implies that the right of self-determination ought not be infringed even in the interest of health. The professional, while obligated to act in the patient's interest, is not permitted to define that interest in any way contrary to the patient's definition: it is not the professional but the patient who determines what "best interest" shall mean.'
>
> Gadow (1983:45)

This view can be considered as 'negative', in that its rationale is based on the idea that the patient, rather than the professional, should be the person to define what is in his or her interests as he or she has a right to make his or her decisions with regard to treatment or welfare. According to this view, the nurse as a professional has an obligation to act in the patient's interest and should not seek to define an interest that in any way comes into conflict with that of the patient.

An example of negative existential advocacy is an acknowledgement of and support offered by an advocate to a patient who wishes to die. According to this view, the advocate should offer support with regard to the patient's self-determination even though this would lead to eventual death, as to do otherwise would infringe the patient's right to self-determination.

According to Gadow (1980), the nurse who is in possession of knowledge concerning his or her patient should be able to help a patient to think through the meaning of his or her life with reference to the patient's experience of their illness, as

illustrated next, by Gadow's (1983) work on the 'lived' and 'object' body.

5c The 'Lived' and 'Object' Body

Gadow (1983:51-55) offers a discussion concerning the nurse's perception of a patient in terms of 'lived' and 'object body'. The 'lived' body for example, refers to the patient's experience of a disease; discomfort in terms of pain, nausea, loss of weight and tiredness. It can also refer to the patient's response to a clinical examination by a doctor, in terms of feeling embarrassed about intimate areas of the body. For Gadow (1983:51-55), the 'object body' refers for example, to a nurse's perception of a patient who has a raised body temperature that would require some form of medical treatment and nursing care. Similarly, a doctor would perceive this person as a patient who requires a medical examination and clinical investigations, e.g. an X-ray, which should be organised and taken, with the aim of diagnosing an illness. The doctor will normally examine and treat many patients during a day and consider his or her actions as a necessary part of clinical practice and may make scant reference to the feelings of the patient. There may be similarities in the way that the doctor offers treatment to a patient, as

compared to the actions of a mechanic who deals with a car that malfunctions.

For Gadow (1983:51-55), the patient's experience of a disease in a 'lived body', forms the basis for the 'object body', that is perceived as a dysfunctional organism and she suggests that the 'lived body' is of greater importance than the 'object body'. For Gadow (1983), the 'lived body' of a patient captures the patient's individual experience of a disease.

From the patient's point of view, the 'object body' may not be considered as belonging to him or her, as through prescribed treatment and care the patient may have psychologically off-loaded it on to the doctors or nurses, for the 'object body' view allows the patient to give permission for the doctor or nurse to undertake procedures. The health care professionals would consider the patient's 'object body' as being similar to that of other people who have the same or a similar illness. The professionals would therefore take the view that all the patients could benefit from an offer of the same treatment, whereas when taking into account individual differences, this may not necessarily be so. From the 'lived body' view, the above

treatment of people could result in differing individual patient experiences and would therefore affect their perception of the treatment and care offered.

For a patient, an 'object body' that appears well does not present a problem, as in health, its natural functions tend to be taken for granted and go unnoticed. The 'object body' may be considered as similar to a mechanical device whose functions are taken for granted when it works well, although through the effect of illness, the bodily functions may become evident due to their absence or malfunction. The patient would typically notice the body when something malfunctions and would normally seek advice or treatment from health care professionals. This is in contrast to the 'lived body' that depends on the patient's experience of an illness that may differ through subjectivity, depending to the individual concerned. The professional, for example a doctor, may give more attention to a patient's 'object body' that can be examined and diagnosed than to the 'lived body', that relates to the patient's expression of his or her own experience. The philosophical differences between the 'lived' and 'object' body can lead to conflict.

According to Gadow (1983), the lived and object bodies are understood as being existentially opposed, though not as opposites. Gadow (1983:51-55) suggests that when a person is well, the 'lived body' is linked to how the person feels with regard to their general health. She acknowledges the importance of the person's perception of their health. With regard to the 'object body' the doctor or nurse may view the patient as one of many and a health screen would be conducted with reference to the normal bodily function indicated by reference to a healthy population. With regard to a healthy 'lived body', the patient may feel well and expect the health screen to confirm the feeling, although he or she may feel a level of anxiety prior to obtaining the medical results.

The 'lived body' is linked to a patient's experience of incapacity such as immobility. The illness may act as a restraint on the natural functions of the body and grossly affect the patient's experience of his or her body. With regard to the 'object body', a doctor or nurse may perceive the patient as making normal progress and this may be indicated to the patient. Therefore, in this way the 'lived body' can be considered as having been

influenced by the 'object body'. There is the potential for the occurrence of internal contradictions within a person.

The task for advocacy, in accordance with the wishes of a patient, is to ensure an integration of the bodies. The 'lived body' offers testimony to the patient's experience of an illness and therefore can be considered as an important aspect of the person that ought not to be forgotten or omitted. The 'object body' can be considered as a mechanism that at the same time belongs to no one and to everyone, the aim of nursing is to enable a patient to integrate the two bodies, to attain their fusion. This fusion would reflect the individuality of a patient and allow the person to acknowledge him or herself, and to realize their self-determination.

With reference to the nurse as a professional, who wishes to undertake a role as patient's advocate, Gadow (1983:51), suggests that he or she should acknowledge that the advocate should participate ... 'as an individual, a complete unity unfragmented by exclusion of any part of the self.' Having offered an account of Gadow's 'lived' and 'object' body

perspective, I will now turn to paternalism, a concept that has the potential to influence self-advocacy

5d Paternalism

For Gadow (1983:43-44) paternalistic acts normally relate to the perceived interests of an individual with an implication that the rights and freedom of others may be restricted for their benefit. In extreme cases, there may be an existence of some form of coercion by others, the aim being to provide some form of good that has typically not been desired by a person, when this has the aim of offering some form of benefit. Paternalism can be considered in strong or weak forms, as described next.

According to Dworkin:

> 'A strong paternalist believes that people may be mistaken or confused about their ends and it is legitimate to interfere to prevent them from achieving those ends.'
>
> Dworkin (2002:6)

Strong paternalism relates to the violation of moral rules with regard to an individual's aim or end concerning the right to self-determination. An example of this is an assumption made by a nurse that due to their state of mental or physical health, a

patient would be unable to use information to make health and welfare decisions. The nurse's rationale would be that other more competent people should therefore make decisions on behalf of the patient. The beneficent / non-maleficent based rationale for this rests on the perception that the nurse should not allow the patient to become worried by facts and make inappropriate decisions. This paternalistic act will result in the overriding of a patient's autonomy.

With regard to weak paternalism, Dworkin states that:

> 'A weak paternalist believes that it is legitimate to interfere with the means that agents choose to achieve their ends, if those means are likely to defeat those ends.'
>
> Dworkin (2002:6)

Weak paternalism need not violate a moral rule of self-determination for it is linked to the nurse's respect for his or her patient. Using this principle, the nurse would seek to enable the above patient to exercise self-determination by the provision of sufficient basic information that should enable the patient to make decisions with regard to his or her health and welfare. The nurse's intention would be to act in support of the patient's autonomy with regard to their decision-making. By undertaking

this action, although the nurse has influenced the delivery of information to the patient for beneficent reasons, the autonomy of this patient would not be overridden.

As a contrast, one can now offer a consideration as to how paternalism may break a moral rule. For Gadow (1980), the single moral rule that is broken by strong paternalism involves an acceptance of some form of coercion, where coercion is identified as an act of forcing individuals to submit to the action of others; for example, when a nurse informs a patient that he or she must have a bath at a particular time.

Those who emphasize that they are using paternalism to assist a patient may offer a positive defence. According to this view a nurse, who has a good level of knowledge about her patient, may perceive that she is the person best placed to make a professional judgement with regard to her patient's treatment and care. In the context of a patient's bath, the nurse may believe that he or she is the person best able to judge the interests of the patient in the context of a requirement for a basic level of hygiene and the available facilities that are on the ward at a time that a nurse wishes the patient to take a bath.

In contrast to strong paternalism, the patients' advocate normally does not wish to make decisions on behalf of a patient and is motivated merely to facilitate the patient's decision-making. This can be considered as approaching a philosophically closer position to a weak concept of paternalism; where the supporter of the patient seeks to identify the needs and preferences of their patient, rather than make an assumption that a professional is considered as the best person to judge what ought to occur in the interests of the patient. A further view of advocacy refers to Curtin's (1979) perspective of advocacy as a natural role.

6 Advocacy as Natural

Curtin (1979) proposes that advocacy can be considered as a natural role that anyone should be able to undertake. It is related to the idea that advocacy be viewed as a natural occurrence, as for example, parents who offer support and protection for their children. Similarly, the role of a nurse through the adopted role of caring for a patient could be conceived as embracing the role as patient's advocate. In this sense, Curtin (1979) suggests that advocacy ought to be considered as part of a nursing role.

Curtin proposes the following definition of nursing:

> 'The end or purpose of nursing is the welfare of other human beings. This end is not a scientific end, but rather a moral end. That is, it involves our relationship with other human beings.' ... 'Therefore nursing is a moral art', she makes the observation that ... 'Nursing science serves this art.'
>
> Curtin (1979:2)

According to this view, nursing involves the pursuit of relationships with other human beings. For Curtin, the relationship between nurses and patients should embrace the aim of promoting good health and has to be considered in the context of communication between nurse and patient, the level of information offered to the patient.

For Curtin (1979), nurses are considered as favourably placed among health care professionals, in that they are in a position to view people from a patient-centred perspective. Nurses are able to view their patients as human beings with different needs, as they spend a lot of time with patients and are able to gauge their progress. This enables the nurse to gain knowledge of a patient and their values and can be linked to Kohnke's (1982) perspective of advocacy, as an act of 'loving and caring'.

6a Kohnke's Perspective of Advocacy

From Kohnke's (1982) perspective, advocacy is considered as an act of 'loving and caring', according to her:

> 'Loving and caring are not automatic; they involve an act of free will, a choice of a way to behave and to see ourselves in relation to others. Some say that loving and caring require a self-imposed discipline; others say that they result from a natural gift. But as is true of all disciplines and gifts, one must learn how to use them, not only for the sake of others but also for one's own sake.'
>
> Kohnke (1982: viii)

Kohnke's (1982) reference to 'loving and caring' may appear to be rather paternalistic in nature. However, her use of the term ought to be considered in the context of her view regarding the previously described role of an advocate, which emphasizes support for decisions that are made by a patient. For Kohnke (1982), the basic requirement for a person undertaking an advocate's role rests on their motivation to offer support for a patient. With reference to a supporting role, an advocate should be able to understand and empathise with the patient and it is in this context that Kohnke appears to use the terms 'love and care'.

With reference to her interpretation of loving and caring as a 'natural gift', Kohnke (1982:viii) suggests that we are not born with ability to love and care, for if the ability to love and care were inborn; it would be common to all humans. The point is made that individuals need to make choices with regard to their self-perception and behaviour towards each other. According to Kohnke (1982), people take on a role as advocate because of an experience that they have had with others, it may also be acquired through the process of learning as it is considered a valuable and right thing to do. Kohnke (1982) suggests that the act of loving and caring are not automatic and universal, they have to be learned. For Kohnke (1982), part of the learning process relates to 'value clarification', described in the following section.

6b Value Clarification

Kohnke (1982) considers value clarification, when the advocate seeks to explore the values held by a patient that can be used to form the basis of a rational action, an emphasis should be placed on the patient's perspective. A patient who has been given adequate and accurate information should be in a position to make decisions concerning his or her welfare and treatment

and he or she is more likely to believe a person who offers sufficient accurate information.

Kohnke's (1982) notion of value clarification refers to an exploration of the patient's values by an advocate, rather than merely describing a situation and exploring the available options with the patient. The advocate does not normally seek to attack the decision itself, however, by making a reference to the values of a patient, the advocate may undermine the decision making process. For example, the patient may fear pain and an emphasis by the advocate on the painful nature of a procedure may persuade the patient to refuse the investigation or treatment.

For Kohnke (1982), the advocate may use value clarification as a basis from where a rationale could be formed. The application of value clarification by an advocate would relate to an assumption that through experience and training, they have a superior knowledge to that of the patient and would be in a position to provide an effective explanation with regard to the patient's illness and treatment. This may lead an advocate to judge that a patient should make a decision with regard to their

treatment and welfare. However, there is an emphasis by Kohnke (1982) that the prime consideration ought not to rest on whether the patient makes a decision that complies with the advocate's judgement. She also suggests that the advocate should be aware there is a possibility that he or she may affect a patient's decision-making process, with the aim of preventing such action.

Kohnke (1982) suggests that value clarification and subtle manipulation are similar in concept, with an implication that when acting as an advocate and seeking to clarify a patient's values, one should be aware of the danger of subtle manipulation. She offers support for the idea that the advocate should fully inform the patient concerning their problem, likely treatment, possible outcomes and available options and an emphasis is placed on the need for a full discussion between the advocate and patient. Value clarification, as a concept, concerns the advocate's relationship with a patient in terms of acknowledging and identifying their values that enables the patient to be offered an adequate level of support.

Gadow (1980) also suggests that the general concept of advocacy refers to the notion of one person helping another to clarify their preferences. In this context, the term advocate could be applied to a nurse who helps a patient to think through their decision and the term 'advocacy' refers to the assistance of a patient to exercise their freedom to make a decision that accurately reflects their interests. In order to gauge accurately the interests of patients, it would be useful to consider their wants and needs.

6c Wants and Needs

Teasdale offers a basis from where the 'wants' and 'needs' of a client can be considered:

> ' ... the starting point for all forms of advocacy is what individuals 'want' as opposed to what they are thought to 'need.' This distinction places clients at the centre of the advocacy process. In contrast, the word 'need' carries the connotation of outsiders deciding what is right for clients.'
>
> Teasdale (1998:39)

Teasdale's (1998) aim is to look at the different types of wants that clients may have and how they may be expressed and to offer some practical advice concerning assessment of these.

The discussion includes advice with regard to assessment of wants and contains suggestions for the avoidance of certain situations. This is intended as advice for those who wish to take on the role of advocate. Written examples of advocacy are used to illustrate the relevant points and an emphasis is placed on the aim of defining advocacy based on wants, rather than the perceived needs of clients. It would be helpful, at this point, to look at instrumental and expressive needs.

6d Instrumental and Expressive Needs

Teasdale (1998:22) identifies an individual's needs in instrumental and expressive terms. Instrumental needs are those that relate to the practicalities of everyday life as for example, financial support and access to health care. Expressive needs are those that are more personal for example, concerning friendship, security and love. These principles have been applied through the establishment of an independent advocacy movement in the United Kingdom that has specific emphasis on areas like learning disability and mental health. Teasdale (1998) links this to a discussion of the British perspective of 'independent advocacy'. I will now offer a

description of the difference and similarities between needs and wants.

The perceived needs of clients tend to have a firmer basis than those of wants, as needs are often acknowledged as formed from some sort of physical or psychological requirement by a client. Some examples offered, are the perceived need for pain relief, or a patient's apparent need for counselling following a traumatic psychological episode. By contrast, wants are sometimes related to the wishes of a patient that may be transitory and based on a preference or whim. However at other times, wants may have a firm physiological or psychological basis as for example, the requirement for food or the formation of some form of interpersonal relationship. At these times, the potential occurs for the merging of wants and needs. Having considered the potential wants and needs of a client, I will offer a description of Teasdale's account of Citizen or Independent Advocacy.

7 Citizen or Independent Advocacy

Teasdale (1998) considers the terms 'citizen' and 'independent' advocacy as interchangeable.

With reference to citizen advocacy, according to Teasdale:

> 'Citizen advocacy originated in the USA, emerging from their strong libertarian tradition with its emphasis on the rights of the individual. In the UK it is more frequently termed independent advocacy.'
>
> Teasdale (1998:22)

He offers the suggestion that any person acting as citizen advocate should be neutral and should not receive payment. The aim of this is to give an advocate verifiable independence, to enable him or her to speak up for people who, for whatever reason, are unable to speak for themselves. For Teasdale (1998), people have differing needs, which ought to be acknowledged by a person acting as an advocate.

Teasdale (1998:105-112) refers to situations where problems may arise through a lack or break in communication. Although these problems are relatively easy to overcome, the differing perceptions can lead to the development of confrontation between the client and the service provider. The junior

professional as a newly qualified nurse, may find difficulty in offering the client effective representation owing to the professional's lack of experience, credibility and power within an organisation. The use of an independent advocate may help in these situations. This should allow the junior professional to register his or her concerns with the advocate and at the same time shelter him or her from potential conflict with an organisation as an employer.

It would seem appropriate, when considering Teasdale's (1998) UK perspective of advocacy, to start with his account of independent advocacy.

The independent advocate would normally be independent of an organization caring for a client and would not have the employee or associated professional obligations. Reference is made to how the type of adopted advocacy may have an effect and the consequences that ought to be considered prior to an assumption of such a role. For example, will the advocate seek to inform and support a mentally competent client or will the role involve the advocate giving a voice to a client that finds it hard to speak and be heard? There are limitations concerning

independent advocacy and these are discussed in Teasdale (1998).

He discusses the parameters of effective independent advocacy, including the referral of clients to an independent advocate who should have a certain level of experience. This may occur in different ways, for example, the client may seek self-referral, or be referred by someone other than the client, or the client's need for advocacy may originate from the presence of a problem that requires some form of support. Confidentiality should be maintained with regard to a referral and it is acknowledged that the client has the right to refuse the offer of advocacy.

Teasdale (1998) holds that an advocate should be an adult with sufficient experience, for example, as identified in the Lincolnshire Link, described in Teasdale (1998:105-111). The advocate should be able to act in the interests of the client, in accordance with their wishes and the person should be kept informed. The advocate should also carry out the client's instructions, be impartial and be able to maintain confidentiality.

Teasdale (1998) also offers a practical application of independent advocacy, as described next.

The concept of independent advocacy is discussed in the terms of the British National Health Service, where the structures may make it difficult for the advocate to gain access to those who have influence and power. The funding of an independent advocacy service may be problematic, for example, when finance originates from a body like the National Health Service, where there may be a perceived conflict of interest. There could be an expectation that an independent advocate should not act or encourage any action against the funding organisation, for such an action could lead to the threat of sanctions (for example, the potential for withdrawal of financial support). The alternative of voluntary funding rests on the continuing good will of people who are asked to donate a portion of their wealth. This form of funding does not offer a security of tenure as it may fluctuate, owing to the ability of individuals to provide a donation. Teasdale (1998) offers an application of citizen advocacy to the 'Lincolnshire Link' (Teasdale 1998:105-111), as illustrated.

A requirement for advocacy was identified by parents of children with learning disabilities in Lincolnshire where the parents wanted more independent forward planning and support than the local social services were willing to provide. 'The Link' sought charitable status and was able to provide a generic service for these people. It is at this point that Teasdale (1998) applies independent (or citizen) advocacy to 'The Link'.

The role of independent or citizen advocacy normally involves a one-to-one relationship between the advocate and the client. For this view of advocacy to be effective, there is a need to establish a long-term relationship between the advocate and client. The advocate's aim is to help the client promote his or her view and if necessary, to speak for the person. The advocate's loyalty normally rests with the client and he/she is motivated to offer a vigorous defence with respect to the person's rights. This occurs in the case of the Citizen Advocacy Lincolnshire Link where the advocates are volunteers from the local community.

With reference to independent advocacy bodies such as 'The Lincolnshire Link', there is an emphasis by the advocate on the need to promote client support through the formation of a

partnership. The form of this partnership depends on the nature and development of the relationship between advocate and client. It is normally desirable that the relationship should be voluntary, long-term and formed on a basis of trust. The independent body should also be aware of the needs of an organization that has a responsibility for a client's care and a relationship ought to develop between the independent advocate and organization, with the aim of facilitating effective communication. The professionals involved may become defensive, for they could perceive the involvement of the independent advocate as an implied criticism of their role. For example, in the case of nurses where part of their role could be perceived as acting in the client's interests and where such a role may be interpreted by the nurses as being part of their professional obligation to act as advocate.

The independent advocate can check that a basic level of care is provided and that professional standards are not compromised. In this respect he or she could be considered as occupying a strong position, as he / she will not have an employment contract that may require the employee to voice concerns to the employer in preference to the media. Having

given an account of Citizen or Independent Advocacy, I will now turn to Collective and Group Advocacy.

8 Collective and Group Advocacy

For Teasdale (1998:21-38), collective advocacy is sometimes referred to as 'class advocacy' and involves organizing a group of people to campaign for a cause. Examples of these groups are 'MENCAP' and 'MIND' (Teasdale 1998:23); these are major charities working with vulnerable people with the aim of improving their quality of life. The aim of these bodies through publicity is to have an effect on social policy. Other organizations such as 'Public Concern at Work' (Teasdale 1998:15) may draw attention to their cause through the use of whistle blowing, as described later in the thesis.

Teasdale (1998) describes a related concept as group advocacy. This refers to an advocate acting on behalf of groups of people rather than for an individual. An example of this is given with regard to a children's nurse acting to prevent closure of a children's ward during the Christmas period, the enactment of this form of advocacy may cause a problem for the hospital authority wishing to close the ward for financial reasons. This

demonstrates that group advocacy is likely to occur over issues of substance and this could be related to the power that is held and exercised by the organizations and individuals concerned.

A further example relates to the observations of Sang and O'Brien (1984), who offer an example of 'The Advocacy Alliance' as such a body that offers advocacy for people with learning disabilities. This enables a potentially vulnerable patient or client to make known their preferences so that decisions made, can accurately reflect the needs of a client. In this way, the 'Advocacy Alliance', as described by Sang and O'Brien (1984), can act to empower the client. It would seem appropriate to look at power and advocacy.

8a Power and Advocacy

Teasdale (1998) does not offer an overt definition of nursing. Instead, Malin and Teasdale (1991:657-658) refer to 'caring' and 'empowerment' involved in the role of nursing. For Teasdale (1998) 'power' is an important aspect of his definition of advocacy.

Teasdale offers a definition of advocacy in the following terms:

> 'Advocacy is about power. It means influencing those who have power on behalf of those who do not. The dictionary definition of an advocate is one who pleads, intercedes or speaks for another. In other words, advocacy is required when people feel vulnerable and powerless.'
>
> Teasdale (1998:1)

He offers a discussion with regard to the need for nurses to consider patient advocacy as part of their role, as nurses can help patients to understand their problems. The patients could be provided with a level of knowledge that would empower them, when making decisions concerning their welfare. Therefore for Teasdale, the act of advocacy is perceived as an important part of the nursing role.

According to Teasdale's (1998) definition of advocacy, he makes the link between advocacy and power. This has occurred because advocacy is often discussed in terms of power relationships between people and is related to collective or group advocacy. According to Teasdale (1998), the role of advocate is based on a premise that a person who makes the choice to act as an advocate, as for example a nurse, who is able to offer support to a weaker party, as a patient. The doctor

may be perceived as a representative of a powerful party, the medical establishment.

Handy (1985) proposes five different types of power. These are:

(1) 'Physical': referring to the use of physical power or coercion; it is normally an unacceptable use of power. Physical power also includes verbal aggression, for example, the employment of a hectoring tone to overcome an opposition.

(2) 'Resource power', where this refers to the possession of a resource that can be useful in the influence of others. The person who has access to the resources has the power to offer or withhold them and this can range from allowing the use of a telephone to the sanction of resources such as finance.

(3) 'Power of position' which is linked to 'resource power' and refers to the position that individuals hold within an organisation or hierarchy. A person at a senior

level in the organisation may have access and control of resources that might be of use to the advocate.

(4) Fourth, 'expert power' refers to the power of expertise or specialist experience where a small difference in expert power between people can give power to one person over another. For example, the nurse's knowledge of the ward routine confers power towards the nurse rather than the patient who does not normally know the routine.

(5) 'Personal power' refers to personality and charisma and it can be linked to position power and the character of those who have power in an organisation. When considering 'power', there is a need to consider the relationships between people with different levels of power.

Teasdale (1998) discusses the potential occurrence of a power imbalance between patients and doctors. It is acknowledged that a healthy person has little need for an advocate in their lives

and that most people are able to cope well with their affairs. However, when admission to hospital is required, an imbalance of power normally occurs between the patient and health care staff. This may be caused by the presence of illness in a patient, who may experience a loss of control over their body. For example, the patient's loss of consciousness has implications for a patient's ability to communicate, or the presence of a physically debilitating disease, causing the patient to be dependent on other people. Owing to their physical or psychological needs, patients normally voluntarily place themselves in the care of others, such as nurses.

Due to a patient's dependence and lack of knowledge concerning the health care system, he or she can be considered as having an ability to exert less power than the nurse. Patients may expect that they should assume a passive role with regard to health care professionals and this could be particularly prevalent in areas that practice institutionalised care. The physiological dependence and psychological expectation of a patient can allow the imbalance of power between the health care professional and patient to go unchallenged. There are examples of established hospital customs constructed by staff,

patients are often unwilling to criticize professional practice on the grounds that the professional must have a good reason for what they are doing. This could be reflected by the view held by the professional staff, that patients possess insufficient knowledge from which to launch an effective criticism of the professional and health care organisation. A case can be made that an effective response to a patient's lack of empowerment should be an encouragement and empowerment to self-advocate. Having discussed the forms of advocacy I will now offer a summary of the chapter.

9 Summary

In chapter two, I have made reference to the differing forms of advocacy, namely, self-advocacy, Gadow's existential advocacy, Curtin's advocacy as a natural role, citizen or independent and collective or group advocacy. The common theme concerning these forms of advocacy relates to an acknowledgement that for clients or patients requiring health care to have an effective voice, there is a requirement for some form of advocacy. The type of advocacy required is dependent on the abilities and needs of the clients or patients and ranges

from self-advocacy, relating to a patient's self-determination to group or collective advocacy, that may be required by people with mental health problems or learning difficulties. In chapter three I will consider some professional issues that relate to advocacy.

CHAPTER 3 PROFESSIONAL ISSUES

1 Should a Nurse Take on an Advocacy Role?

The argument that professionals, such as nurses, ought to take on an advocacy role has implications for the relationship of healthcare professionals with their clients. The act of advocacy by the professional tends to be personalized to a particular individual or to specific issues that may affect a client. The nurse can make the case that he or she is knowledgeable about the healthcare system and is likely to be able to communicate with influential people. The nurse should also be in the position to offer an appropriate and effective response. He or she may perceive an obligation to help a patient where required and this may be considered as an integral part of a nurse / patient relationship. Nurses and patients can be considered as natural allies, in that both can be viewed as having less power than doctors in the health care system and the patients may feel less intimidated by nurses than by doctors.

1a Support for an Advocacy Role

All of the five nursing perspectives offer support for an advocacy role. According to Gates (1994), nurses spend a large proportion of their time with people and are therefore in a favourable position to act as an advocate on behalf of their patients. Gates (1994) offers the following definition of 'advocacy' that can be readily applied to nursing, as:

> 'The process of befriending and, where necessary, representing a patient, client, partner or protégé in all matters where the nurse's help is needed, in order to protect the rights or promote the interests of that person. The practice of advocacy must be undertaken in a true partnership, where the nurses see these partners as friends and therefore afford them the same care and love as they would to any of their own friends or relatives.'
>
> Gates (1994:2)

From the above definitions, one can suggest that Gates offers support for the concept of advocacy.

Gadow's (1980) offer of support for an advocacy role is based on the fact that a nurse is intimately involved in the twenty-four hour care of his or her patients, placing him or her in a strong

position with regard to the role of patient's advocate. According to Gadow (1980) the nurse occupies a position, where he or she can get to know the patient well and to ensure that necessary information is given, so that a patient can make decisions concerning their treatment.

According to Gadow (1980) the nurse, acting as an advocate, ought to form a participative relationship with a patient, with the intention of identifying and fully understanding the patient's illness in terms of personal meaning, experience and effect. For Gadow (1980), a patient's self-determination is based on the right to do what he or she wishes, so that the patient rather than a health care professional makes the decision. As previously suggested, Gadow (1980) emphasizes the importance of a patient's self-determination, where this person's understanding of an illness and associated investigations may influence their decision concerning the available treatments and their side effects. For Gadow (1980), the patient's experience of an illness ought to be a major factor in any consideration with regard to advocacy.

According to Gadow (1980), the role of a nurse should include that of acting as patient's advocate and advocacy should be therefore normally be considered as an 'existential' element of a nursing role. For her, the role of the nurse should relate to the patient's needs as an individual and she offers the suggestion that the role of a nurse as advocate should reflect this philosophy. A nurse, who is able to offer a patient information and support concerning decisions to be made with regard to his or her treatment, may enact this.

Gadow (1980), distinguishes existential advocacy from other concepts of advocacy, i.e., that of paternalism and patient's rights. She accepts that, with reference to paternalism and advocacy, conflict may occur in health care. For her, the nurse must try to reconcile nursing's traditional support of the patient with the expectation by others that nurses should work as partners in medicine. This concerns the role of the nurse with reference to the view held, that care of patients should be comprehensive and personalized. The emphasis is on patient-centred care and this is considered as a contrast to a concentration on the dysfunction of an organ or system within a person as can occur when a patient is labelled according to their

illness. The view of individualized nursing embraces the intimate physical care that is offered, involving the activities that the patient would normally carry out for him or herself and the nurse may be the first person other than the patient to carry out such care. Gadow (1980) considers the nurse as the person among the identified health care personnel who is able to view a patient as a human being with individual strengths, physical/psychological traits and this is seen as a precondition for advocacy.

According to Gadow (1980), the philosophical foundation of positive existential advocacy is considered as applicable to any situation and is regarded as a pre-requisite to the free determination of a nurse-patient relationship and the form that this relationship should take. Existential advocacy can help people to gain a clear understanding about what they want; it can also help to clarify the values of those involved in situations and to aid decision-making.

1b Problems With the Advocacy Role

Some problems have been identified with regard to an advocacy role. Gates' interpretation of an advocacy role appears to represent a potentially large commitment by the nurse, in terms of time and emotion and this could be considered as unrealistic when one considers the workload of a nurse; for example, when working in an acute adult nursing area.

Gates (1994), acknowledges that this represents a heavy commitment for a nurse, when he suggests that:

> 'Because of the commitments of such a partnership it may be necessary for a nurse to seek the assistance of an independent advocate. Such assistance should be sought when the demands of professional or employer / employee roles prevent nurses from affording their patients the requisite degree of care or commitment.'
>
> Gates (1994:2-3)

With regard to nursing professionalism and accountability, Gates (1994) offers a discussion of the implications of a nurse's advocacy role and he makes an observation that in some situations nurses ought to take on an advocacy role. He

however qualifies this by acknowledging that they should be aware of the possible consequences and tensions that may arise from such a role and suggests that nurses ought not to be placed under pressure to accept this role when it could cause a conflict of interest and, or distress.

1c Gates' Four Principles

Gates (1994) expands on the above, when he identifies four principles that a nurse ought to consider when deciding whether to undertake the role of advocate. These are:

a) 'Accept that it may not always be appropriate for the nurse to act as advocate.'

Gates (1994:82)

One of the reasons offered by Gates (1994:66-7) for the inappropriateness of a nurse acting as a patient's advocate, is that nurses are normally employees of a hospital or other organisation and may not be able to be independent of the organisation's interests.

There may also be some dissonance between the nurse and the patients in his or her care, for the two parties may come from

different socio-economic backgrounds and the nurse may even, for some reason, take a personal dislike to his or her patient. Gates (1994) offers a description of some ethical dilemmas that may have an effect on a decision made by a person, with regard to whether or not he or she should act as a patient's advocate.

If a nurse makes a decision not to act as an advocate, this may come into conflict with his or her intent to act in a caring manner towards a patient. Although the nurse would not wish to actively harm a patient, the act of refraining from undertaking the role of an advocate could result in the patient's welfare being compromised. Gates (1994:37-41) acknowledges that bodies other than nurses may be better placed to act as advocates on behalf of clients or patients.

Gates (1994) considers the potential effect of an advocacy role on a nurse and this is described in b), when he suggests that one should:

b) 'Recognize that should the nurses act as advocates they are likely to experience, with some intensity, a range of emotional responses to complex and difficult situations.'

Gates (1994:82)

Gates (1994) acknowledges that a nurse who wishes to take on the role of patients' advocate should be aware of the possible emotional effects that this can bring. Gates (1994) accepts the importance of adequate preparation for this role.

Gates (1994) offers the suggestion that there ought to be support for the advocate, as identified in (c), when he suggests that an advocate should:

c) 'Be prepared to discuss feelings experienced with trusted colleagues, or seek professional counselling for support.'

Gates (1994:82)

It is important that a person who wishes to act as an advocate should know that support is available with the aim that such a role can be strengthened.

Gates (1994) notes that the nurse may not always wish, or be able to undertake an advocacy role and should be able to indicate when this is so. He or she should be able to refer the client or patient to an advocacy organisation who may be more suited and able to take on the role, as identified in d) where Gates (1994) suggests one ought to:

d) 'Recognize that there is no need to be fearful about or ashamed of not defending a patient's rights in person. The nurse must learn, instead, to refer the patient to an independent advocate or advocacy scheme, should difficulties be experienced.'

Gates (1994:82)

Having identified Gates' four principles, with regard to nurses taking on the role of advocate with regard to their patients, an argument related to the concept of advocacy can be made on the basis that the notion of advocacy can be considered as questionable, will now be discussed.

1d The Coherence of Advocacy

Allmark and Klarzynski (1992) hold the view that 'advocacy' can be considered as a questionable notion and nurses may, regardless of the requirement of their patients, practise advocacy. Such patients are considered by the authors to be pawns in a professional power game that occurs between the nurse and doctor. The nurse's employer may hold a perception that the nurse lacks the power, knowledge and skills that are required of an effective advocate. From this base it can be deduced that the nurse as a professional, may find it difficult to maintain an objective stance when acting as advocate. There

will be an obligation by the nurse to work within certain rules and regulations set by the employer that may have an effect on the nurse's advocacy role. In this sense the nurse cannot be considered as neutral, for there is the potential that there may be an unwitting collusion by the nurse with the employer's policies regarding the care of and communication with patients. This is based on the fact that the nurse is employed by the same organization that has a responsibility for the client's health care. There ought also to be a consideration with regard to the time limit that a nurse can spend on forming a relationship with a client, as this can restrict the nurse's ability to act as an effective advocate. Teasdale (1998) offers a contrasting view to that of Allmark and Klarzynski (1992) and this is identified as the 'middle position', as described next.

1e The Middle Position

Teasdale, et al (1998:24) points to a middle position with reference to nurses and their role as patient's advocate where he accepts that the nurse's role as advocate is linked to possession of power. The personal qualities of the nurse, such as determination and the ability to tolerate uncertainty, are considered as important and there is a requirement for the nurse

to attain a certain level of knowledge and skill with regard to advocacy. Nurses, through a motivation to care, are often willing to adopt a role as an advocate without a careful consideration of the consequences. The use of advocacy agencies that are independent of the employer and are considered as neutral ought to be entertained. The effectiveness of advocacy can be related to the amount of power delegated from the patient and employer to the nurse. Having discussed differing views of advocacy, Teasdale (1998) is able to offer a description of a way forward.

Teasdale (1998) suggests that the fact that advocacy is required by clients, demonstrates that society is far from perfect. The need for advocacy by sections of people, for example, those with learning disabilities, the elderly and those with mental health problems, serves as an indicator that the provision of services by society are sometimes inappropriate or, at the very least, less than adequate. A power difference may be present between clients, their relatives, carers, the health care professionals and those who run the services and it is accepted that the person who voluntarily acts as an advocate may have to consider the potential risks that are involved.

1f Further Negative Factors

Teasdale (1998) acknowledges that there are risks associated with the role of advocate, and that these risks relate to the potential for the occurrence of conflict between professionals, for example, doctors or nurses and their patients. With reference to whistle blowing and the professional, there is the potential risk to a career (as illustrated by the Pink case-study in part two of the thesis). Many health professions, including nurses, have codes of conduct that are designed to protect the patient's interests. The code may be also used to protect the professional, who holds the belief that he or she has a duty to act as 'whistle blower' in the interests of his or her patients. Proposals were made by the 1997-2001 Labour Government to give employees certain 'whistle blowing' powers in the public interest. This concerned, for example, the presence of a dangerous practice that could not be reversed or modified by an appeal to the management of an organization.

According to Teasdale (1998), there are different degrees of risk. For example, a low-level risk could relate to communication between health care professionals. A high level risk may relate to a nurse's perception of the need to act as a whistle-blower on

behalf of a group of elderly patients, while at the same time risking his or her position as an employee (as described in the Pink case-study). The nurse who is employed and at the same time wishes to undertake the role of advocate would normally have a degree of obligation toward her employer, who is charged with the responsibility of providing patient care. The nurse cannot therefore be considered as wholly independent of her employing organization, as in the case of an independent advocate. Therefore, before the nurse is able to accept a role as advocate, he or she should consider how the attendant risks of advocacy could be reduced, as described next.

Teasdale (1998) proposes that the advocate should attempt to forecast the possible occurrence of risk that may cloud the advocate's judgement concerning the issues that are involved. Teasdale (1998) offers a suggestion that an advocate ought to adopt an assertive and non-aggressive approach with the aim of facilitating an effective handling of a difficult situation. He also makes the point that he or she ought to forecast the possible risks prior to deciding to take on an advocate's role. An example can be given of a patient having an unreasonable expectation of the health service, as for instance, that the service should

provide a twenty-four hour companion service for one patient in a NHS ward. Teasdale (1998) offers suggestions for steps that can be taken to assess and then facilitate a reduction of such risks.

Teasdale (1998:14) makes reference to the act of whistle blowing, where it is thought that the continuation of an action or policy may result in individual harm. The advocate may feel that it is necessary to stop a policy or action and, if unable to do so, may be faced with the dilemma as whether or not to place the information in the public domain, by going to the media. There may be a contractual constraint on such an action, for example, a contract of employment. This may be used as a basis for the discipline and dismissal of an advocate who may be subjected to intimidation from colleagues and threats from management concerning possible redeployment and promotion prospects. Such an act of 'whistle-blowing' is related to a professional person's level of conduct and accountability, as illustrated by reference to the Pink case, described later in the thesis.

With reference to Gadow's existential advocacy perspective, the practice of existential advocacy involves the application of resources that are at the disposal of the professional, as nurses, and these are directed towards the patient with the aim of meeting their needs. There should be an emphasis on the requirement of a nurse to view a patient from a holistic perspective, with the aim of designing appropriate care, the nurse is perceived as normally the best person in the health care system to deal with the patient. The nature of nursing care, as a sustained and intimate occurrence, offers an opportunity for the employment of a nurse's repertoire of skills and abilities. I will now offer a consideration of the differences that may occur in the Professional-Patient relationship.

2 Professional-Patient Relationships

Gadow (1980) identifies three main areas where differences can occur in the professional-patient relationship. These are: 1) the focus: 2) the intensity of the situation and: 3) the perspectives held by both people.

1) The focus refers to the patient's perception of their problem and effects that this has on his or her life. The patient's view is necessarily self-orientated, as he or she will obviously be the person most closely involved. In contrast, the focus of the professional is normally away from the self, for the professional would typically be interested in the patient's welfare, rather than his or her own.

2) The intensity of the situation refers to the immediacy of the problem and the distress that can be caused by it. As previously suggested, the patient is the person most affected by the symptoms of a disease and the possible side effects of treatment. The professional typically feels a sense of urgency but does not experience the problem first hand. However the professional may demonstrate a level of concern and should be able to reflect on how to alleviate the patient's distress.

3) With reference to the different perspectives held by the patient and professional, the patient is

personally involved with the disease through their experience. The professional is externally involved, through caring and there may be a level of emotional involvement with regard to the patient.

The differences with regard to the above three areas with reference to the relationship between the patient and the nurse concern three areas regarding:

a) The 'focus'; in terms of a patient this refers to his or her experience of illness, for example, pain and the patient's psychological concern regarding an illness and its effects. This may lead to the patient having to concentrate on his or her illness at the expense of other everyday activities. The nurse at work however, has an obligation to concentrate on the care of his or her patients and to set aside personal problems.

With regard to:

b) The 'intensity'; the patient may experience a lot of pain as part of his or her illness; this would lead to a requirement by the patient for some form of analgesia. The nurse would not be able to feel the patient's pain, but should be able to appreciate how much pain the patient is likely to suffer and be in a position to offer analgesia as pain relief, also to show empathy towards the patient.

The related idea of:

c) 'Different perspectives' refers to the internal experience of the patient who is most directly involved with the illness and this is a contrast to the external perception of the nurse. The patient often acknowledges that the nurse is willing and able to give care that should benefit the patient. The nurse may be affected by the condition of the patient, for example, when the patient's death is predicted.

An acknowledgement of the above three points can be considered as desirable, when one considers the differences in the nurse-patient relationship, as the development of this relationship occurs. For Gadow (1983), this is considered as an important basis for the occurrence of advocacy as she lays an emphasis on nurses valuing and offering their patients respect and this is developed with reference to 'existential advocacy'. Having previously considered the differences in the professional–patient relationship. I will now consider the factors that ought to be considered by an advocate.

3 Points to be Considered

Teasdale (1998) offers both an encouragement and a warning to those who wish act as patient's advocate. Teasdale (1998) acknowledges that institutions charged with the responsibility of providing health care may act to disempower their clients. He accepts that although unintentional, this may still occur and also warns of the potential occurrence of personal and professional costs for the nurse who accepts an advocate's role. He acknowledges that the nurse may incur employment costs, where a potential for promotion may be reduced. The nurse may also experience stress as a result of his or her perception of the

situation and role in relation to the client for example, he or she may suffer internal conflict when the issue concerns a patient for which he or she has nursing responsibility.

Gates (1994) acknowledges, as described earlier in this chapter, that tensions may occur between a person taking on the role of advocate and working as a nurse and that the two roles may be mutually exclusive. This may lead to role strain due to the different demands made on the nurse by organizational bodies such as the employer, the Nursing and Midwifery Council (NMC) and individuals such as patients, their relatives and nursing colleagues. This may lead to a nurse acknowledging that it may not be possible or desirable to take on such a role, for in doing so, the nurse may incur personal costs. The possibility of role strain has to be considered when one makes a decision whether or not to act as an advocate.

Turning to Kohnke's (1982:9) perspective, there are three levels of advocacy; the first refers to the role of a patient and self-advocacy; the second, to the advocate acting in support of a patient or client. The third level of advocacy refers to the larger community, of which the advocate is part. This level of advocacy

can be interpreted as meaning any action that the advocate may wish to take with the aim of giving voice to and supporting concerns of people in the community. For example, The Advocacy Alliance, as described by Sang and O'Brien (1984), can be applied to vulnerable groups such as elderly or people with mental health problems that are living in the community. Alternatively, the role could relate to the ability of an advocate to make a case, where the advocate is a professional person with good communicative skills who is likely to obtain the required result. This has implications for the professional who takes on the role of advocate as a nurse and is related to the advocate's action role.

4 An Action Role

According to Kohnke (1982), the advocate should engage in an action role to support a patient's decision. There is an acknowledgement that this role does not require that the advocate should approve of the patient's decision. The patient should be made aware that he might experience pressure from others to change decisions that he may not wish to change. It should be made clear to the patient that he or she should not

give in to those pressures unless he or she wishes. The consequences for the advocate may relate to the possible interference in the actions of others, who are trying to lessen the patient's confidence in his own ability to make decisions.

5 Internal Contradictions

As a professional the nurse may possess internal contradictions and according to Gadow (1980), the two contradictions that obstruct self-determination in health care for nurses, are the differences between a practitioner's personal and professional involvement in patient care. The personal involvement of a practitioner as for example, a nurse, refers to his or her individual belief and feelings toward a patient and the care that is planned. The professional aspects of nursing relate to a specific code of behaviour and standards that are expected. A nurse may experience internal contradictions with regard to the welfare and care of a patient that could be related to the nurse's personal preferences and professional obligations. This could affect the nurse's ability to make decisions and therefore must consequently have an effect on a patient. The prerequisite of a successful adoption and application of existential advocacy by nurses rests on the basis that any internal contradictions

relating to personal and professional issues concerning the nurse have to be overcome. The existence of internal contradiction can lead to an alienation of the self and personal confusion, this may result in the nurse becoming engrossed in personal and professional considerations concerning the care of the patient and may potentially affect this care. As intimated previously, the personal and professional considerations that a nurse has to acknowledge, do not always rest comfortably with each other.

Gadow (1980) perceives the potential for an occurrence of a dichotomy between the nurse and his or her patient; the professions normally emphasize that their members should behave in a particular manner towards patients and normally personal relationships between nurses and patients are discouraged and regarded as unprofessional. From a traditional point of view the personal and professional roles are aspects that a practitioner should keep segregated. There is an emphasis on the professional avoiding personal interactions; this relates to the professional's expression of personal feelings or values when working with a patient whose lifestyle the professional as an individual does not approve. From this point

of view, it is suggested by Gadow (1983) that professional individuals can be considered as interchangeable, in that all of these people should be able to articulate a professional response to situations that would normally lead to a lack of expression of their individuality.

A further view articulates an idea, that the role of a professional is one of many that is normally undertaken by people in their lives, for a person normally exhibits different facets of personhood according to the assumption of a specific role. It can be said that professionals exhibit some personal behaviour through the mere articulation of their role. This could be interpreted with reference to the professional's abilities in relation to that role, as for example; the humanity demonstrated by a professional whose role includes a management function. Having considered some of the tensions that can occur between a nurse's personal and professional role, I will now consider the differences of perspectives held by the nurse as a professional and that of a patient.

For Gadow (1980), the difference in personal perspectives between that of the nurse and patient relate to the body rather

than emotion. The patient personally experiences his or her body and the associated perceptions that arise from it and this leads to the formation of subjective perceptions, whereas the nurse as an outsider normally experiences the body of a patient from an objective and scientific point of view.

6 A Practical Application

Gadow (1980) offers a description of a patient's gynaecological examination. From the patient's lay perspective, the examination is intensely personal and related to the patient's notion of privacy, therefore any attempt to examine this area of the body may be perceived by the patient as an invasion of privacy. The nurse's professional perspective would normally account for a patient's examination as a necessary clinical procedure; the nurse would typically take an impersonal view of the patient's body during examination that is based on a view that this represents a malfunctioning structure. The nurse would also typically consider the patient's embarrassment as a natural consequence of such a clinical examination and scant attempt may be made to lessen the patient's embarrassment, apart from the normally acknowledged convention of maintaining the patient's modesty by concealing the appropriate parts of the

body. Further embarrassment that may be experienced by a patient would typically be considered as normal during this type of procedure and the nurse could assure the patient of the routine nature of such an examination. As previously described, the patient may experience a contradiction between his or her own personal perception and feelings towards his or her body and that of the professional undertaking the examination. It would seem pertinent at this stage to offer a discussion as to what is meant by 'private', (as applied to the patient), and 'public' (as applied to the nurse).

Gadow (1983:51) links the nurse's experience concerning the potential for his or her personal and professional involvement with the patient, to a separation of the patient's body into 'private' and 'public'. The 'private' concept of the body refers to the personal knowledge and experiences of a patient and the 'public' concept relates to the public facets of the body. An assumption has been made, that the nurse's personal involvement with her patient could affect her function as a professional. There has also been an acknowledgement that the patient's subjective view of the body could act as a contradiction with regard to a clinical perspective of a body as an object.

The nurse may view the patient from an objective perspective, even though the nurse holds a perception of a patient as a person. For example, the nurse could perceive Mrs Jones, the patient in her care, as a person. However, from a nursing perspective, the operation that Mrs Jones requires may reduce her to the woman who is the fourth patient on the operating theatre list for an abdominal operation. The nurses' view of their patients in professional and objective terms, rather than their perception of the patient as a person, can be linked to the resources, nature and organization of the Health Service. Typically, this has an effect on the amount of time that nurses are able to spend with their patients. This is also linked to the expectations that nurses make of themselves and others, through their appeal to the code of conduct (NMC 2002), which acts as a regulatory influence with regard to their role. Should a nurse exhibit over-familiar behaviour towards a patient, this may be perceived as crossing the line that divides professional from personal relationships that can be difficult to identify, leading to a discussion concerning a professional's access to the body of a patient. I will now consider the case that can be made for and against a nurse acting as patients' advocate.

7 The Arguments Regarding Advocacy

There are arguments for and against the nurse taking on a patient's advocate role and some of these will be discussed next.

7a The Case For Patient Advocacy

As previously described, all the authors make the point that they consider patient advocacy should be an integral part of the nurse's role and there are three reasons for this. First, with regard to the work of Gates (1994) and Teasdale (1998), the United Kingdom Central Council for Nursing and Midwifery (latterly replaced by the Nursing and Midwifery Council), offers support for the role of the nurse as patient's advocate. The members of the Council have formulated a Code of Conduct (2002, see appendix 2) that normally reflects the moral beliefs with regard to the role of the nurse as a patient's supporter and carer, that are typically held by a nurse as an individual, and also nursing as a profession.

Second, the nurse, when caring for patient typically possesses knowledge of the health care system, its function and normally has a good clinical knowledge of patients in his or her care. This

enables the nurse to facilitate an effective interpretation and clarification of information by the nurse for his or her patient and this can be considered as forming a sound basis for an advocacy role.

The third reason refers to the fact that a nurse can be considered as removed from his or her patient's relatives and therefore can maintain a level of impartiality and objectivity with regard to both the patient and relatives. These reasons offer a sound basis from where the case can be made for nurses taking on a role as patient's advocate. In contrast, I will now take this opportunity to consider the case that can be made against nurses taking on the role as patient's advocate.

7b The Case Against Patient Advocacy

There are three reasons that can be identified with regard to nurses declining to accept a patient advocacy role.

First, the nurse may lack a personal moral obligation to act on a patient's behalf as for example, when a nurse is caring for a patient who has problems that the nurse considers as self-inflicted as in a suicide attempt, or a patient who has HIV due to

unprotected sexual intercourse. This could be linked to a nurse's lack of knowledge concerning these problems that may lead a nurse to stereotype his or her patients negatively, based on a lack of understanding with regard to the cause of a patient's social behaviour and lifestyle. The relatives and friends of a patient may have a better understanding of these factors and therefore may occupy a stronger position than that of the nurse, with regard to acting as patient's advocate.

Second, the nurse is normally employed and therefore cannot be considered as neutral, for the nurse would have certain moral and legal obligations to her employer. One such obligation could be that the nurse should make known her concerns with regard to patient care only to his or her employer, rather than publicising them in the press. This would have implications for the nurse who considers that it has become necessary to 'whistle-blow' after attempts to use the conventional channels of communication with his or her employer have failed.

Third, when undertaking the role of advocate, the nurse runs a personal and professional risk in terms of disciplinary and promotional consequences. For example, when a nurse

perceives that there is a need to 'whistle-blow' regarding the resources that are available for patient care and standards of nursing care that can be offered. The nurse who attempts to 'whistle-blow' may risk an adverse reaction from an employer at a professional and personal level, for example, being passed over for promotion and having his or her place of work in the clinical areas moved with the aim that the nurse should leave employment in that organisation. A further risk relates to the assumption of a nurse's rescuing role of a patient coupled with an associated risk of paternalism. Similarly, when he or she is caring for a non-competent patient, the nurse ought also to consider whether an advocacy role is appropriate. Such a patient would not normally be able to articulate his or her preferences, decisions and therefore the nurse acting as advocate could not ensure the absence of paternalism with regard to any decision that is made, whatever the nurse's motivation. It would seem pertinent at this stage to offer a discussion of the advocacy role.

7c A Discussion of an Advocacy Role

The underlying justification for the assumption by a nurse of an advocate's role has been previously identified and has

implications for the nursing role. If a nurse does not take on the responsibility of acting as patients' advocate, this may be left to others who may consider such an action as part of their role, as for example, doctors and administrators. These people may not possess a nurse's breadth of knowledge concerning the patient and his or her care. The nurse typically possesses a certain level of skill in dealing with people, including an ability to sense when patients may want to know every detail about their illness and when it may be sensible to leave such information to a later and more pertinent time. In this way the nurse's actions may lessen the risk of strong paternalism and help to create the conditions where the interests of the patient can be adequately represented.

The rationale offered for the nurse's reluctance in assuming the role of patient's advocate has been previously described. The negative reasons are considered as an insufficient basis on which to claim that nurses ought not to take on the role of advocacy, as safeguards can be put in place to overcome them and adequate responses can be made in defence of the nurse acting as an advocate. The reasons and rationale for nurses assuming an advocacy role are in my view, sound and ought to

outweigh the reasons for not taking on such a role. One way of calculating whether, in certain circumstances it is appropriate to act as advocate, is to use an 'Advocacy Flow Chart' as described in Teasdale (1998).

8 The Advocacy Flow Chart

Teasdale (1998:33) describes an advocacy flow chart, as illustrated in Appendix 1. This can be used to indicate a client's need for advocacy and the decisions that have to be made by the potential advocate. It has been constructed with reference to an analysis of one hundred and fifty critical incidents as cited by health care professionals from their clinical practice. The first consideration relates to the client's ability to identify his own wants, if he is able and the question is raised as to whether the advocate supports the client's wants. If the client is unable to identify his wants, the chart indicates whether the advocate can assume the client's wants. If the client is unable to express their preferences and the potential advocate is unable to ascertain the client's wants and is also unwilling to take risk by assuming an advocate's role, a suggestion is made that the potential advocate ought to offer some form of help other than that of advocacy. If the potential advocate offers support with regard to

the client's wants and is willing to risk advocacy and perceives that the client, with help, can make decisions (self-advocate), the chart suggests that empowerment of the client ought to occur. It is proposed that in the absence of self-advocacy the help of an external advocate should be sought. The advocacy flow chart embraces the relationship between the advocate and client or patient and therefore has, at a certain level, to take into account the ethical considerations with regard to advocacy.

9 Summary

Chapter three refers to some professional issues that concern the role of advocate and the professional nurse-patient relationship. Some positive and negative points are identified and explored concerning an advocate's role. The content of the chapter indicates that a nurse should consider the professional issues when contemplating whether or not to take on a role as an advocate. A clinical application of Gadow's perspective on advocacy is identified, demonstrating the relevance of her ideas and the use of an Advocacy Flow Chart is described, where one can consider a situation that may require advocacy and assess whether or not one should take on a role as advocate. In the

next chapter, I will consider the strengths and weaknesses of the five authors' positions on advocacy.

CHAPTER 4 AN EVALUATION OF THE FIVE VIEWS

I will now consider the strengths and weaknesses of the five authors' views of advocacy.

1 Gates' View

There are two strengths with regard to Gates' (1994) perspective. The first concerns his thoughtful and balanced account of the general principles of advocacy that he is able to apply to nursing. He cites many illustrations of advocacy, for example, with reference to clients who have a learning disability; these are used to identify a need for someone to assume an advocacy role for a vulnerable client. Gates (1994:41) suggests that the successes of advocacy schemes are due to commitment, good organization, independent funding and effective communication. Gates (1994) also offers a definition, description and discussion of advocacy and can therefore be considered as a useful nursing resource.

The second strength concerns his acknowledgement that advocacy has to be considered in context of a situation that exists in the nurses' place of work and that there is the potential

for an advocate to incur personal costs. The complexity of organizations such as hospitals and the expectation of the different people that come in contact with the nurse can complicate an advocate's role. In order to offer clarification, Gates (1994) has provided an account of advocacy and has drawn attention to some of the problems that can occur when nurses take an advocacy role. There is a criticism that can be made with regard to Gates' (1994) views of advocacy, as described next.

From my reading of Gates, (1994) there is one identified weakness in his account of advocacy, when he allows for the view that nurses may not always be considered as the best people to take on the role of advocate on behalf of their patients. It could be argued that a person who does not have any formal employee links to the organization should be the person to assume the role of advocate. However, Gates (1994) neglects to suggest that such a 'citizen advocate' or 'independent' person (as described in Gates, 1994:6) may possess and have less access to knowledge than that normally held by a nurse. This does not seem to be adequately discussed in his book and can be considered as a serious weakness.

Having identified this criticism, I will now consider Gates' (1994) response. Gates (1994) would suggest that one should also consider whether nurses who are employed by an organisation and charged with responsibility of caring for a patient or client, could run the risk of being viewed as being too close to such a body. In this context, an independent advocate could be considered as a more appropriate person. The issue concerning such an advocate's depth of knowledge could be challenged on the basis that an independent advocate should be able to support a patient or client, irrespective of their level of technical healthcare knowledge. Therefore, the advocate should be free of potential influence from a healthcare organisation, as for example, an employing hospital. I will now turn to Teasdale's (1998) account.

2 Teasdale's View

There are four strengths in Teasdale's (1998) account of advocacy. First, he is able to demonstrate an understanding of the complexity of the term 'advocacy'. He describes how the three different views of advocacy, namely; self-advocacy, citizen advocacy and collective advocacy may be applied to care

related situations as they arise, his theory therefore provides a firm academic basis for his book. Second, in common with the other four theorists, he stresses the importance of respecting the preferences of patients. Third, Teasdale (1998) acknowledges the existence of power relationships between the professional carer, as a nurse or doctor and his or her patient. Fourth, he acknowledges the presence of risk that may be associated with advocacy and offers suggestions as to how these may be minimised. Having described the strengths of Teasdale's (1998) account of advocacy, I will now identify a criticism of his work.

There is one criticism that can be made of Teasdale's (1998) book and this refers to a problem concerning the nature of his interpretation of 'self-advocacy'. Thompson (1995:20) defines the term 'advocate' as, 'A person who supports or speaks in favour.' For Teasdale (1998) the concept of 'self-advocacy' is interpreted as the empowerment of a patient that is achieved by ensuring that he or she has adequate information to make an informed decision with regard to the available. The patient ought to be therefore normally in a position to express his or her preferences concerning treatment or care. It would therefore

follow that if the patient were able to make an informed decision concerning his treatment and welfare, he would not need an advocate. Should the patient require information concerning his treatment or welfare, he should be able to obtain this directly from the appropriate professional or access help from an external source. Therefore, with regard to a patient who is able to make the necessary decisions concerning his welfare, the term 'self-advocacy' could be considered as a contradiction, with a potential that its use could lead to confusion.

This criticism of Teasdale's (1998) account of advocacy invites a defence of his position. A justification of Teasdale's (1998) position could be made on the basis that an attempt to redefine the term self-advocacy as a form of patient or client autonomy, with regard to informed decision-making, would amount to an exercise in semantics. A patient acting as a self-advocate is normally offered the necessary information to enable him or her to make a decision. The title assigned to this patient, whether it is 'self-advocate' or other can be considered as immaterial; the crucial factor being that the patient is able to make informed decisions regarding his or her welfare. I will now consider Gadow's (1983) perspective.

3 Gadow's View

The fundamental strength in Gadow's (1983) account of advocacy rests on her ability to offer a firm academic basis for Advocacy. This is accomplished in terms of a), her emphasis on allowing a patient to practise self-determination and b), her conception of the 'lived' and 'object' body. With reference to a patient's self-determination, (a) Gadow's (1983) work on existential advocacy relates to the freedom of people as patients to self-determine their lives in terms of their preferences concerning treatment and care. The emphasis for Gadow (1983) is a requirement that nurses should offer their patients adequate information with the aim of providing a basis that allows the patient to make an appropriate decision. Gadow (1983) rationalizes correctly, that the patient is the person who has the illness and therefore is best placed to make decisions concerning her treatment and care. With regard to Gadow's (1980) theoretical framework, she places similar emphasis to that of other authors on advocacy, namely the importance of a patient's self-determination.

With reference to her conception of the 'lived' and 'object' body, Gadow (1980) is able to give a firm rational basis for a patient's personal experience of their disease and linked to the possible treatment by a nurse, of a patient as one a class of people with a particular disease. In this way she can offer an adequate explanation for the relationships that occur between the patient and the professional carer.

Therefore, according to Gadow (1983), the nurse should attempt to understand and empathize with the patient with the aim of appreciating their social and medical background and acknowledging the importance of the patient's experience. Gadow (1983) refers to the 'lived' body where a nurse ought to seek to understand the patient's experience of an illness, thereby allowing the nurse a certain level of insight with regard to the patient's problems and consequent experience. This, for Gadow (1983), forms the basis of advocacy. Although Gadow's (1983) perspective with regard to advocacy can be considered as applicable to the sentient patient, there is a problem with regard to patients who are non-sentient or silent. One ought to question the way in which a nurse could gain information about

the preferences of such patients and this is discussed in further in the third criticism that I offer, with regard to Gadow's account of advocacy.

Gadow's (1983) work on the 'lived' and 'object' body, distinguishes her apart from other authors, who do not offer this philosophical basis for their work. Gadow's (1980), work has obvious application to the role of a nurse. The strength of Gadow's (1980) position with regard to her conception of advocacy ought to be considered with an acknowledgement that there are three weaknesses that have been identified in her account, as described in the next paragraph.

There are three weaknesses in Gadow's (1983) account of advocacy. The first criticism of her approach to advocacy concerns the role of nurse as patient's advocate. The development of complex interpersonal relationships between a nurse and patient can be influenced by many factors as for example; the past experience of individuals may affect each party's perception of the other, having the potential to adversely affect patient care. Gadow's (1983:51) does not appear to adequately take into account that nurses as human beings may

find difficulty in relating to some patients, when she rejects the professional, private distinction with regard to the advocacy role.

A second criticism refers to the available resources (particularly when one applies this to the British National Health Service), which are allocated for health care. Due to advances in health technology and the need to undertake certain clinical procedures on a day care basis, the nurse may work in an area where there is a high turnover of patients. He or she may not be able to perform an adequate assessment of patients and adequately grasp the underlying factors that may be affecting patients. From this point of view, and due to the structure and organization of the nurse's working environment, he or she may not be able to see the patient from a holistic point of view. A lack of available nursing time may mean that the nurse will not be able to fully discover a patient's problems. It follows therefore, that the nurse may not be fully aware of the need to assume the role of patient's advocate. The nurse's lack of knowledge concerning his or her patient, may lead to an inadequate appreciation of the possible consequences of an advocacy role. In this context, the nurse may not be perceived as best placed to fulfil a role as patients' advocate, for a person who works

within an inadequately financed and organized system could find that they are unable to give an adequate level of patient care.

A third criticism of Gadow (1983) refers to her emphasis on patient autonomy. Gadow's stress on the importance of patient autonomy may be appropriate for those wishing to act as nurse advocates for patients in a society, as in the UK or USA. However a question could be raised with regard to Gadow's conception of advocacy, when applied to the provision of healthcare in societies other than the USA. Those societies may embrace a health care philosophy that differs from societies run on the USA model, placing less of an emphasis on the importance of acknowledging a patient's autonomy.

The criticism of Gadow's (1983) emphasis on patient autonomy can also be applied to silent patients, e.g. those who are unconscious, or are at an advanced stage of Alzheimer's Disease. Her emphasis on patient autonomy is applied to the drafting of 'advanced directives' and the accumulated knowledge of the patient held by a person who has been close

to the patient (Gadow 1989:357-358). However, she is unable to offer an adequate explanation as to how the nurse can gauge effectively the wishes of a silent patient, relying instead on the nurse's subjective interpretation of a silent patient's wishes, by placing herself in the patient's position. Due to the presence of an obvious communication barrier, this does not provide an adequate explanation as to how a nurse can act as an effective advocate for a silent patient. However, according to Gadow (1989: 541), this is considered in a more positive light, as ... 'the essential basis for a moral commitment to advocacy.'

Gadow (1983) is able to offer a defence for her case, that the nurse has a professional responsibility to ensure that adequate resources are made available for patient care (as in the case of Graham Pink).

With regard to the first criticism, Gadow (1983) would refer to the fact that the nurse should consider him or herself as a professional person and that their behaviour should reflect this. Gadow (1983) would expect that the nurse should set aside personal prejudices and disregard patient information that cannot be supported. The nurse should also take into account

that a person, in their role as patient, is normally considered as unwell and that this may have an effect on his or her behaviour.

Gadow's (1983) response to the second criticism would refer to the nursing problem of giving sufficient and good, appropriate nursing care under such circumstances. She would recommend that nurses should use their professional judgement to communicate with management with regard to the requirement for more funding and this should allow the provision of the funding required for adequate nursing of patients. Gadow (1983) would hold the view that it is the responsibility of the nurse in such circumstances to take a stand with the aim of securing more funding to adequately finance patient care.

With reference to third criticism of Gadow with regard to patient autonomy, one could respond that Gadow's (1983) approach to advocacy could be applied in those differing types of society. For Gadow (1983), the wishes of a patient are considered as paramount and consequently, any advocate should consider the requirements and wishes of the patient as of prime

importance. On this basis, Gadows (1983) account of advocacy ought to be considered as defensible.

With reference to the criticism concerning silent and non-competent patients, Gadow's (1989) emphasis on a nurse's moral commitment to advocacy ought to be considered as an aspect of care within the nursing role. When one considers advocacy as a part of a caring role, Gadows (1989) recommendation that nurses should try to gauge the patients' preferences seems to be a demonstration of a desirable moral commitment to advocacy. It now seems appropriate to consider Kohnke's (1982) perspective.

4 Kohnke's View

There are two strengths in Kohnke's (1982) account of advocacy. The first concerns her view that this application of advocacy to nursing can be considered as a complex and demanding role. For her, the concept of advocacy is based on a patient's requirement for a certain level of information. The role of an advocate is perceived as that of informing and supporting

a patient or client and there is a discussion as to how far this support should be carried.

With regard to the second strength in Kohnke's (1982) account of advocacy, she acknowledges that in respect to nursing, there may be competing professional obligations. For example, the general management responsibilities of a G grade nurse would influence the time available for the practice of nursing care. Having considered some of the strengths of Kohnke's (1982) view, the next paragraph will identify some of the weaknesses in her view.

There are two weaknesses in Kohnke's (1982) account of advocacy. These relate to; first, 'informing, supporting' and advocacy; second, her definition of 'loving and caring'. The first weakness that will be explored concerns Kohnke's (1982) notion of 'informing and supporting.'

With reference to the first weakness, one should consider in what sense advocacy relates to Kohnke's (1982:8) ideas of 'informing and supporting'. She seems to make a general

assumption that the majority of advocacy involves a person who is willing to act as a patient's mouthpiece, where the role of advocate involves that of acting as a form of communication conduit. This is based on an assumption that most patients are able to think rationally, to express their preferences and can be regarded as competent. One can question whether all competent people know what they do and do not want. Also the notion that the advocate should inform and support a patient cannot be applied to patients who are mentally incompetent, for example, where patients have Alzheimer's disease. In such cases, this form of advocacy can be considered as inappropriate.

With regard to the second weakness, Kohnke's (1982:vii) definition of the 'loving and caring' as an interpersonal relationship is based on individual choice and free will and does not adequately define the meaning of the term. This can lead to a subjective interpretation of 'loving and caring' that may depend on the motivation and perception of the individuals involved. For example, a nurse may perceive that to make an inquiry about a patient's social circumstance is considered as the right and caring thing to do. The patient may however, perceive the same

inquiry as a form of interference in his or her personal affairs. With reference to this example, Kohnke (1982) offers an inadequate justification for 'loving and caring' and she is unable to identify whether it is a natural occurrence or self-imposed discipline.

In the light of these criticisms, I will now offer a defence of her position. Kohnke's reply to the first criticism concerning her stance on 'informing and supporting' can be considered as relating to an exercise in semantics. She would offer support for the principle (identified by the other four writers), that a patient should be the person to make decisions concerning his or her treatment, welfare and that an advocate's role should be interpreted as ensuring that a patient has sufficient information to enable him or her to make decisions. For Kohnke (1982), this would be considered as the fundamental principle. However, as previously identified, any act of informing and supporting a non-sentient patient seems to be inappropriate.

Kohnke's (1982:viii) view with regard to 'loving and caring' reflects the fact that there is insufficient knowledge concerning the origin and development (whether natural or learned), of this

behaviour by one person toward another. She accepts that 'loving and caring' may have a personal effect on the advocate but emphasises that an advocate, when caring for another person, should place this in context with that of a desire to care. For Kohnke (1982) the act of 'loving and caring' represents an important part of the advocate's role as a carer and acknowledges that such a person normally has a desire to perform a social duty. In this respect, the act of advocacy ought to be considered as a creditable act that ought to be pursued. Finally I will consider Curtin's (1979) perspective.

5 Curtin's View

There are two strengths in Curtin's account. The first strength with regard to her version of advocacy refers to the fact that nurses are normally in contact with their patients and should therefore possess a level of knowledge with regard to their patient's treatment and care. The second strength relates to the nurse being normally conversant with the structure of the health service and therefore possessing an awareness of the power relationships that exist between the health care professionals

and their patients. On the basis of this view, Curtin (1979) deduces that nurses are favourably placed with regard to offering patients support in terms of ensuring that their rights are both acknowledged and supported. Having considered the strengths of Curtin's (1979) view of advocacy, I will now offer a discussion of the two identified weaknesses.

Curtin (1979) holds many ideas with regard to advocacy that are similar to the later work of Gadow (1980), whose perspective has been described in chapter four. However there are two criticisms that can be made of Curtin's (1979) paper on advocacy.

The first criticism of Curtin's (1979) position, refers to her assertion that advocacy occurs as a natural process. The natural role of advocate could be applied to areas other than nursing as for example, a mother acting as an advocate for her child. However, in a relationship that is more complicated as for example, with reference to a nurse and patient, the role of advocate could become more demanding. This can be considered as arising due to the nature of the nurse - patient relationship and the expected nursing, professional, employee

and caring roles. In this context therefore, the role of advocate ought to be considered as a learned, acquired and skilled role rather than that based on natural caring instinct as for example, in a mother – child relationship.

A second criticism concerns Curtin's (1979) distinction between human and patient's rights. Curtin (1979) makes a clear distinction between the concept of human and patients' rights that ought to be acknowledged by a nursing advocate. According to Curtin's (1979) view, patients have special needs that differ from those identified by an appeal to basic human rights. For her, the human rights model would be considered as inadequate with regard to meeting all of the patient's requirements; therefore a special category of rights is required to be articulated with the aim of addressing the needs of a patient.

One can question the necessity of such a clear distinction between human and patient rights. Curtin's (1979) distinction between human and patient's rights seems to be unnecessary since the suggested extra patient's rights could simply be added on to what is normally considered as human rights. The patient

has rights because he is human, not because he is a patient. Having described her position with regard to advocacy, one can now offer a defence of Curtin's (1979) position.

For Curtin (1979), advocacy is considered as an integral and vital part of the nursing role, for she refers to the concept of advocacy and patient's common humanity and rights. In this context, the nurse is perceived as an ideal person to take on a role as advocate, on the basis that the relationship she forms with a patient would enable her to assess the need for patient advocacy and support the patient's choices. For Curtin (1979) the rights of patients, regardless of their origin (as human or a special category of patient's rights), ought to be accorded respect.

6 Summary

During chapter four, I have identified and discussed the strengths and weaknesses of the five authors' views of advocacy. These views hold common ground on certain

aspects of advocacy and differ on others. In chapter five, these similarities and differences will be explored.

CHAPTER 5 THE FIVE POSITIONS

1 Introduction

In the previous chapters of the thesis, I have undertaken a literature review and critical assessment of the five nursing perspectives concerning an application of advocacy to the health care of patients. The themes relating to advocacy, with reference to the views of Gates (1994) and Teasdale (1998), (from the British perspective) and the views of three nursing theorists from the United States of America, namely those of Gadow (1983), Kohnke (1982) and Curtin (1979) have been described and discussed. This has enabled me to identify the North American and British perspectives of advocacy.

As previously suggested, the Americans, identified as Gadow (1983), Kohnke (1982) and Curtin (1979), consider that decisions ought to be taken at all times by the patients. From this perspective, the role of advocate should reflect this philosophy by concentrating on the empowerment of the patient by ensuring the patient's access to information and providing the patient with encouragement, as necessary.

As a contrast, the British view of advocacy as described by Gates (1994), offers a broader definition of advocacy than that of the Americans, including more involvement by the advocate with regard to offering their patients' information and support. The British Perspective also allows for a possible role of a third party, in pleading and defending the cause of patients as for example, described in independent advocacy.

The British version of advocacy, as described in Gates (1994) and Teasdale (1998) suggests that the advocate should have a role with regard to the patient's decision making and this should not, as in the American version, be left entirely with the client. Teasdale (1998:32) offers support for the different types of advocacy, on the grounds that the form of advocacy implemented should depend on the patient's needs and also whether he or she is in a position to receive information and make the necessary decisions concerning treatment. Teasdale (1998) also acknowledges that some patients may not be able to make these decisions. Where situations occur that inhibit the patient's ability to make decisions, he acknowledges that there may be a need for the enactment of Collective or Group advocacy.

The British accounts of advocacy, as illustrated in this thesis, can be considered as more flexible than those of the Americans. The Americans could identify that the British view would potentially allow for the occurrence of paternalism, with regard to the perceived needs and desires of the patients who are mentally incompetent or silent. From the British point of view, the American Health Care System lays emphasis on the right of an individual to make decisions concerning his/her welfare and this system should acknowledge the silent patient's need for legal representation with regard to his/her interests. This could cause a financial burden for the patient and a consequence of this philosophy could result in the escalation of the cost of medical treatment due to the need for doctors to prescribe exhaustive tests to prove the legitimacy of their treatment. Having identified the American and British advocacy perspectives, it would now seem pertinent to briefly identify the similarities and differences of the five previously described advocacy accounts offered by Gates (1994), Teasdale (1998), Gadow (1983), Kohnke (1982) and Curtin (1979).

2 The Positions of the Five Authors

Some interesting and instructive similarities and differences are perceived when reviewing the stance of the five authors with regard to advocacy. Although there is a general agreement between the writers that nurses should, as part of their professional role, be able to act as an advocate, each of the authors offers a slightly different approach with regard to their discussion of advocacy.

2a The Similarities

Essentially, all the authors come to the conclusion that patients who are competent should be the people considered as having an ability to make decisions concerning their treatment and welfare. However, one has to acknowledge that there are differences of emphasis that occur in the authors' approach to the nursing advocate and these will be identified here.

Gadow's (1983) perspective offers a strong case for a nurse taking on an advocacy role, as for her the nurse should embrace this role as part of a holistic approach to patient care. Indeed, based on the development of a professional relationship that typically includes a level of trust by the patient, the nurse is

perceived by Gadow (1983) as the obvious candidate for such a role. Similarly, Curtin (1979) offers a strong case for the nurse advocate role with the rationale that nurses ought to accept this role because it is the right thing to do from a human rights and humanitarian point of view. She also acknowledges some of the problems that the nurse may encounter when undertaking such a role. A weaker interpretation is offered by Kohnke (1982), for whom the importance of advocacy is linked to patient centred care. This is not afforded the level of importance, as perceived by Gadow (1983). For Kohnke (1982), there is an acknowledgement of the risks that are inherent in the role of the nurse as patient's advocate and she offers a detailed account of the problems that nurses may encounter when undertaking such a role. Having considered similarities with regard to the views of the five authors, it would now be pertinent to consider the differences.

2b The Differences

The major difference in the five authors' approach to advocacy rests on Gadow's (1983:51-55) conception of the 'lived' and 'object' body. This distinction allows Gadow (1983), as described previously, to acknowledge that from a 'lived' body

perspective, patients are able directly to experience the effect of a disease in terms of pain and discomfort. Other examples include nausea and the potential for embarrassment due to the body's production of flatus as a consequence of a disease, or as an effect caused by a medical investigation of a patient's body, as in the case of a 'Barium Enema'.

In contrast, the 'object' body, as identified previously, refers to the perception of the patient's body by a health care professional as a nurse or doctor who may view the patient's disease in a similar way that a mechanic would perceive a machine as having a mechanical fault.

From the above distinction made by Gadow (1983), concerning the 'lived' and 'object' bodies, she is able to discuss the application of this distinction to the roles of the patient and health care professional. At one stage she is also able to offer a discussion with regard to an effect of these two concepts on a person, if a health care professional were to become a patient and in this way is able to illustrate the articulation that could occur between the 'lived' and 'object' body perspectives.

3 Preference for Gadow's Perspective

With reference to the five authors' accounts of advocacy, I have come to the conclusion that of these authors, Gadow (1983), offers the most convincing account. Gadow's (1983) view with regard to patient advocacy is linked to her philosophical perspective that patients possess 'object' and 'lived' bodies. (The latter allows the perception that each patient ought to be considered as an individual with a particular set of experiences, feelings and perceptions).

As will be demonstrated later in the thesis, Gadow's (1983) above philosophical perspective has a resonance with Habermas' (1987) concept of 'system' and 'lifeworld'. It is on this basis, that Gadow's account of advocacy sets her apart from the four other accounts and this is the rationale for suggesting that her account ought to be considered as the most applicable to Habermas' (1987) perspective.

One ought to acknowledge that Gadow's (1983) emphasis on the primacy of a client or patient and her assertion that the advocate should support the patient's right to be fully informed and to make decisions concerning his of her treatment and care, can be considered as sound and creditable. Her philosophy may be regarded as a universal guiding principle that nurses ought to adopt, when working in the health care systems in the United Kingdom, United States and other societies.

The criticisms levelled against Gadow (1983), concerning the number of patients that the nurse has an obligation to care for and countering the fact that the nurse may not agree with the patients' illnesses and care, can be overcome if a society provides adequate funding for its health care system and if the nurse acknowledges his or her professional obligation to act in the interest of the patient. Having identified Gadow's (1983) perspective on advocacy, as the most convincing, I will now offer a summary of chapter five.

4 Summary

In this chapter I have offered a discussion concerning the British and North American perspectives of advocacy. The similarities and differences of the five authors' positions on advocacy are identified and I have offered a rationale for selecting Gadow's position as offering the most convincing account of advocacy that is based on a sound philosophical approach that can be applied to the work of Habermas.

In part two, chapter six, I will describe Habermas' (1987) theory with reference to system and lifeworld and will apply this to advocacy with reference to the Pink case. I will then offer a discussion of advocacy and make the case for an extension of advocacy theory with a view of creating a proposal that should help nurses to acknowledge the potential for their role as patient's advocate.

PART 2 HABERMAS' PERSPECTIVE AND ITS APPLICATION

Preview

In part two, I will describe Habermas' perspective and will apply his work to that of Gadow, nursing and healthcare. Habermas (1995) has developed a clear philosophical framework relating to communication that can be applied to advocacy. As described in chapter seven, Habermas (1995:93) has constructed a method by which competing norms can be fairly and impartially judged, using the principle of universalization ('U'). He also offers a practical application of discourse ethics identified as ('D'). Habermas' (1987) concepts of 'system' and 'lifeworld' are described in chapter six and later in the thesis, these notions are applied to the NHS and advocacy.

CHAPTER 6 SYSTEM AND LIFEWORLD

1 'System' and 'Lifeworld'

Habermas (1987) has written extensively on the 'lifeworld' and its importance as a philosophical concept. When considering the 'lifeworld', one ought also to look at the 'system' and its relationship to the 'lifeworld'. Habermas offers an important suggestion:

> ' ... that we conceive of societies simultaneously as systems and lifeworlds.'
>
> Habermas (1987:118)

For Habermas (1987), a system and lifeworld ought normally to be considered as linked and interdependent. It would be pertinent at this point, to offer a definition of what is meant by the term 'system'.

2 System

Habermas, offers a definition of living systems when he states that:

> 'Living systems are understood as open systems, which maintain themselves vis-à-vis an unstable and hypercomplex environment through interchange processes across their boundaries.'
>
> Habermas (1987:151)

According to this definition, the presence and continuation of a system is dependent on its ability to survive and flourish in a changing environment, as can be observed in a complex social structure. For example, in an advanced Western Democracy where there is a need to form and maintain communication and trade links with other states.

According to White systems theory:

> 'envisions strategic actions guided by systemic imperatives. These imperatives operate through the "de-linguistified media" of money and power.'
>
> White (1994:100)

For Habermas (1987), the concept of 'system', with reference to money and power can be applied at a national level, where a society initially forms, with the consequent development of an economic and monetary system. With reference to money, such a society is typically based on the capitalist system; where a society has a common interest in maintaining trade relationships with other societies, as for example, by trading with the European Union and then joining the Union at a suitable time. Such an economic relationship may form the basis of a mutually beneficial trade agreement

The membership of the Union may also enhance the power and status of a small nation and this may form part of the reason for a nation's wish to join such a partnership. Power relationships between societies may also be demonstrated through an international perspective, where the presence of a rogue state may lead to war, as for example, the Iraq war of 2003, where the ruling regime was changed.

According to White's interpretation of Habermas' (1987) thinking, White states that:

> 'A system becomes more rational as its complexity increases; that is, as its range of adaptation to environmental changes is enhanced.'
>
> White (1994:104)

For White, this leads to the development of an increasingly complex and diverse set of social structures in a society, which in turn facilitates material production that is considered as desirable in a capitalist economy.

As an alternative to the capitalist system, a society may be founded and formed on the basis of some form of religious belief. Indeed, the capitalist and spiritual examples of society are often interlinked, for example, with reference to the English society that is typically considered as Christian and represented by the Church of England, while at the same time embracing a capitalist economic system.

In contrast to a social system, the economic aspect within a society is considered by Habermas (1987:169) as a 'subsystem' that relates to 'adaptation', in terms of regulating a society's economic activity. Similarly, according to Habermas (1987:169), the administrative subsystem is linked to 'goal attainment', with reference to the formation of policy and decision-making in a society by bodies such as 'The Civil Service', whose role is to plan and run the day-to-day services that allow the successful function of a society. An example of these services in Britain would be the National Health Service, funded by National Insurance and public taxation that the Government has a responsibility to apply, collect and distribute as required.

A society and its associated systems, therefore, normally form an essential support and reference point to those who live and work in the society. People who live in a society are in an interaction with a society and its systems. For example, the general public may use and hold a high regard for the National Health Service, while at the same time perceive the need to engage with the economic system through work and a weekly need to shop and pay bills. This form of interaction normally

leads to the presence of systems and subsystems that have a positive or negative effect on an individual and their lifeworld.

3 Lifeworld

A further influence on people is described by Habermas as the 'lifeworld'. Habermas offers a definition of the 'lifeworld', when he states:

> 'I can introduce here the concept of the *Lebenswelt* or the Lifeworld, to begin with, as the correlate of processes of reaching understanding. Subjects acting communicatively always come to an understanding in the horizon of a lifeworld. Their lifeworld is more or less formed from diffuse, almost always unproblematic, background convictions.'
>
> Habermas (1984:70),

Habermas offers an expansion of his definition when he states that;

> ' ... the lifeworld appears as a reservoir of taken-for-granteds, of unshaken convictions that participants in communication draw upon in cooperative processes of interpretation.'
>
> Habermas (1987:124)

According to Habermas (1987), the lifeworld ought to be considered as a form of backdrop, presupposed in communicative action. For Habermas (1984:xvii), the lifeworlds of people are formed on three levels, namely: the structural components of culture, society and the person. The reproduction of the lifeworld occurs through cultural reproduction, social integration and socialization that depend on communicative action, namely understanding, coordination and sociation.

According to Habermas (1987:63), communication is the method through which we transmit and reproduce our lifeworld. The transmitters are identified as: cultural reproduction, through which cultural traditions and meanings are conveyed down the generations; social integration, when we are typically able to recognise the norms of cooperation and interaction; and socialization, through which we acquire individual and collective identities.

By our ability to transmit and reproduce the lifeworld, succeeding generations are able to learn from accumulated

collective experience, which should prevent the generations from endlessly repeating the experience. According to Outhwaite (1996:191), this experience is a 'concrete historical form of life or the conduct of an individual life.' A physical example of this would be knowledge about the following of night by day. Further, a socially related example of this is the normally accepted value that is placed on human life. There is an inherent danger in this method of communication, that information may be changed or lost.

Habermas (1995) offers a related illustration, with regard to communicative action, as described later in this part of the thesis, when he states:

> 'The actor stands face to face with that situationally relevant segment of the lifeworld that impinges on him as a problem, a problem he must resolve through his own efforts. But in another sense, the actor is carried or supported from behind, as it were, by a lifeworld that not only forms the *context* for the process of reaching understanding but also furnishes *resources* for it.'
>
> Habermas (1995:135)

With regard to contemporary medical social application, as illustrated in Social Trends (2003:61), the lifeworld can be linked to the social factors that have an effect on a doctor and patient. For example, with reference to Social Trends (2003:61), where the doctor may typically experience an economically advantageous upbringing, having taken advantage of the opportunities that were afforded to him or her as a child and linked to parental encouragement. According to Social Trends (2003:61), seventy four percent of children whose parents are 'Higher Professional' in socio-economic terms attain five or more GCSE's at grades A-C.

As a child, the doctor would typically have attended schools that enabled him or her to go to university to read medicine and then engage in a medically based 'expert culture', as described by Cooke (1994:17). As a contrast, a patient may have had a poorer upbringing, for example, the parents may have a socio-economic classification of a 'routine' occupation (Social Trends 2003:61) and attended schools that typically did not envisage that their children would normally go to university, leading to a lack of educational and other social opportunities. According to

Social Trends (2003:61) twenty nine percent of children of 'routine' occupation parents attain five or more GCSE's at grades A-C.

A general point can be made that the lifeworld background of an individual would therefore have an influence on their perception of a society and the values that they hold personally. For example, the experience and perception held by the majority of the British population of the importance of the National Health Service. This relates to the public's willingness to pay increased taxes, with the proviso that the money is spent directly on this service. Similarly, an individual's socialisation with respect of a requirement to work for a sufficient payment, would embrace the values of a capitalist society. An individual who has been socialised in this form of society, where this would have been considered as the norm, would have learnt this.

The 'cultural structure', as identified by Dews (1999), is normally passed down socially through the generations and the

citizens may largely take this for granted. This typically leads to shared understanding, for example, the need to earn a living, the normally accepted assigned gender role and this may be difficult to influence or change (a notable exception, in relation to gender role would be the rise of the women's suffrage movement). This could lead to a constraint being placed on the beliefs and actions of individuals. Therefore the individual's perceptions and beliefs would be influenced by the lifeworld.

For Habermas (1987:145), the lifeworld is linked to communicative action between people and the goal of forming a consensus that is based on the formation of a better argument. This should occur in a society that acknowledges the importance of freedom of expression. However, a society that is based on an ideology other than that of a freedom of expression may use power at its disposal to frustrate attempts by its citizens to form a consensus; especially, a consensus that challenges the ideological basis of such a society.

Habermas (1984) gives an example of the link between the lifeworld and communicative action, as described later in this part of the thesis, when he states that:

> 'The idea of the lifeworld is introduced as a necessary complement to the concept of communicative action. It links that concept firmly to the concept of society; and by directing our attention to the "context forming horizon" of social action ...
>
> Habermas (1984:xxv)

With reference to interpersonal communication Habermas goes on to state that:

> 'Through this communicative practice they assure themselves at the same time of their common life relations, of an intersubjectively shared lifeworld. The lifeworld is bounded by the totality of interpretations presupposed by the members as background knowledge.'
>
> Habermas (1984:13)

Therefore, according to Habermas (1984), the lifeworld partly determines the life experience of an individual. Habermas makes the point that people typically share certain aspects of their lifeworld, depending on the knowledge and experience

gained by previous generations and the current media. Therefore, the presence of the Royal Family and British Society is typically regarded as a form of normality in our society. However, when a disagreement arises, for example, with reference to the 2003 Iraq War, any formal disagreement may reflect the personally held beliefs and personality of an individual. For example, a person who holds that it is morally wrong to go to war may not do anything about it, whereas, another person who holds the same belief may feel obliged to join a protest.

4 The Articulation of System and Lifeworld

As suggested previously, for Habermas (1987:153), the concepts of system and lifeworld ought to be considered with reference to each other. To explain these concepts, I will offer the following illustration. A strong connection of systems to lifeworld can occur when the system develops from the lifeworld, as for example, the development of a village based system that would accurately reflect the lifeworld of its inhabitants.

This forms an uncomplicated social system that is composed of simple social structures. In this context, the people living in a village would know the person who is in charge and may have been brought up and educated with them. The village would have economic sources, as (e.g. money lenders) and locally owned shops. The simple system and lifeworlds of the population and those in charge of the village would be very similar and the different parties would be able to relate easily to the perspectives that are held by others.

As a contrast, a system and lifeworld may diverge. I will now offer an example of a complicated social system and structure, as that of an advanced and largely city dwelling capitalist society. For economic reasons, the city people would have individually differing lifeworlds and they may not be able to agree a consensus. The diverse institutions may have developed specialised subsystems, having their headquarters in another city or country. Therefore, the city dweller may typically deal with people who do not have an interest in, or appreciate his or her lifeworld. The dweller would be treated as

a 'customer' rather than a known individual and would be subject to the normal rules of the organisation.

For Habermas (1987:153-154), there is an acknowledged potential for the development of a tension between the lifeworld and subsystems, leading to their eventual separation and 'uncoupling'. According to Outhwaite:

> 'As new systems emerge, notably states and market economies, they become increasingly detached from the social structures through which social integration takes place.'
>
> Outhwaite (1994:88)

An explanation is offered by Habermas (1987) when he acknowledges that a system may develop at the expense of a lifeworld, which can become provincial ...

> 'In a differentiated social system the lifeworld seems to shrink to a sub-system.'
>
> Habermas (1987:173)

The uncoupling that may occur between the system, subsystems and lifeworld, as described in Outhwaite (1994:90) means that the cultural structure as experienced by a person could differ from the system and subsystems that form the norms of a society. For example, the development of the cultural 'hippy' movement in the nineteen sixties, with the implicit questioning of capitalist values and society's authority, sat uneasily with the notion, at that time, that it was considered as the norm to function within an economic system and to act within the law. With reference to the above 'hippy' example, the uncoupling of system and lifeworld can explain the need for the development and application of critical theory, as described by Habermas (1987:374-403). Furthermore, the uncoupling of system and lifeworld, as according to Habermas (1987:173), can be applied to the relationship between the health service and a patient. The health service may consider that its waiting list system ought to be considered as fair. The patient who has a long wait for treatment, however, may consider such a system as impersonal and unfair, with very little opportunity for redress.

5 Summary

In chapter six, I have described and discussed Habermas' (1987) perspective on 'system' and 'lifeworld' and these concepts have been applied to his (1987) work on 'communicative action'. Habermas' (1987) perspective of the 'system' and 'lifeworld' seems to have particular relevance to the National Health Service and as a basis for discussion of advocacy. These topics will be discussed at a later stage in the thesis, for a further medical and nursing application of system and lifeworld is made at a later stage, in this part of the thesis. In the next chapter, I will turn to Habermas' perspective on critical and other theories.

CHAPTER 7 CRITICAL AND OTHER THEORIES

1 Preview

In this chapter I will offer a summary of Habermas' (1995) perspective with regard to discourse ethics. He has created a framework in which the conditions for discourse are identified and against which the validity and effectiveness of a discourse may be tested. The framework can be used on occasions when disagreement could occur and it should enable the participants in discourse to agree a fair and equitable solution that ought to be acceptable to those involved.

Habermas' (1995) aim is to determine the conditions, where an individual or group can accept valid norms in discourse that are acceptable to all. For Habermas (1995), for a norm to be held as valid and according to the principle of 'U', people should be able to agree to the consequences. The norm ought to be justified through a discussion and in so doing, through the application of 'U', they would be able to judge whether the norm is valid and fair to all. With reference to the related principle of 'D', according to Habermas (1995), a norm can be achieved

through the use of discourse ethics ('D') that is proposed as a procedure for the conduct of practical discourse. An important part of Habermas' (1987) work relates to critical theory.

2 Critical Theory

Jurgen Habermas (1995) is a philosopher who has drawn his ideas from the 'Frankfurt School'. He has undertaken a substantial amount of work on Critical Theory. Therefore, it would seem appropriate at this point in the thesis to offer an account of the basis of Critical Theory.

Held makes an observation that:

> 'Critical theory, it should be emphasised, does not form a unity; it does not mean the same thing to all its adherents'.
>
> Held (1980:14)

Held (1980) illustrates this point when he offers an account of critical theory with reference to a variety of different philosophical perspectives, for example, those held by Marcuse (1941) and Adorno (1974).

According to White (1995:4), the roots of critical theory lie prior to the Second World War when the Frankfurt School carried out philosophical and social investigations that were critical of the culture, economics and politics of Western societies. White (1995:4) identifies that the Frankfurt School was formed by a group of philosophers who, during the late 1920's, founded the Institute of Social Research in Frankfurt. When Hitler came to power, he closed the Institute and the School was subsequently relocated to the USA.

According to White (1995:4), the Frankfurt School developed a philosophy called 'Critical Theory', that could be used to criticize ideology. Critical theory poses questions that relate to an individual's goal with reference to their society and where there is a dominant social system and is concerned with the emancipation of people. With regard to systems and lifeworld as previously described, Habermas (1987:734-403) accepts that people should look critically at systems and society; critical theory could then be used for example, to criticize the philosophical base and function of any society; as for example, a communist or fascist state. Habermas (1987:374-403) offers

support for the idea that critical theory relies on an interpretation of man's history, leading to an understanding of life and it can also be used to consider how social policy is formed. One can also use it to consider the conditions that exist, or are necessary for communication.

Habermas (1987:374-403) harbours a concern that for critical theory to be considered as effective, it has to have practical application. Habermas (1987) argues that critical theory is no longer needed to show the social content of philosophical theories, rather, it can be used to co-operate with philosophy in the study of a rational approach to a discussion of social issues, based on logic and reason. From the Habermasian (1987) perspective, critical theory can be used to study, give recommendations for and possibly offer answers to social problems.

Habermas' (1987) discussion of critical theory can be applied to the health service, its patients and employees; e.g. doctors and nurses. Further application of critical theory to nursing is made by Browne (2000) and Mill et al, (2001). In order to make

effective use of critical theory, it would be necessary to consider the historical development of the Health Service. For example, consider the development of health care based on an individual's ability to pay and the different types of facilities offered from poor law to private hospitals. Also, one must consider the growth and development of the professions within the health care system, for example, medicine and nursing.

The critical theory perspective, according to Habermas (1987), can be used to consider the development of a health service, for example, when this allows the domination of individuals and groups. White, (1978) refers to other instances with regard to the historical development of power by a Board of Governors' chairman in a hospital and the nursing matron, who was answerable to the chairman. The domination of nursing and the expectation of subservience of nursing to the medical profession have been well documented; many nurses at that time considered that they could not question the instructions of doctors.

White (1978) acknowledges that the historical development of nursing with reference to other professional groups and the health care system has, in general, had an effect on the perception of nursing held by nurses, other health care professionals and the public. This has led to nursing being traditionally considered as a female dominated vocation that is less powerful than either the doctors or hospital management. Nursing therefore, has had to work hard to challenge long held assumptions concerning its caring role and has also to acknowledge the current need to develop an effective advocacy role with regard to the patients.

Browne (2000:44), links critical theory to the 'emancipation of nursing' by encouraging nurses to read and apply theory. Mill, et al (2001) also acknowledges that critical theory can be used to link nursing theory to practice. Mill, et al (2001) and Browne's (2000) ideas of empowering nurses by encouraging their scholarship, can be applied to others in the health service, who are considering whether to undertake an advocacy role. Critical theory embraces the ideal that individuals in the health service should feel that they are able to speak freely, as for example

when an individual, as a member of staff, should be able to comment on the levels of nursing in the clinical areas. This can be applied to a nurse who wishes to undertake an advocacy role on behalf of patients, for the nurse should be able to feel that he or she is able to speak on behalf of his or her patients as required, even though this may mean criticizing the health service. According to Browne (2000) and Mill et al (2001), the informed nurse's intention would be that improvements in patient care should be made and the relevant resources accessed and the provision of this would be considered as part of the nursing role.

Although Browne (2000:46-7) suggests that 'there is no disagreement about nursing's fundamental commitment to a greater social good', she makes an important criticism of nursing's application of critical theory, when she suggests that there can be an uncritical reliance on critical theory that may lead to a 'privileging of the collective over the individual and general over particular knowledge.'

An example of an application of critical theory to a nursing role is given in the description of the Pink case study, as described later in the thesis. In this example, Graham Pink, a charge nurse, chose to take on the role of advocate on behalf of his elderly patients, who were largely unable to speak for themselves.

Having offered an outline of critical theory, the suggestion can be posited that it does not offer instant solutions; instead it offers a way of resolving conflict. The presence of conflict refers to behaviour and communication between people and this can be linked to the moral development of an individual.

3 Psychological and Moral Development

I will start this stage of the thesis by identifying what is meant by the term 'morality', (which can be considered as basis for a discussion of Kohlberg's (1981) moral development). Glover offers his perspective on 'morality', when he states that:

> 'There is no general agreement how the word 'morality' should be used. Some people think of morality as a set of rules laid down by God. Others think of it as a set of socially imposed rules with the function of reducing conflict in society. Others say it

> is a set of principles about how we ought to live that apply to everyone impartially, or which can be defended by appealing to the interests of people in general.'
>
> Glover (1988:22).

Having described Glover's perspective on 'morality', I will now offer a related description of Kohlberg's (1981) three levels of moral development as identified in the next section, which can be considered as a prerequisite for an individual's development of a sense of morality.

Personal moral values are determined in part, by the make-up of an individual. They are also subjected to influence and acquisition during childhood from the family, and later from school, friends, the neighbourhood and media. The process of socialization that exposes the person to the differing perspectives held by others in society has an effect on a person's moral values. The work of Kohlberg proposes three levels of human development, containing six stages, as described by Kohlberg (1981).

For Kohlberg, the first level of moral development is the preconventional level and corresponds to stages one and two. The second level is the conventional level, corresponding to stages three and four and the third level is the postconventional or principled level, corresponding to stages five and six where a person may wish to make a personal stand with regard to an issue. To expand further:

a) Stage one of the preconventional level relates to the egocentric view, referring to obedience with respect to rules and authority. Relationships are formed between parent and child that may include the need by the parent to exert control with regard to the child, by use of rewards and sanctions, as for example, the use of praise and punishment, where punishment leads to fear of authority.

b) Stage two refers to individual purpose and exchange. This stage relates to an individual doing what is considered as beneficial to oneself, while acknowledging that other people have to be taken

into account. There is a separation of the individual's point of view from that of others.

c) The third stage relates to the conventional level, for example as in adulthood. Here there is mutual acknowledgment and expectation for the need to conform and the perspective of an individual is linked to that of others.

d) The fourth moral stage refers to the development of a social system and conscience. The individual is aware of the potential effect of his action on others and the need to make a contribution and he or she is also able to appreciate the view of those in the system.

e) Stage five relates to an acknowledgment of prior rights, social contract and utility and there is an acknowledgment of both the legal and moral points of view, although an individual may experience

difficulty in integrating them. At this level, contracts that are formed between individuals are freely entered into and there is a concern that the actions ought to be lawful and considered as beneficial to a group. This post-conventional or principled level could refer to a person wishing to make a stand with regard to an issue that is based on their conviction.

f) Stage six refers to the recognition of morality and development of universal ethical principles, where the individual has perceived the validity of principles, such as justice and become committed to them. A person is offered respect and seen as an end rather than a means.

Having described the human levels of moral development, as according to Kohlberg, one can now identify Habermas' (1995) view with reference to the basis of communicative action between people and the development of individual moral consciousness, where there may be a presence of internal

moral conflict. The moral values held by a person can be considered as the foundation of any communicative action and for Habermas (1995), Kohlberg's level six is considered as the most morally desirable.

Having made the link between personal moral values and communication, it seems pertinent at this stage to take this link a stage further, by offering a description of the theory of communicative action.

4 Communicative Action

Habermas (1995:ix, 100) offers a description of the theory of communicative action as linked to moral-philosophical, rather than empirical-psychological considerations. The goal with regard to a situation is to reach a common understanding and harmony. The participants engage in a search for mutual understanding by considering and offering the relevant arguments that could lead to the formation of a consensus.

To evaluate social processes, Habermas (1984:42) appeals to the theory of communicative action, for example, with reference to 'the ideal speech situation', as described later in this chapter

and in Habermas (1984:42). The aim is to form a consensus and obtain open and equal access to communication, although this ought to be placed in the context of the surrounding social environment, for example, with reference to a type of society, where there may be inequality and / or repression.

An illustration of communicative action as a form of consensual action could take the form of a discussion and an agreement concerning a policy. For example, the criteria used to treat cancer patients, which may differ from the criteria used with regard to patients who require non life threatening general surgical procedures. Habermas (1995:100) offers a suggestion with regard to the aim of 'reaching an understanding'. He proposes that an agreement should be reached between two people on the basis of a claim that is considered as valid and as acceptable to both parties. The aim is to provide valid and convincing reasons that are able to withstand critical scrutiny. However it ought to be acknowledged that although those involved in communicative action may reach an understanding, this does not necessarily mean that they will reach an agreement. For example, there may be an acknowledgment by

those involved, that a disagreement has occurred due to a rejection of what the other says.

The participants who undertake communicative action may not necessarily wish to search for an understanding or consensus, as for example, when one person wishes to kill another. The only understanding that occurs would relate to an acknowledgement that one person has the intention of harming another. One can now consider what is meant by rational communicative action, as described next.

Rational communicative action between individuals presupposes that a person has a level of communicative competence that can be demonstrated through the use of basic communication. Habermas (1995) offers a discussion regarding the basis of communication between people and this can be linked to practical issues that are reflected in the notion of discourse ethics as a specialist and practical form of communicative action, which could be useful when one considers nursing.

A practical application with regard to communicative action between patient and nurse, may relate to the patient wishing to know more about his or her diagnosis. For example, this may take the form of a discussion between the nurse and his or her patient concerning the diagnosis of a malignancy, where a discussion may relate to empirical evidence, with reference to an X-ray that has been previously been prescribed for a patient by a doctor. The patient would normally perceive a nurse as giving information based on truth, especially if this relates to information that has been previously given by a doctor. Communicative action can be considered in contrast to strategic action, when the truthfulness of the communication may be affected by strategic action, as described in the following paragraph.

According to (Habermas, 1995), this occurs where a person is primarily motivated to influence the behaviour of another, for self-interested reasons. According to him, strategic action is oriented towards punishment and reward, where he states:

> 'In strategic action one actor seeks to influence the behaviour of another by the means of the threat of sanctions or the prospect of gratification in order to

> cause the interaction to continue as the first actor desires.'
>
> Habermas (1995:58).

With reference to strategic action, influences that are unrelated to the argument can be introduced with the aim of influencing the other participants towards a certain outcome. The strategic actor may use a form of manipulation to attain an end; the action is linked to the use of sanctions and rewards as a means of achieving ends. It would be useful at this point to expand upon the distinction between strategic and communicative action.

This distinction is able to provide a framework for the interpretation of social phenomena. Communicative and strategic action can both be considered as forms of communication that are at times interchangeable. This is illustrated when a political discussion occurs with the aim of forming a consensus, while at the same time there is an acknowledgment that the act of attaining a political consensus may be of benefit to those involved.

The employment of communicative and strategic action for Habermas (1995), would relate to the situation at hand and the moral judgement of those who are undertaking discourse. A person who is truthful and honest would normally try to reach an agreement through a valid discourse that would normally include negotiation and co-operation. Another person may be aware of the potential for personal benefit and through a motivation of greed, seek to achieve a result that would be of benefit to him or her. Although it is useful to consider communication with reference to the distinction between strategic and communicative action, it would be helpful at this stage, to consider communication relating to co-operation and consensus.

Communicative action may also occur when there is an expectation of co-operation and consensus and it could be used to support validity claims rather than the manipulation of others, as in the case of strategic action. For example, communicative action occurs between relatives who have a genuine concern regarding the care of a physically dependent elderly person. Through communicative action, the elderly patient's relatives may not be able to reach an agreement concerning the care of

the person, without regard to a consideration of cost or financial benefit. There is an emphasis on mutual recognition and reciprocation, where the relatives seek to cooperate for altruistic reasons and come to a consensual agreement that the elderly relative should be cared for, rather than being left to look after him or herself. The application of strategic action in this case, would allow the relatives to be concerned about the potential financial rewards that may become available on the elderly person's death and this would be a factor that the relatives may take into consideration. Strategic and communicative action can provide a framework for the interpretation of social phenomena. Having described communicative and strategic action, one should now consider the four validity claims that are the necessary conditions for discourse.

5 The Four Validity Claims

Turning now to validity claims, these form a basis for the occurrence of undistorted communication that can be considered as language to be used, when speaker's claims are constrained by the following four validity claims. These are identified by Habermas as:

a) 'That the communication should be comprehensible

b) based on truth and

c) should reflect the rightness and,

d) truthfulness of the content.'

Habermas (1995:58)

I will consider first the condition that the communication should be comprehensible between the involved parties:

a) This presupposes that the parties involved have an ability to comprehend and undertake communication. For example, during a communication that may occur between doctor and patient, when a doctor should use language that the patient is able to understand.

b) For Habermas (1995, pp. 59-60), the truth claim refers to the 'existence of a states of affairs.' Truth is considered as factual with reference to the nature of a society and the notion that a discourse or communication is based on truth, can be perceived as important in that it is considered as a

> key concept in any communication. Any attempt to distort the truth may indicate the existence of a type of society for example, fascist, as in Nazi Germany, when the truth may be manipulated for political reasons. A lack of truth and a consequent lack of credibility of a communication may result in the premature closure of discourse. For example, a citizen in Nazi Germany may decline to read the press due to the lack of valid truth in the news reports.

There is a requirement that the content of a truth claim should not mislead and this can relate to the mass media for example, with reference to market forces, where the owner could have an affect on the way that issues are reported in a paper. The truth claim is a basic claim that relates to the content of speech, in terms of whether it contains verifiable information that is based on truth. The communication may contain empirical information for example; the information may be based on concrete indisputable evidence that can be proved.

A communication's empirical foundation strengthens the basis on which a claim can be considered as valid and Habermas (1995) proposes that an acknowledged valid communication ought at the same time to be truthful. It can be inferred from Habermas' (1995) work that for a person to be considered as truthful they ought to speak sincerely and believe in the content of their communication. This can be considered as a necessary prerequisite of this form of communication, as validity claims are the central planks upon which discourse ethics are based.

Therefore, the credibility of any communication rests on whether it is based on a verifiable truth, or what is believed to be the truth. Alternatively, should a communication be based on anything other than the truth, as for example a lie, or a cynical manipulation of the truth, there would be a loss of credibility and belief in the communicant by the person who is receiving the information.

I will now consider the rightness validity claim, when a nurse may be considered as occupying a position where a judgement can be made, as to the rightness of a validity claim. This forms

a basis of a communication that may occur between a doctor and patient, as described in 'c':

c) A crucial point made by Habermas' (1995:60), concerns the term 'rightness of actions', that refers to the 'observance of norms' that can be considered as forming a basis for the moral justification of a claim. The rightness of actions is taken as referring to the content of the norms and whether the norms can be considered as defensible.

The above can be linked to social values and the rightness claim therefore implies a link to personal relationships, the social world and the effects that this can have on communication. A nurse may judge that the patient may not be able psychologically to make use of objective information that is offered and that the truth may do the patient more harm than good. The claim to rightness can be applied when the nurse's assessment of the patient leads him or her to a perception that there is a need for information and ensures that the information is given in such a way that it would not cause the patient harm.

The distinction between truth and rightness can be described as follows. Truth claims are descriptive and correspond to objective states of affairs that are normally measurable and factual. In contrast, claims to rightness relate to normative ideas, i.e. when a discussion occurs with regard to 'what ought to be,' hence they apply to the sphere of moral discourse. An example will now be offered of a truth claim that forms the basis of a discourse.

There is an example in the context of nursing which illustrate a discourse based on truth claim, where truth claims are linked to information that is verifiable and factual. For example, the number of times that a patient has had his surgical dressing changed during a day. Also, the constraints of working with inadequate staffing levels, (as described later in the Pink case,) can be linked to whether patients are being neglected through the use of measurable criteria; for example, whether patients in bed are being left in their excreta.

Turning to the rightness claim, this would refer to nurses and doctors monitoring such a situation. The norm for them would be that patients should be offered hygiene facilities and a

change of personal clothing and bed linen to solve the problem immediately and then offer regular toilet facilities to prevent the occurrence of this problem in the first instance. This would require the provision of a sufficient number of nursing staff and should prevent the harm to patients for example, psychological harm of embarrassment and physical harm with regard to the risk of the patient developing pressure sores.

The nurse may take the view that a patient should be offered a certain amount of truth-based information that could be perceived by the nurse as relating to the patient's experience of life that could be considered as a benefit to the patient, in that the information should not worry the person. This can be considered as a contrast to the description of empirically based truth claims as described in 'b':

d) According to Habermas (1995:59-61), the claims to truthfulness differ from the claims to truth, for the reference to the concept of truthfulness can be considered as being related to the behaviour of a person. The claim to truthfulness can be used to reveal the character of the participants in

communication and their relationships to others that may influence the communication.

I will now briefly consider the difference between the terms 'true' and 'truthful' as referred to by Habermas (1995). A 'true' communication is normally based on objective evidence that is acquired first-hand. In contrast, a 'truthful' communication concerns information that is passed on and is based on the communicator acquiring information that he believes to be true, although the description of a situation may be second hand and difficult to verify.

For Habermas (1984), only the second and third validity claims of truth and rightness can be defended in discourse, for with regard to the 'truth', a speaker should be able to convince the listener as to the content of the speech. Similarly, 'rightness' is linked to justification when the speaker should be able to offer a justification for the claims that are made.

In a clinically applied context, the four validity claims have implications for communication between nurses, doctors and

patients. A nurse may suggest to a doctor, that he or she should simplify the information that is given to a patient and leave out some of the potentially distressing elements. A clinically applied example could be given, of a nurse who is caring for a patient with a malignancy; when a communicative action should be constrained by validity claim (a), that refers to a communication concerning the patient's diagnosis being comprehensible and offered in terms that the patient can understand. Validity claim (b) refers to truth, where the communication with a patient for example, should be based on the available medical evidence and the extent of the disease. The validity claim (c), of rightness, can relate to a doctor's assessment of the psychological state of the patient. This would indicate whether the patient would be able to cope with a full discussion concerning the illness, or whether the patient would benefit from a simplified version based on the truth.

The majority of health care professionals, as doctors and nurses, would agree that a patient should be offered information concerning their illness. The validity claim of truthfulness (d) can be applied to the level and amount of information that is given by a doctor to a patient and this may be influenced by the

doctor's knowledge of a patient's ability to understand and make constructive use of information. For example, the doctor may calculate that too much information may cause the patient undue worry and that the person should be offered a reduced and manageable amount of information (which could include truth being minimised). From a doctor's point of view, this should prevent the patient experiencing a high level distress, as for example, with reference to a diagnosis of cancer. Some doctors may even calculate that it would be preferable to lie to a patient on the grounds that the truth would cause the patient unnecessary harm.

All the validity claims have the potential to act as constraints on communication between a doctor, patient and nurse. The patient's perception of his or her diagnosis may have an effect on the professional judgement of doctors and nurses. This may concern the level and quantity of clinical information that is offered to a patient and the ability of such a patient to make constructive use of the information, as opposed to being frightened by it. A balance has to be achieved where the patient is given sufficient information that is described in a sensitive manner, with the aim of creating a level of understanding that

enables the patient to make an appropriate decision. The nurse may then be able to clarify any points that the patient does not understand and offer the patient information that would be considered as useful.

6 Discourse Ethics 'D'

As described in the Glossary, for Habermas (1995), discourse ethics ('D') can be considered as a framework for the conduct of moral discourse. Habermas (1995) identifies discourse ethics as having three principles, these are:

1) A principle of universalization, (which will be described later in this chapter), where there is the intention to set conditions for impartial judgment.

2) The conditions for practical discourse, (defined as 'D', as described below) are identified, from which universally valid norms may emerge, that could meet the needs and be accepted by the participants.

3) Later in this chapter, the suggestion is made that those who are involved can only achieve a consensus when there is free participation.

Habermas (1995:65)

With reference to the second principle, Habermas offers a definition of discourse ethics as:

> '(D) Only those norms can claim to be valid that meet (or could meet) with the approval of all affected in their capacity *as participants in a practical discourse*.'
>
> Habermas (1995:66)

Discourse ethics facilitates the democratisation of a discussion and offers a set of guidelines that can be used. It sets out the rational basis of a conversation or argument and can be considered as a formalized version of communicative action, as described previously in this chapter. Habermas goes on to state that:

> 'The principle of discourse ethics ... already presupposes that we can justify our choice of a norm'.
>
> Habermas (1995:66)

(For example, one should not harm others).

Discourse ethics involves communication within and across communities between those who are able to do so. For Habermas (1995), discourse ethics ought to have a firm, logical and rational base, from where argument can occur and decisions can be made. He perceives that there is a necessity for a dialogue between people and for the identification of social norms, although there ought to be an acknowledgement that a dialogue also presupposes norms. An ideal conversation occurs when the participants in a discussion hold a reasoned and firm position, based on a belief that something is right.

Habermas (1995) acknowledges that moral claims are normative and not descriptive. According to him, discourse ethics enables us to express our moral intuitions and allows the participants to develop a normative, generally accepted consensus, for example, with reference to a generalised interest in a right to life, or a more specific interest that concerns the acceptance of a particular lifestyle.

I will now describe the elements of discourse ethics. Habermas' (1995) 'programmatic justification of discourse ethics' requires four components (1) - (4) respectively:

1) 'A definition of a universalization principle that functions as a rule of argumentation.'

(Habermas, 1995:96).

2) 'The identification of pragmatic presuppositions of argumentation that are inescapable and have a normative content.'

(Habermas, 1995:96).

3) 'The explicit statement of that normative content (e.g., in the form discourse rules).'

(Habermas, 1995:97)

4) 'Proof that a relation of material implication holds between steps (3) and (1) in the connection with the idea of the justification of norms.'

(Habermas, 1995:97)

With regard to number one, for Habermas (1995) the rule of argumentation is constrained by 'U' or the principle of universalization, as will be defined later in this chapter. With reference to potential influences on communication, the type of

society that people live in will influence an individual's ability to express their thoughts freely and without constraint. It ought to be acknowledged though, that any communication may involve an argument, the identified consequences of which ought to be acceptable to those involved in the communication. In an ideal situation, a democratic society ought to facilitate individual expression based on the force of the better argument.

With reference to number two, the people who wish to undertake a form of discourse should be aware of the nature and implication of what they are going to argue. They should also be aware of the background issues and be able to consider the points for and against an issue, while bearing in mind the type of conclusion that ought to occur.

According Habermas (1995), the use of discourse rules in moral argumentation offers a means where a conflict can be resolved through those involved reaching a consensus. This would involve the participants in acknowledging that it is considered as the convention and right that one should listen to the points made in an argument before offering a response and that those involved in argumentation ought to speak and listen in turn

without interruption. It is through the constructive use of discourse rules of argumentation that a conflict can be prevented or if necessary, resolved.

With regard to number three and as described in the last paragraph, the rules of discourse provide a framework where those involved in argumentation have an opportunity to undertake effective and consensual communication. Adherence to the principle of non-contradiction by people involved in discourse would imply that the participants are serious and sincere in their intention to argue, where the issue can be discussed dispassionately and effectively through the employment of discourse rules.

The statement in number (4) relates to components (3) – (1), where, according to (3), a statement of discourse rules may be considered in relation to the mental competence, motivation and sincerity of those involved. The definition of the principle of universalization (as described later), as a rule of argumentation in (1) would enable those involved in communication to accept the consequences, if they were to perceive that the interests of those involved were taken into account. This may act as a

constraint on (3), where the rules of discourse should ensure those that participate in the discourse have a genuine interest in the subject.

The rules of discourse ethics can be applied to clinical situations, where those involved, as doctors, nurses and patients, have a certain level of interest and motivation to communicate with each other and the potential effect of discourse on other people ought to be acknowledged. Those involved in discourse should also be aware of the implications of their communication that ought to be conducted on an impartial and consensual basis. According to Habermas, a key feature of discourse ethics is that:

> 'Discourse ethics does not set up substantive orientations. Instead, it establishes a procedure based on presuppositions and is designed to guarantee the impartiality of judging.'
>
> (Habermas 1995:122).

Therefore, Habermas (1995) does not perceive that discourse ethics should act as an influence on its participants. Discourse ethics ought to be considered as a neutral procedure that ought

to be followed with the aim that at some point in the discourse, the participants can come to some form of judgement and agreement.

Habermas (1995) suggests that discourse ethics can be considered as a framework from where a discussion or argument that lacks a hidden agenda can occur with regard to issues that may concern a policy or action, that ought to be taken in response to a given set of circumstances. This is in contrast to the perceived aim of discourse that it should facilitate discussion and produce arguments that are based on the norms that can be justified as for example, in a group or society. The previous discussion of discourse ethics enables me at this point to introduce moral discourse.

7 The Rules of Moral Discourse

The rules of a moral discourse, according to Alexy (1978), as referred to by Habermas (1995: 89), require rule (3.1):

> "Every subject with the competence to speak and act is allowed to take part in a discourse".
>
> Alexy (1978:40)

Similarly, Alexy (1978) suggests rule (3.2):

a) "Everyone is allowed to question any assertion whatever". And:

b) "Everyone is allowed to introduce any assertion whatever into a discourse",

c) "Everyone is allowed to express his attitudes, desires and needs".

Alexy (1978:40)

Alexy (1978) also suggests rule (3.3):

"No speaker may be prevented, by internal or external coercion, from exercising his rights laid down in (3.1) and (3.2)".

Alexy (1978:40)

In this way, moral discourse facilitates the setting of a high standard of national consensus, for example, with regard to issues as crime. Habermas (1995) makes the point that moralities are able to take into account the weaknesses of others. The principles of solidarity and justice that I refer to as (a) and (b) respectively, can be considered as applicable, for principle:

'a'), offers equal respect and dignity to individuals and ...

'b'), acts to protect the interpersonal relations of the individual that are required for the individual to survive.

Habermas (1995:200)

Sometimes, the content of human communication is concerned with conduct that is based on the perceived moral claim that a person is right or wrong. Claims to normative rightness should be strengthened, if the content of the discourse were based on the perception that the pursuit of an action or policy is made on an assumption that this will relate to an agreement reached by all involved. There is a requirement that people should endeavour to offer a coherent argument; this applies to ethical issues that are perceived by the participants as important. For Habermas (1995:200), the issues are discussed with the discourse participants' reference to their perception of what is held as morally right, and individuals communicating through discussion and argument are able to achieve this. Communication between people relates to the 'Ideal Speech Situation' and this is considered in the next section.

8 'The Ideal Speech Situation'

One should note at this stage of the thesis, that although Habermas (1979 and 1984) has made limited references to the 'Ideal Speech Situation', other philosophical commentators as Giddens (1985), have written extensively about the framework and regard the 'Ideal Speech Situation' as a central plank of Habermas' (1984) thinking. I shall follow them with regard to their thinking and acknowledge the 'Ideal Speech Situation' as an important part of Habermas' (1984) theoretical apparatus.

I will begin with Giddens (1985), who describes the conditions that are required for an ideal speech situation, where he states:

> 'A claim to truth ... is an assertion that any other person able to weigh the evidence would reach the same conclusion as the individual making that claim. This in turn means that the notion of truth is tied to presumptions about the circumstances in which it is possible for arguments to be assessed in such a way that (1) all pertinent evidence could be brought into play, and (2) nothing apart from logical, reasoned argument is involved in an ensuing consensus. It is these circumstances which Habermas (1984) calls an ideal speech situation.'
>
> Giddens (1985:131)

Therefore, as previously described in the Glossary, with reference to Giddens (1985):

> 'An ideal speech situation is one in which there are no external constraints preventing participants from assessing evidence and argument, and in which each participant has an equal and open chance of entering into discussion.'
>
> Giddens (1985:131)

Habermas (1984) forms a link between the previously discussed validity claims and discourse ethics to the 'Ideal Speech Situation'. Habermas offers the following description:

> 'Only in theoretical, practical and explicative discourse do the participants have to start from the (often counterfactual) presupposition that the conditions for an ideal speech situation are satisfied to a sufficient degree of approximation.'
>
> Habermas (1984:42).

Habermas' (1984:42) work on the 'Ideal Speech Situation' has been identified an ideal framework with regard to the conditions for speech that are based on validity claims. Stress is laid on the importance of attaining a consensus of opinion and therefore, the views that are held by individuals and groups may

differ from those in power and this could lead to potential criticism of a body or system.

The 'Ideal Speech Situation' can be used as a framework, where it can demonstrate weakness of communication within institutions and it is able to provide an objective basis for a consideration of critical theory. The 'Ideal Speech Situation' as a framework, can be used to assess structures and processes, for example, free speech and the extent that this falls short in a democracy. According to Giddens (1985:131), the 'Ideal Speech Situation' "is inherent in the nature of language". The framework is acknowledged by the participants as having the right to an open and equal access (as opposed to restricted access) and unrestricted communication throughout discourse. The participants should be motivated to understand a topic through their discussion and a discourse should ensure that participants are able to attain a genuine consensus, based on the acknowledged importance of a forming a better argument that can be considered as acceptable to all.

The participants should not possess an ulterior motive, for the aim of Habermas' (1984:42) 'Ideal Speech Situation' is, that the force of the better argument should prevail. The 'Ideal Speech Situation' for Habermas (1979:90), is considered as a 'critical principle' and as a 'procedural criterion' that can be used with the aim of resolving disputes and attaining a consensus. It should be considered as a way to foster communicative rationality that serves to underpin a critical principle and can be used to form a basis for problem solving. Through the medium of a constructive discussion or argument, an agreement can be reached that is acceptable to those involved, thus providing a genuine consensus (as opposed to a false consensus, which may be obtained through, for example, some form of restricted access).

The notion of an 'Ideal Speech Situation' surely forms the basis of a strong argument for the applicability of discourse ethics. The four discourse validity claims, as previously described, serve to underpin Habermas' (1984:42) 'ideal speech situation', for the validity of a discourse is based on the communication being comprehensible, based on truth, rightness and on the

observance of truthfulness and norms. These factors should be considered with reference to the motivation and behaviour of those involved.

Habermas' (1984:42) 'ideal speech situation' can be considered as a framework that can be applied to advocacy. This framework can be used with reference to a patient who is unable, or finds difficulty in participating in a form of discourse. For example, as a result of a speech defect, or with reference to their communication with a doctor, that ought to result in their being able to access a nurse who is able to speak on the patient's behalf. A nurse should also promote the perspective that the patient would wish to be expressed, if he were able to do so; for example, on a medical ward round, where a nurse could articulate the patient's wishes.

According to Habermas (1995), discourse ethics can be seen as a way to facilitate a forum for moral argumentation, where individual positions can be justified and where the participants can work towards an agreement, even though an overall benefit may not be maximized. He suggests that the procedure of

discourse ethics not only concerns a formation of an arena where specific problems can be discussed, it also enables the result of a discourse to have an influence on other people who are involved in communication on a similar subject. Therefore, in this way, one discourse may affect the outcome of another.

Moral argumentation normally occurs when the validity of a norm is challenged and moreover, the formulation and application of a social policy relates to the norms of a society and that of its citizens. These norms generally relate to the universal values and beliefs held by people in and outside the society and it would therefore seem pertinent at this point to describe what is meant by the term 'Universalism'.

9 Universalism

Habermas (1995) introduces the philosophical tool of 'U' or 'Universalism' as a way of evaluating competing norms. A discourse conducted as according to this principle should make an agreement possible, when the interests of everyone are taken into account and are considered as acceptable to all. The

term 'Universalization' or 'U' is linked to valid norms. Habermas offers a definition of 'U' as:

> 'All affected can accept the consequences and the side effects its general observance can be anticipated to have for the satisfaction of everyone's interests (and the consequences are preferred to those of known alternative possibilities for regulation).
>
> Habermas (1995:65)

Or as Habermas later states:

> 'For a norm to be valid, the consequences and side-effects that its *general* observance can be expected to have for the satisfaction of the particular interests of *each* person affected must be such that *all* affected can accept them freely.'
>
> Habermas (1995:120)

According to the principle of Universalization, a framework is proposed where moral discussion / decision making can occur in an environment that is free of constraints, where everyone would come to the same decision and a universal agreement should have been achieved. It is linked to the universal exchange of perspectives, which means that a person is required to consider the perspective of others and this idea can

be applied to people continually checking each other's perspectives, as in the concept of ideal role-taking.

People can employ 'U' as a tool for establishing a legitimate norm and this enables a distinction to be drawn between individual claims. To give an example, with regard to the contribution of an individual to a society through taxation and national insurance, the majority of people would support the use of a system based on the ability to pay by those who have a certain level of wealth. By doing so they are able to support the idea that the state should provide a certain level of public service, for example, with reference to the care of older people. Those who are unable to afford the required payment would not have to make a contribution to the services, even though they have the right to unrestricted access to the nationally provided services.

'U' can be applied to communication between nurses, when nurses endeavour to understand each other's perspective; an example of this could be with reference to who should be acknowledged as a registered nurse by the Nursing and Midwifery Council. This demonstrates the principle that the

acceptance of a norm by those affected, is a requirement of the principle of Universalization.

Although some claims can be met through the deployment of 'U', others cannot; as for example, where claims contain antagonistic, irreconcilable elements. It may be considered as impossible that the consequences could be considered as acceptable, as there may be too many differences between the people involved. In this case, people may come to an agreement to disagree. The purpose of 'U' is to draw a distinction between the claims that are and are not considered as acceptable.

Using the principle of 'U', there may be an attempt through discussion, to include individual divergent beliefs and claims with the aim of reaching a view that are acceptable to those involved. For example, the libertarian idea supported by Nozick (1974), that people ought seek to work with the aim of self-finance, rather than relying on State finance for support may be acceptable to all those involved in discourse on the topic. There may be disagreement between those involved in discourse, with regard to the extent to which self-reliance is required and this

could be accommodated through an acceptance by members that there are times when people hold different opinions that may lead to disagreement. This may lead to an agreement by those involved to disagree on a particular view. The principle of Universalism can be linked to Kohlberg's theory of moral development, as described in the next paragraph.

10 Universalism and Moral Development

Universalism or 'U' can be linked to stage six of Kohlberg's (1981) theory of moral development, where an individual is able to acknowledge morality and the development of ethical principles. This accords with Habermas' (1995) stance with regard to 'U', that allows for the presence of a framework from which a discussion may lead to an agreement concerning a decision that could be considered as acceptable to all involved.

With reference to Habermas' (1995) framework, both 'U' and Kohlberg's stage six can be considered as formal and substantive principles that may be used when thinking about an issue. For example, in the Pink case with regard to the need for an increase in staffing levels, Kohlberg's stage six would encompass a respect for patients as persons that require a

certain level of care. The provision of staffing levels would reflect this and staffing the unit with a sufficient amount of nurses would be considered as the right thing to do.

Similarly, Habermas' (1995) 'U' would facilitate a framework where in, an absence of constraints those who are charged with the responsibility of calculating the need for a level of staffing should be able to come to an agreement that ought to be acceptable to all. Such an agreement could be that the required finance should be made available so that such an increase can be afforded. These concerns can be linked to moral discourse, as discussed in the next paragraph.

I will offer a description of moral discourse, where this can be considered as an all-embracing term arising from Habermas' description of moral intuition. For Habermas:

> 'Moral intuitions are intuitions that instruct us on how best to behave in situations where it is in our power to counteract the extreme vulnerability of others by being thoughtful and considerate.'
>
> Habermas (1995:199)

This illustrates that a moral intuition informs us with regard to behaviour in certain situations and can be used to form the basis of a moral discourse that is able to give a voice to these moral intuitions. According to White (1971:61), moral pronouncements serve as a forum where questions can be posed; it does not necessarily provide the answers. This leads to the next topic, that of Universalism as a bridging principle to discourse ethics.

With regard to Universalism ('U'), this is viewed by Habermas (1995) as a bridging principle to discourse ethics ('D'), in terms of linking a general hypothesis to particular observations. Practical discourse can be considered as a way of linking an individual to a public forum. This offers support to individual interests, while at the same time allowing him or her to be isolated. For Habermas (1995), rules of discourse are inescapable; they are not considered as conventions that can be broken.

Habermas (1995) also considers 'U' as a further normative constraint for those involved in discourse, 'D'. Therefore 'D' is constrained by 'U' and those involved in a related discourse

ought to take into account the effects on people and the consequences that would follow, a knowledge of a discourse's outcome has historically affected many of the world's decision makers. This confirms the notion that communication has to be considered with reference to the effect that it will have on other people. I will now identify criticism that can be made of Habermas' work.

11 Criticism of Habermas

Having considered the views of Habermas (1995) in this chapter, it would be useful at this point to articulate four weaknesses that can be observed with regard to Habermas' work.

With reference to Pellizoni (2001:69), the first objection concerns a requirement for ideal conditions with regard to the occurrence of a dialogue, which may be at a distance from a concrete situation. This can be interpreted as a criticism of Habermas' 'Ideal Speech Situation.' In a nursing context, this may be illustrated by a practical concern, relating to the time that is available for the occurrence of communication. For example, in regard to the action that ought to be taken for the

welfare of a patient in a clinical emergency, where a previous directive or decision has not been made, and there could be a lack of time available to canvass the views of interested parties and to come to a decision.

According to Pellizoni (2001:69), this objection is weak, on the basis that Habermas' theory ought to be considered as 'a regulatory ideal, a benchmark against which the existing institutions or the reformist projects can be measured.' An allowance could also be made that, in such a situation, the nurse should employ his or her professional judgment. Habermas' theory ought to be therefore considered as an ideal that one ought to work towards.

The second objection, as according to Pellizoni (2001:69), 'concerns the distinction between moral and ethical issues.' Where 'moral questions can be viewed as particular cases of ethical ones.' When employing this perspective, our individual 'good' may be considered from the perspective of a broader collective, for example, humanity. This can be applied to

medical ethical issues, such as euthanasia, where the actions aimed at benefiting an individual, due to their circumstances, could be at odds with wider social values. Pellizoni (2001:82) cites an example of this, when he refers to Habermas' (1991 and 1992) approaches to abortion, where Habermas (1991) 'considers abortion to be an ethical issue and then (1992) a moral one.' This, for Pellizoni, is considered as contradictory. This objection is identified by Pellizoni as an example, of what Habermas (1996a) would refer to as a 'collision of discourses.'

Habermas (1987) would counter this by acknowledging that there would be an occurrence of a conflict of values, however, a fair and acceptable solution should be found, through an application of Habermas' approach to discourse ethics. This would create the necessary conditions for such a discourse to occur.

Pellizoni's third objection refers to the idea that

> 'non-strategic agreement only occurs when the parties reach consensus on the reasons for choice.' He then poses the question: 'To what extent is a strategic compromise the only possible outcome of a discussion in which the parties are unable to define a common reason?'
>
> Pellizoni (2001:69)

For Pellizoni (2001:69-70) 'Intractable controversies', where the parties have different strongly held beliefs can often lead to a dispute where the parties emphasize different facts or interpretations, so that each party seeks to refute the evidence as offered by the other party.

Habermas (1987) would counter this objection on the basis that the parties involved in a dispute should be able to facilitate a discussion where they should be able to reach a consensual agreement. Habermas would acknowledge that this may involve a protracted discussion, however, the aim of obtaining a consensus that is acceptable to all parties should be the main objective. He would acknowledge that the parties may be

unable to form a consensual agreement and reach a decision to disagree. However, this should not deter the parties involved from engaging in a future discussion with the aim of forming a consensus.

A further objection concerns Habermas' work relating to his concept of 'lifeworld'. Habermas' (1987) concept of 'lifeworld', when applied to nursing care, can be criticised on the basis that his version presupposes the presence of homogeny between a nurse and patient, which may typically be absent. For when considering advocacy, one should not presume that the nurse as an advocate, could possess the same level of knowledge and experience as that of a patient. The patient and nurse may come from differing social backgrounds and would normally possess differing levels of knowledge with regard to a health service.

In answer to this objection, when undertaking the role of advocate, the nurse is required to seek an understanding of the

presence and importance of the patient's 'lifeworld'. In this way, she should be able to overcome this problem.

Having identified and discussed some of the objections with regard to Habermas' perspective, I will now offer a consideration of discourse as a communicative link.

12 Conclusion: Discourse as a Communicative Link

Discourse normally occurs as a communicative link between people, it is directed towards the achievement of a mutual understanding. With regard to one's lifeworld, a discourse can be used as a base, with reference to the prevailing system and lifeworld, from where political and social practices can be defended and challenged. This chapter has introduced discourse ethics 'D' and Universalism, 'U' and there has also been an acknowledgement that 'U' can be linked to 'D', where 'D' represents a practical application of 'U' as a framework for the conduct of discourse.

Habermas (1984) firmly links 'discourse' to the previously identified validity claims, when he states:

> 'I shall speak of "discourse" only when the meaning of the problematic validity claim conceptually forces participants to suppose that a rationally motivated agreement could in principle be achieved ... .'
>
> Habermas (1984:42)

He also links discourse to the construction of an argument, that he suggests, ought to be long enough to facilitate a discourse. For Habermas (1995) discourse presupposes valid norms that could be met:

> 'With the approval of all affected in their capacity as participants in a practical discourse.'
>
> Habermas (1995:66)

for example, in the case of advocacy.

The related concepts of communicative and strategic action have also been considered with reference to the motivation of those that are involved in discourse. Communicative and strategic action can both be acknowledged as forms of

communication and in this sense are almost interchangeable. The difference lies in relation to the potential motivation of those involved in strategic action, as opposed to the lack of motivation in relation to communicative action. These are linked to moral considerations with reference to discourse that have also been discussed, for example: Kohlberg's preconventional level stage two of human moral development refers to the purpose of the individual and the need for an exchange of information.

At a higher moral developmental level, a link has been made between Habermas' (1995) 'U' and Kohlberg's sixth stage of moral development, where there is an acknowledgement of the presence of ethical principles by which all humans should be guided. The chapter includes four criticisms that can be levelled against Habermas' work and these have been answered. In chapter eight, I will offer a description of the Pink case and will apply the work of Habermas to it in chapter nine.

CHAPTER 8 THE PINK CASE

Having described Habermas' (1984) work on communication, I will now give an account of the Pink Case, as illustrated by his letters to The Guardian (1990:21). In the paper, he offers a description of nurses' working conditions and standards of patient care in an elderly care unit of a hospital at night. The case is also later detailed in Turner (1992).

1 Graham Pink's Background

In 1952, while on National Service in the Navy, Graham Pink qualified as nurse. He subsequently worked at Withington Hospital in Manchester and also in Canada, at the Toronto General Hospital. He returned to the United Kingdom during the mid 1950s and became a teacher, having formed the conclusion that nursing did not offer men a career. However, he kept his nursing links by undertaking night duty at weekends. During that time, he studied for an Open University degree and subsequently a master's degree in education. At the age of fifty, he took early retirement from teaching and had an opportunity to return to nursing working as a nurse tutor but he found that the role did not offer him enough of a challenge. He took a post as

staff nurse in a clinical area and applied for a post as a night charge nurse at Stepping Hill Hospital, on the elderly care unit. During the interview for the post, he suggested that the position should be offered to another younger candidate who needed the salary as he was financially secure and did not need to work. Nonetheless the hospital offered Pink the appointment.

Stepping Hill Hospital was classified as a general hospital in the Stockport Health Authority. By August 1989, Graham Pink had been employed for two years on the elderly care unit at the hospital as a night duty charge nurse. The unit was comprised of three wards containing 72 beds that were designated for the care of physically ill elderly people. The hospital had a general manager and an assistant general manager, the latter had specific responsibility for the elderly care unit at night, and worked on the elderly care unit at least one night per fortnight.

2 The Case

According to Snell (1997), while Graham Pink was working in the elderly care unit, he became concerned about the nurse staffing levels at night and the resulting care that the patients

were offered. He felt the need to do something about this and decided to write a letter in which he expressed his concerns. These were supported by descriptions of nursing staffing levels and care in his area of responsibility. The first letter was addressed to the Chairman of the Stockport Health Authority and was written on 24th August 1989. When writing his letter, Pink calculated that on his ward he required three or four nurses on night duty. The management of the hospital replied, indicating that the ward required one nurse. The Chief Executive of the hospital met Mr Pink, listened to his concerns and then asked the Assistant General Manager to satisfy himself with regard to the staffing levels and nursing care standards on the elderly care unit at night. The Assistant General Manager offered to investigate the issues that Mr Pink had exposed.

As alluded to in Hunt (1995), at that time and later, Graham Pink did not wish to ask his colleagues for support, as he was aware that they needed to work for financial reasons and he did not want them to jeopardize their jobs.

Pink sent further letters to the Assistant General Manager, indicating the need for a complement of at least two nurses per ward on night duty. After five weeks, nothing had changed and it was evident to Mr Pink that the hospital's management was not going to take action with regard to the staffing levels on the elderly care unit at night.

The Assistant General Manager agreed with Pink that there was a need for more staff in this and other hospitals; however this was placed in the context of the financial resources that were made available throughout the hospital. The requirement of managers to provide a health service in context with the efficient use of available resources is discussed in Wall (1998). The point was made to Pink, by management, that if more staff were made available to the elderly care unit, this would have affected the staffing levels of other wards in the hospital. At the same time Pink was thanked by management for bringing his concerns to their attention.

Pink subsequently sent letters to the Chief Executive of the National Health Service, the Secretary of State for Health and

the Prime Minister. The response from Whitehall was that general management had been introduced in the National Health Service and had been charged with the responsibility for decision-making at a hospital and clinical level; it was therefore not appropriate for the Government to establish nursing arrangements in those hospitals. It should be noted at this point that Pink had not attempted to contact the NHS Commissioner (HMSO 1992a), who was willing to receive complaints from health service staff on behalf of their patients.

After having written approximately fifty letters containing twenty to thirty thousand words over a period of seven to eight months, Pink felt that he was not getting anywhere. He took advice from a Member of Parliament and forwarded the letters to the Guardian Newspaper (1990). The Guardian acknowledged the material's importance and presented the information by publishing the letters to tell their own story. The paper received a large public response and many people identified with what Pink had said.

Once Pink had publicized the information, his night sister colleagues formed a perception that the publicity had cast a slur on them and the hospital, which would result in an adverse reaction by the relatives of patients on the unit. Pink's colleagues felt that he was naïve and should have coped with the situation. The General Manager wished that the action had never happened and that the issue could have been settled without press involvement. It would seem useful at this stage to describe the content of the management's report.

3 The Report

According to the BBC (1992), the management prepared a report to address the staffing issues raised by Graham Pink and this was intended to be a detailed and final response. A teamwork system was used by the hospital with regard to manpower planning and six levels of care were identified as:

1) Dangerous

2) Barely safe

3) Less than adequate

4) Adequate

5) Good

6) Excellent

The management report concluded that the care given on the hospital's elderly unit at night was designated as 'adequate'. This was defined as 'Patients receive adequate levels of care, although not every need is met', (BBC 1992). The Health Authority concluded that, given the resources that were available at that time, standards of patient care were adequate. The Authority suggested that this was also the view held by the key people that were interviewed.

Graham Pink challenged the Health Authority's findings that patients received adequate care. On the basis that the Health Authority's figures that indicated for the unit as a whole, patient care was 0.16% less than adequate – a figure that could be used to justify the need for extra funding of the staff budget. According to the night management team, nursing-staff were moved from other areas of the hospital to the unit at night and

the nursing managers and night sisters helped with patient care on the unit, as required. It was on this basis that the Health Authority defined the level of care as 'adequate' and that the general manager wrote a letter to Pink, requesting he should not become involved in further publicity. It should be noted that there were nursing colleagues who agreed with Graham Pink, but were concerned that they might be seen to be "rocking the boat" (BBC 1992).

After a further incident involving the care of a patient, Pink went to the Stockport Express paper, who ensured that he was aware of the repercussions that would occur as a result of further publicity. Pink was prepared to accept the consequences and took the view that the staffing levels on the elderly care wards were more important than the personal consequences that he could experience as a result of his action, as described in Pink (1992). The relatives read of the incident in the local press and the patient involved was identified.

This led to the managers taking out a disciplinary action against Mr Pink on the grounds of a breech of confidentiality. During

August 1991, the Health Authority found Pink guilty of gross misconduct. As an alternative to dismissal, the employer offered Pink a transfer to the community, on the grounds that Pink was unable to work in a large organization where he had to relate to people. Pink declined the offer, as he felt that this was not appropriate due to his lack of training and experience in this area of nursing. The Authority then dismissed him for a breech of confidentiality. Graham Pink took his case to an industrial tribunal and subsequently lost an appeal against his dismissal.

This case study illustrates that both the hospital's management and Pink, held a perception that there were national and local funding deficiencies in the health service. This was reflected in the levels of nursing staff that were made available to care for the hospital's vulnerable elderly patients at night. The presence of these perceived deficiencies formed the basis of Pink's decision to make a stand with regard to the care of elderly patients and to make the public aware of the hospital's need for more nurses, by going to the press.

The Pink case highlights a criticism of Gadow's (1989) approach concerning advocacy and the silent patient, as described in chapter four. Although typically many of the patients on Pink's unit were conscious, some had Alzheimer's or other illnesses that affected their rational ability. Therefore the same criticism of Gadow would apply in this case study; namely, how can a nurse accurately gauge a patient's preferences when they are unable to articulate them.

4 Summary

This chapter has described the Pink case, detailing the professional background of Pink and the circumstances that influenced the case. This can be applied throughout the National Health Service and Private Sector and illustrates the conditions and restraints that affect the work of nurses. Owing to his previous career and resulting financial status, Pink felt that he had little to lose by voicing his concerns, a position that few nurses occupy. This has to be a consideration, when reading the details. Nevertheless, this case is considered as a landmark, in that it illustrates the importance of compiling detailed information concerning a situation and acting according to one's

conscience, even though there may be adverse consequences for the individual concerned. Having described the Pink case study, in the next chapter, I will apply the work of Habermas (1995) to it.

CHAPTER 9 HABERMAS AND THE PINK CASE

1 Introduction

In this chapter I will discuss the application of Habermas' (1995) work on communication to the Pink case study with reference to Kohlberg's levels of moral development, as described in Habermas (1995:123-4), and also Habermas' (1987) work on system and lifeworld and his (1984) work on communicative and strategic action. I will discuss an application of the previously described four validity claims that can be related to Pink's discourse, and will apply the principle of Universalism that can be employed as a constraint on argumentation. A similar application can be made with regard to 'ideal speech situation' and 'advocacy', as described previously in the thesis. A relevant area to begin application of Habermas' (1995) work, is with reference to moral development, as discussed in the next section.

2 Moral Development

With reference to Kohlberg's three levels of moral development, Pink's management colleagues appeared able to reach the

post-conventional and principled level of moral development. The basis for this observation rests on the fact that Pink's nursing colleagues were able to take a broad view and felt that all specialties ought to be afforded a certain level of financial resources, with reference to the employment of nursing staff. This formula can be applied to the nursing staffing levels with regard to patient care, when the available limited resources are evenly distributed to the medical, surgical and elderly care wards. This is in contrast to the resources being allocated solely to one particular clinical area, as in the case of the elderly care wards, where those can often be perceived as the most deserving.

Pink's colleagues' acknowledgement that the hospital should be considered as a united entity that contained the above medical and nursing specialties was emphasized, when his night sister colleagues moved nursing staff from surgical, medical wards to the care of the elderly wards, as the need arose. Furthermore, the night sisters raised the nursing staff levels on the elderly care wards by working clinically on the unit themselves. This acknowledgement by the night sisters, demonstrated their ability

to think morally at a post conventional level, in that they were able to consider and respond to competing claims for nursing staff from differing clinical areas. They attempted to increase the elderly care unit staffing levels by individually working in that area.

With reference to the above case study, Pink in contrast, was able to reach a conventional stage of moral thinking, where an individual has developed a social consciousness and is aware of a potential for action or actions, this having been attained through his or her life experience and education. Pink was able to make a coherent case for extra financial resources that should adequately fund the staffing levels required on the elderly care unit and he made an assumption that when management learned of the facts, they would respond with swift action. In this case study, Pink referred solely to the requirements of patients in his care and did not appear to take into account that management had to consider the levels of nursing staff allocated to his unit, in the context of the hospital as a whole, as a response to the then Government's policy towards the health service. He failed to acknowledge that

management had to be seen to distribute the available resources effectively. Pink's exclusive concentration on his unit, demonstrates his conventional level of moral thinking. However, Pink could also claim to be universalizing a level six norm when he expressed his concern that all of the elderly patients on the unit should be given a good level of care by the nursing staff on the ward. However, this aspiration did not appear to be attained or acknowledged in the case study. One can now apply Habermas' (1987) work on 'system' and 'lifeworld' to the Pink case study.

3 System and Lifeworld

With regard to the Pink case study, Habermas' (1987) work on system can be applied to the then prevailing Conservative Government's policy, of making the health service managers responsible and accountable for financial resources, with the aim of providing cost effective patient care. Pink found that the health service and its management appeared to be hierarchical and unresponsive to his internal letters. It was only when he felt compelled to publish the letters in the Press, that he had a swift response.

Habermas' (1987) lifeworld can be applied to the life experiences of patients, who may have had little knowledge of the health service, how it was run and may also have been in an unfit mental state to express their experiences and observations. The lifeworlds of Pink and his colleagues can also be applied, where colleagues had to work for economic reasons, whereas Pink did not. This had an influence on the two parties' perception of staffing levels and the subsequent effect of this on patient care. Lastly, the lifeworld can be applied to management, whose role it was to provide economically justified patient care within a health system; this required a certain level of staffing to maintain safe patient care. For management, Pink's letters were to be dealt with through agreed procedures and management perceived that Pink's action of going to the press circumvented those agreed procedures.

4 Communicative Action

The Pink case study can also be analyzed in terms of Habermas' (1984) theory of Communicative Action. The act of communicative action presupposes Pink's communicative competence. As previously suggested, Pink took the view that

by identifying his concerns and communicating these to management in writing, this would be sufficient to ensure that action was taken to remedy the problem.

Pink's view was based on the belief that his communication with management should have led to the development of a consensus between the nurses and management, that nursing staffing levels should have been maintained at an adequate level, with the aim of facilitating the required level of patient care. This should have included the provision of sufficient time for nurses to talk to their patients. It would now be pertinent to consider the motivation of Pink and the management, in terms of strategic action.

5 Strategic Action

The Pink case can be analyzed in terms of strategic action, for this occurs when a person is motivated primarily to influence the behaviour of another. With regard to this view, the letters written by Pink to the management, government and press can be considered as examples of strategic action, as he was trying to

influence these bodies with regard to the levels of nursing staff on his unit.

Strategic action can also be applied to the act of management in the Pink study, when they were aware of the need to manage staffing levels within the available financial resources and resorted to a strategy of moving staff to the elderly care unit from other areas of the hospital. This would have been enforced at the time, by management awareness of the need to keep within a budget. Their posts were based on performance related pay, where an inability to manage services within a limited budget would have resulted in the managers involved, losing their financial bonuses or employment.

Strategic action can also be applied to the press, who were motivated to print Pink's story with the aim of increasing their paper sales. They thought that the story would be of interest to the public and that the letters did not require an explanation. There was a good response to the story from other nurses and the public at large, which confirmed they had captured the interest of the public. Having considered communication in

terms of strategic action, I will now consider an application of the four validity claims, as previously described, to the Pink case.

6 The Four Validity Claims

The Pink case can be analyzed in terms of the four validity claims with reference to Pink, his nursing colleagues and management. These are:

a) That Communication Should be Comprehensible

This presupposes the ability of the involved parties to communicate in a comprehensible manner and through the content and articulation of his speech, Pink was able to fulfil this validity claim. The public could understand the content of Pink's speech; letters were published in The Guardian and identified with the issues that were raised. Pink's nursing colleagues were also able to offer a good level of communication, as their speech was based on logic and this enabled them to form a sound rationale as a basis for their speech. Similarly, the hospital's management was able to form a coherent case for the content for their speech. The next

claim, which I will consider with reference to the Pink case study, is concerned with 'truth'.

b) The Truth Claim

With reference to the truth claim as previously described, I refer to Habermas' (1995:59-60) 'existence of states of affairs.' Pink was able to provide factual evidence with regard to the verifiable numbers of staff on duty in specific clinical areas at night and he was able to document specific clinical incidents that arose with regard to the patients on his ward. His colleagues were able to offer accounts of incidents that they believed were based on truth and were a reflection of the staffing levels at the hospital during the night. Management was able to offer a justification in support of their communication with references to the available resources. This was supported by an investigation that had been undertaken into nursing staffing levels by management and the tools and procedures that were available for use when the management personnel sought to interview Pink. A further related validity claim that can be considered with reference to the Pink case concerns the claim to 'rightness'.

c) Claim to Rightness

As according to Habermas (1995:60) and as described previously, this claim refers to the rightness of actions and the observance of norms. The rightness claim can be considered from Pink's point of view, when he perceived that his first action should be to draw to his employer's attention the staffing levels on the elderly care unit at night. When there was a lack of response from the employer, Pink came to the conclusion that by first, approaching the management executive of the NHS and then the politicians, at different levels of government, there would be some form of response. Then, failing this and as a last resort, he published the facts in The Guardian on the basis that he was acting for a cause that was right. With reference to the rightness claim and his colleagues, Pink had the support of some staff at the hospital. They acknowledged the problem and the need to do something, although in some instances they felt unable to offer direct support for Pink, because of their financial obligations, which necessitated their employment at the hospital.

When Pink raised his concerns, some of his nursing colleagues took offence and this was based on their perception that his criticism implied that they were not doing a good job. They also felt that the reputation of the hospital would be diminished and that patients' relatives would become concerned and distressed with regard to the content of the publicity. Management accepted that there was a requirement for more staff; however they took the view that in order to provide extra staff, resources would have to be diverted from other areas in the hospital, resulting in a staffing deprivation in other clinical areas. It ought to be acknowledged that the key norms with reference to the Pink case study concern the prevention and relief of suffering in the care of the elderly unit at the hospital. Having considered 'rightness', I will now consider the claim of 'truthfulness' with regard to the Pink case.

d) The Truthfulness Claim

With regard to the claim to truthfulness, as linked to the behaviour of a person and as previously described, Pink's aim was to tell the truth. Part of this equation was based on the fact that Pink did not have to work and rely on income from his post

as charge nurse. Therefore, he did not appear to hold any vested interests, although he felt that he had to tell the truth, even though management tried to dissuade him from going to the press, on the grounds of a potential public loss confidence in the hospital. Pink's nursing colleagues also ensured that they aimed to tell the truth, although there were some comments from them regarding Pink's conception of nursing staffing levels and the presence of constraints. His colleagues felt a certain amount of betrayal by him, in that they held a perception that his account could influence the public's opinion of the hospital. With regard to management, they had a vested interest in the avoidance of publicity, for the exposure of conditions in the hospital would have led to an investigation and a concern with regard to their competence. There would have been a possibility that the management could have been replaced.

As previously stated, the notion of truth differs from that of being truthful, for true communication is based on objective, first-hand information and this is in contrast to a truthful claim. Information can be passed from one person to another and the individual who acquires second-hand information may hold the belief that

it is true. Having applied the four validity claims, it would seem pertinent to apply 'discourse' to the Pink case.

7 Discourse

I will now consider 'discourse', as applied to the Pink case. Pink's letters to the management and the act of publicizing them were examples of communication. These were aimed at fostering an internal understanding of the situation and when, in Pink's perception, this did not appear to occur, he resorted to publicity. According to his perception, his claims were based on truth and they were considered as right, as the management appeared to understand (possibly too well). They were able to foresee the negative implications of whistle blowing in terms of the hospital's reputation and the potential effects of this on their personal ambition. They acknowledged Pink's positive intent to gain more staff, however they had to take into account government policy at the same time, which had initiated general management with the remit of effective management of limited available resources. The management acknowledged that hospitals had to work within the political and management system and that this was considered as the norm in the health

service. The principle of Universalism 'U' can also be applied to the Pink case.

8 'U' Universalism

I will now consider 'U' or Universalism in application to the norms of the Pink case. 'U' is previously identified in chapter eight in this thesis and as previously alluded, can be described as a principle where the people involved in a moral discourse are able to accept the consequences and side effects, for the satisfaction of everyone's interests. With regard to 'U', a principle is proposed with respect to the conditions for a moral discussion that ought to occur in an environment that is free of constraints. Moreover, stress is laid on the importance of taking into account differing points of view, as held by those involved in a communication, and the creation of an environment that would enable everyone to come to the same decision. This should enable those involved to achieve a universal agreement, ideally through the 'ideal speech situation.'

With reference to an application to the Pink case, a norm held by Pink can be expressed in terms of 'U', for example, the norm that there should be sufficient funding of the health service. It may then afford the resources to provide nurse-staffing levels that would allow for adequate communication between nurses and patients, who should then be well cared for. With respect to the Pink case and this norm, there was a general agreement between the management of the hospital, staff, patients and their relatives. There would also be an agreement that Pink ought to bring his nursing staffing level concerns to the hospital's managers. Having been informed of these concerns they should be able to agree with Pink, that extra financial resources ought to make available to the hospital's management with the aim being to engage extra staff for the hospital, in particular the care of the elderly unit.

One can therefore suggest that an agreement existed at this level between hospital's management and Pink, with regard to the norm that there should be adequate levels of nursing staff in the elderly care unit and that in this way, the criteria for 'U' was satisfied. Initially there was an agreement between Pink and the

hospital's management that the grievance procedure ought to be observed. Pink exercised his professional right and duty to make known his concerns with regard to the care of the elderly unit's staffing levels by using the appropriate channels and the hospital's management was in agreement with this action.

However, an inability to achieve a valid norm and to satisfy 'U' occurred in the Pink case. This concerned the presence of a fundamental disagreement between Pink and the hospital's management with regard to action that was required to ensure that extra resources were made available, with the aim of alleviating shortages of nursing staff in the elderly care unit. After pursuing the hospital's normal grievance procedure and perceiving that nobody appeared to be listening to his concerns and that nothing was being done to alleviate the situation, Pink felt that he had a duty to publicize his observations on the nurse staffing levels.

Although there was an agreement between Pink and management, that more staff was required for the hospital and elderly care unit as a valid norm, the management was not

prepared to place the information in the public domain. This was due to a concern that those in the higher levels of management in the health service and Government would perceive the hospital's management as ineffective.

In the Pink case, the grievance procedure helped to keep the information within the NHS domain, thereby denying public access. The above can be applied to the inability of the two parties to agree a valid norm concerning the need for publicity with regard to staffing levels. The case can also be made that the conditions, as according to 'U', did not apply in this instance, as Pink and the management did not agree to disagree. Indeed, there was an absence of any form of agreement between the two parties, as there appeared to be little common ground between the two, with regard to the perceived requirement for a publication of the facts.

From the above discussion one can make the suggestion that 'U' can be applied to the Pink case through different levels of thought, as for example, on one level, where the conditions of 'U' were met when Pink, his colleagues and management could

achieve a consensus and an agreement regarding the need for more staff, and when Pink and the management could agree a consensus on the need to communicate these concerns internally within the hospital.

At another level, the conditions of 'U' were unable to be met, when there was an inability to achieve an agreement and consensus with regard to how higher staffing levels should be facilitated and could not be achieved. Furthermore, the conditions of 'U' could not be met with regard to an agreement about the need to go to the press. Moreover, there was an absence of evidence in the study, that an agreement to disagree could be attained. At the end of the study, there appeared to be mounting difficulties between Pink and management and there was evident difficulty with regard to the aim of the two parties understanding each other's perspectives, although both Pink and the management agreed on the principle that there was a need for more staff in the health service.

'U' can be used to identify the acceptability or otherwise, of claims with reference to the affected parties in the 'Pink' case

study, as for example, patients, nurses and hospital managers. For instance, the claim made by Pink and some of his nursing colleagues that there was a need for more staff can be considered as acceptable, as opposed to how this could be achieved. For example, the management's solution of moving staff from other clinical areas was not really acceptable to Pink, as this did not fully address the underlying problem of the hospital's staffing levels.

The norm for Pink, that nurses should be able to give a good quality of care, including having the time to communicate with their patients, can be expressed in the terms of 'U'. Pink made his decision to go to the press in order to gain publicity for his case that the wards of the hospital in which he worked were understaffed. It would seem relevant at this stage, to briefly link 'U', as a constraint on argumentation, as applied to the Pink case. With reference to the Pink case and Universalization which functions as the rule of argumentation (as described in Habermas, 1995), the need for an adequate debate regarding staffing issues was not fully addressed in this case. Thus the

lack of a management response encouraged Pink to place his story in the public domain.

Linked to the explicit statement of the normative content (i.e. Discourse rules), as according to Habermas (1995), the people involved in communication, in the Pink case, acknowledged the seriousness of the communication. As management limited Pink's communication, the rules of discourse were not fully adhered to and this should not have occurred. I will now consider an application of the Ideal Speech Situation.

9 Ideal Speech Situation

In application of the ideal speech situation as identified by Giddens (1985), those patients who are vulnerable and elderly and who are unable to speak for themselves, ought to be able access a nurse who is able and willing to speak for them. A nurse, as demonstrated in Pink's case, is able to speak on his or her patients' behalf and is also normally in possession of knowledge with regard to the hospital and management system and how it works and the nurse is normally aware of the

procedures with regard to communication. He or she, as patient's advocate is normally capable of acknowledging the validity of his or her case and is capable of forming and articulating a better argument that should be the foundation of a successful advocacy role, as according to the ideal speech situation.

Pink was able to articulate the need for more staff on the grounds that there were insufficient numbers of staff to deliver the appropriate level of care that was required by the patients. His argument for more staff was based on factual evidence that was gathered from personal sources and later, through the management's investigation of staffing levels. The factual evidence forms the basis of truth and rightness of this case.

Pink's communication rested on the validity claims of truth and rightness and an argument could not be made against his case for more staff. His work background and financial resources meant that he did not have to take a post as charge nurse and therefore did not have to consider the effect of the case on his employment prospects. His previous experience of dealing with

people and situations informed him of the need to pursue the goal of drawing attention to the staff shortages despite personal consequences. There was a consensus between Pink and many colleagues with regard this, however his night sister colleagues and management did not share this view.

Although Pink told the truth, and his case for more staff could not be argued against, he failed to provide a better argument on the grounds that he considered the staffing levels mainly with regard to the elderly care unit rather than that of the whole hospital. His seemingly parochial approach failed to take into account the issues of staffing that came from considering the hospital as an entity. This leaves Pink's approach to resolving staffing issues by resorting to publicity, open to the criticism on the grounds that any response offered by the management and government could be fragmented and aimed at solving local problems, rather than solving the long-term problem of the NHS as being continually under resourced. In their response to Pink's case, the hospital's management appeared to be able to acknowledge the need for publicity concerning staffing levels. One can now apply 'U' and 'D' to advocacy and the Pink case.

10 Application of 'U' and 'D'

I will now turn to the application of Habermas' (1995) definitions of 'U' and 'D' to advocacy and the Pink case. Using Habermas' (1995:65) definition and description of 'U', as illustrated in chapter seven, those involved in the Pink case should be able to come to an agreement. Habermas (1995) suggests that this should take into account the views of other people through the exchange and checking of individual perspectives, even though this may result in an agreement to disagree.

'U' can be employed as a critical principle that could be used as a test to ascertain whether communication is conducted according to the norms of the parties involved. It could also be used to identify whether it would be possible to reach an agreement that could satisfy the interests of those involved. An example being, that the norm for most people in a society is that there should be an adequate health service available to care, as required.

Both principles of 'U' and 'D' can be applied to advocacy when a norm held by the majority in a society, that adequate health care for the citizens ought to be afforded, is potentially compromised by political decision making and consequent management policies and actions. The case can be made in support of the nurse to act as an advocate on a patient's behalf, on the grounds that the nurse works in the hospital as part of the health care system and is aware of the structure and channels of communication. There would be an expectation by the public that nurses, as part of their caring role, would be able to articulate effectively the concerns of the patients, relatives and colleagues, by the act of speaking out when it was felt that there was a need to do so.

With regard to his case, Pink felt his norm that nurses should be able to give good nursing care and have the time to talk to patients, was compromised due to a lack of available resources that the hospital managers were able to provide. Having considered this, he decided that he had to bring his concerns to the attention of the management and politicians. When there was a lack of response he decided to publish his observations in

the media, with the aim that something should be done regarding the resources that were made available for the employment of nursing staff.

11 Summary

In this chapter I have applied the work of Habermas to the Pink Case. This has enabled me to link Habermas' concepts to the different actors and their roles within the Case Study, for example, the role of Pink and that of his night nursing colleagues and hospital management. All of Habermas' (1984, 1987 and 1995) work can be applied to this study, for example, the conditions that are required for discourse and the validity claims. In the next chapter, I will look at an application of Habermas' (1995) work to that of Gadow (1983) and advocacy, through the use of another case study.

CHAPTER 10 APPLICATION OF PERSPECTIVES

1 Application of 'System' and 'Lifeworld'

There is a clear link between Habermas' (1987) account of system, lifeworld and the notion of advocacy. One should acknowledge that a health service forms part of a social system and that the staff and patients experience their lifeworld when they interact with the health service. This experience will normally have an effect the development of professional relationships between staff and patients.

A link can be made between Habermas' (1987) concept of 'system' and Gadow's (1983) 'object' body perspective. For example, with reference to a system, as the National Health Service, where a Government's level of financial investment in healthcare has an effect on the amount and complexity of treatment that is available to patients. The operation of this system can be linked to a patient's object body, in terms of whether the patient's physical problem is assessed as a clinical emergency, or whether the person is deemed as a suitable candidate for a potentially lengthy waiting list. This may give

rise for a justification of advocacy, on the grounds that the 'system' may view the patient's object body as having a non life-threatening disease that can be treated at a later date. The patient's perspective however, would normally be influenced by his or her 'lifeworld' and 'lived' body experiences. Therefore, the patient may come to a different conclusion and require a form of advocacy.

At a societal level, the system and resultant philosophy of a society can heavily influence the form that a health service may take, for example, as in the United States model, which relies heavily on personal insurance to fund its service. This is in contrast to the British model, which is based on National Insurance of its citizens to fund a service free to all at the point of delivery.

With reference to the points made above, the role of advocacy in the United States and the United Kingdom has the potential to be influenced by the values held by a society. With regard to advocacy, the United States of America, for example, tends to

rely on a patients' rights model, where the patient is offered information and expected to make decisions concerning their care and treatment. A third party, in the United States, may be interpreted as the involvement of a patient's lawyer, who is normally paid by the patient or their insurance company with the aim of legally representing the interests of the patient. This system does not normally rely heavily on the presence of patient advocacy groups.

In contrast, the British model of a universal state supported healthcare does allow for the development and presence of advocacy groups, whose role is interpreted as the provision of support for patients. To-date, the British system does not normally rely as heavily as the United States on legal representation of patients.

2 Application of 'System' and 'Lifeworld' to Gadow

The application of Habermas' (1984) concept of the 'lifeworld', as previously described, has a resonance with Gadow's (1983) account of existential advocacy. In terms of Gadow's (1983) emphasis on the importance of a patient and their experience, she perceives that the patient ought to be the person to make informed decisions with regard to his or her treatment and care. Gadow (1983) acknowledges the importance of nurses striving to offer holistic patient care and as previously identified and Gadow offers a detailed account of the patient's experience in terms of having a 'lived' body and 'object' body.

Gadow's (1983) description of the 'object' body has been previously identified and refers to the illness and consequent treatment that a patient may have to endure. The illness, treatment and their effects can be measured objectively, through monitoring the patient's progress and performing the necessary investigations, with the aim of identifying the progress of the illness and effectiveness of treatment.

As previously described, for Gadow (1983), the 'lived' body refers to patient's experience and reaction to an illness, the accompanying medical examination and associated investigations. The patient's perception of these events would relate to the patient's previous experience of health care and the society that the patient lives in and his or her view of life. For example, the patient may believe that in British society, one ought to expect and accept a certain level of pain, without an overt personal response; for example, crying. This may be different from a Mediterranean society, where it is often culturally acceptable to express an individual response to pain.

Similarly with regard to a system or subsystem (as described by Habermas 1987), the fact the fact the British national health care system has a policy of not charging its patients for emergency health care would have an effect on a patient's perception of the society (system) that they live in. This would normally be shared by the 'lifeworld' and 'lived' body, in terms of an expectation that should the patient require emergency care, the standard of care offered would not be dependant on the health care insurance policy that the individual has (as in the

case of the United States of America). This knowledge may engender feelings of comfort for the patient and this would relate to the 'lived' body.

With respect to advocacy and the potential for the patients' lifeworld, which will be based on his or her subjective experience of life and healthcare, one has to acknowledge that the patient's lifeworld would have an effect on his her perception of their illness and care. This would in turn have an effect on the patient's 'lived' body experience, as described by Gadow (1983).

The link can be made between Gadow's (1983) work on existential patient advocacy and Habermas' (1995) account of discourse ethics. As described previously, the four validity claims can be considered as a necessary precondition for discourse. The comprehensibility and level of truth with regard to the content of a discourse between doctors and patients can be linked to Gadow's existential advocacy, where a competent patient normally wishes to have an adequate amount of information with regard to his or her 'object body' (as according

to Gadow 1983) that is based on truth. The patient would normally trust the doctor or nurse to offer a truthful account of the facts. In this context this level of communication would be right and serve to enhance the patient's understanding of their problem and required care. The patient would trust the nurse or doctor and this can be linked to Gadow's (1983) 'lived body', where the patient should be satisfied with the level of information offered. The patient should be then in a position where they can make decisions about their treatment and welfare. Gadow's (1983) 'lived' and 'object' bodies can also be closely linked to Habermas' (1984 & 1987) work on the 'system' and 'lifeworld', where this can be applied to the health care system and patients' experience of their illness and treatment / care. Habermas' (1984) perspective forms a firm academic basis for Gadow's (1983) account of advocacy, based on the experiences of illness and health care that her patient have undergone. One can now consider the lifeworld in the context of the doctor / patient relationship.

3 Clinical Application of Lifeworld

With regard to the relationship between a doctor and patient, Habermas' (1995) reference to the lifeworld in terms of context and resources can also readily be applied. The ability to achieve a consensus could be inhibited by the patient's potential lack of education compared to that typically acquired by the doctor and conversely, the doctor's possible lack of experience of living in an economically deprived social setting. It is in this context that the concept of 'movable horizon', as described by Habermas (1987:123-124), can be applied. This would allow the doctor and patient to forge an understanding, even though they may have come from differing social backgrounds. This understanding ought to be facilitated through the doctor's acquired knowledge derived from Cooke's (1994) 'expert culture', as applied to medicine. The doctor's medical school curriculum should have embraced the social influences that typically underpin patients' problems, resulting in a more socially aware medical practitioner.

Scambler and Britten (2001:57) make the connection between the previously described differing lifeworlds of a doctor and patient. Scambler (1987) suggests that attempts made by a doctor to understand the patient's lifeworld are temporarily set aside when the patient's treatment is decided by the doctor on the basis of his or her clinical judgment. Nevertheless, for a doctor to make an assessment of a patient, there would have to be some appreciation of the patient's lifeworld, for example, with reference to the patient's adverse social conditions that have predisposed the patient to a chronic respiratory problem. Cooke's (1994:16) reference to 'overlapping lifeworlds' can be applied here, when the doctor should seek to understand why the patient has developed the problem by employing the rationale that the problem is typically exacerbated by the patient's social conditions and that these ought to be addressed as part of the patient's treatment.

Communication problems, according to Scambler (2001:57) arise when for example, a doctor ignores a patient's lifeworld. Similarly, this problem is also acknowledged in Gadow's (1983) account of advocacy, as for example, when the doctor or nurse

does not take into account the patient's experience of an illness or problem, or when the patient's lifeworld is blocked. Porter (1998:145) refers to the 'colonisation' of the lifeworld, when for example, the health professional, the nurse or doctor, may reduce the patient's lifeworld, in terms of communication, to a technical function. For example, concerning the use of medical or nursing jargon and abbreviations that the patient may not understand. Similarly, according to Scambler (2002:123), 'the voice of medicine' may have the effect of distorting communication and the relationship between a doctor and patient, when the doctor has his or her own medical lifeworld that may not accord with the wishes of the patient. This problem can also be applied to the nurse / patient relationship, as described in the following case study and discussed later in this chapter.

4 Use of a Case Study

It is my intention to use a description of the fictitious case study of Gaynor Jones, with the aim of applying the work of Gadow (1983) and Habermas (1995). The case will be made that an adjustment of Gadow's (1983) theory with regard to advocacy could occur, when one considers a framework for discourse

ethics, as proposed by Habermas (1995). It would be useful at this stage to begin with a description of the case study.

4a The Case Study

Gaynor Jones is a thirty seven year old married woman who lives with her husband Bob, and one fifteen year old teenage daughter, Christine, who is at school studying for her GCSE's that she will take next year. Gaynor has one sister, Sally who she has not seen for ten years. Gaynor has been admitted to a ward with oncology beds, as she had previously been diagnosed as having cancer and unfortunately, this has spread widely throughout her body. She is in hospital for a general nursing assessment that would include the aim of pain alleviation until her death.

Her initial bowel cancer symptoms first appeared in the form of an altered bowel habit, she had complained to her husband of feeling tired, but she had attributed this to her age. She had been embarrassed about her disease and felt that she could not seek medical advice concerning her bowel habits, as her parents had always discouraged her from talking about such

things because they were deemed as unsuitable for discussion. For this reason she had not raised the topic of bowels in conversation with her husband.

The diagnosis had been made during a late stage of the disease, when Gaynor had started to experience abdominal pain and swelling, noticing blood in her faeces. She also felt very tired and had made observed that she had lost a lot of weight over a relatively short period of time, although she had not been on a diet. This had worried her husband, who suggested that she should have a medical examination to ensure that all was well.

On seeing her General Practitioner, Gaynor had confided the true symptoms and the time that had elapsed from their onset to the day that she was seen in her G.P.'s surgery. The G.P. subsequently arranged a set of clinical investigations with the local hospital to confirm the diagnosis. An urgent appointment was arranged with the oncologist at the District General Hospital, where the diagnosis was confirmed and Gaynor was informed of the prognosis. Due to the extent of the disease, the treatment that was most relevant to Gaynor's needs was

considered by the consultant to be palliative care through the use of drugs to relieve pain. She appeared to understand the extent of the disease affecting her body and the consequent prognosis. She indicated that she accepted this as her fate and began to plan for an early death.

Before Gaynor's admission to hospital, she had confided in her husband that, when a severe deterioration in her physical condition occurred, it was her wish that her life should be terminated. He had indicated to her that he could not agree with her desire to end her life, although he could appreciate her point of view. One can now make an application of Gadow's (1983) 'Lived' and 'Object' body to the case.

5 The 'Lived' and 'Object' Body

With reference to Gadow's (1983:51-55) 'lived' and 'object' body as described in part three, Gaynor's sex, age, and the fact that she has a physical bowel cancer problem should be the factors that ought to be considered. One also should acknowledge the progression of the disease and the physical effects that these would have on Gaynor in terms of measurable effects. For example, the occurrence of unexpected weight loss and feelings

of nausea, also deterioration in body function with reference to a normal ability to self-care. Other symptoms could be a loss of physical strength leading to a difficulty in the gaining and maintenance of mobility, and physical independence. The 'object' body will be considered next.

In application to the case study, the above examples of Gaynor's physical problems that relate Gadow's (1983:51-55) conception of the 'object body' should enable a nurse who is responsible for Gaynor's care to identify her present and future physical problems. The nurse would perceive that Gaynor has a diagnosis of cancer in common with many other patients. The nurse should then be able to identify the components of care that could provide a nursing assessment of Gaynor with reference to physical observations and the identification of required nursing care with reference to Gaynor's hygiene, dressing, and any other activities that require assistance. The nurse should also be able to acknowledge Gaynor's requirement for a referral to other health care professionals, for example, a dietician to ensure adequate nutrition and the physiotherapist to

ensure an adequate programme of exercise with the aim of continued mobility.

With regard to Gaynor's disease, when considered in light of Gadow's (1983) conception of 'object body', this should enable a nurse to design an effective plan of care having elements that the nurse would consider as common practise for people with cancer. There should be an acknowledgement though, that the care could be amended as required. This should facilitate a flexible approach to nursing care that could be planned and implemented according to Gaynor's needs. But the doctors and nurses may expect that Gaynor should make herself available on the ward as required for medical examination, clinical investigations and nursing care. The referral of Gaynor to other professionals would be considered as part of a plan that would be based on a holistic nursing assessment of Gaynor. I will now turn to an application of the 'lived' body.

As described previously, Gadow's (1983:51-55) 'lived body' perspective refers to the bodily experience of a patient who has some form of illness or is required to undergo some form of

investigation. An example of Gaynor's experience of her illness could be an associated pain and discomfort, feeling of nausea and tiredness, as in the case of a person who has cancer. A barium enema could be cited as an example of an embarrassing, uncomfortable investigation that could include Gaynor feeling bloated, nauseated and tired. The 'lived body' perspective would also give prominence to Gaynor's concerns and worry concerning the investigations and disease and she may refer to the cancer as 'growing inside'. She may also harbour concerns regarding the amount of pain that she will have and the effectiveness of analgesia. Having applied the 'lived' and 'object' bodies, the next section will offer a consideration of Gadow's (1983) existential advocacy.

6 Existential Advocacy and the Case Study

For Gadow (1983), the previously described perspective of existential advocacy is interchangeable with advocacy and it can be used to determine the nature and form of a nurse-patient relationship and be used to clarify the values held by those involved in decision-making.

With regard to the case study, existential advocacy can be used to identify the patient's requirements, preferences and wants. For Gadow (1983:51-55), the concept of existential advocacy involves the nurse in viewing the patient through a holistic perspective and working with the patient to clarify his or her wants based on information with reference to both the 'object' and 'lived body', as previously described. In relation to the case study, Gaynor's preferences concerning her physical nursing care are quite easily identified and addressed. This would also include any referrals to health care professionals other than nurses, for example, a dietician. The nursing and care by other professionals should be framed on the needs of the patient, Gaynor, who should be consulted at every stage to ensure that she feels fully involved during her care. This should minimise the possibility that Gaynor may feel that there is a loss of control and that she has, in effect, given her body to the professionals that are caring for her. When taking into account Gaynor's 'lived body' experience, the nurse should consider Gaynor's perspective of the disease and associated investigations. The nurse should also be aware of the effect of the illness on Gaynor through her physical experience of the illness and associated investigations. I will now offer a consideration of Gadow's

(1983:51-55) position on existential advocacy and the 'lived' and 'object' bodies, with reference to Gaynor's impending death.

7 Gadow's Position

I will now consider the views of the nurses from Gadow's (1983) perspective with respect to her concepts of 'object', 'lived' body and existential advocacy, should Gaynor wish for any reason that her life be terminated.

With regard to the 'object body' (Gadow, 1983:51-55), her response to such a request would be that the nurse as advocate should explore the presence of any physical reasons that may lead Gaynor to take this view. For example, a question could be posed as to whether she is suffering some form of physical deterioration that nursing knowledge and the employment of technology could alleviate. For instance, relief of discomfort and nausea through the use of an appropriate drug administered at a sufficient level to alleviate the problem. The level of nursing intervention, for example, with regard to the use of analgesia, may need to be increased with the aim of preventing and alleviating problems, such as pain. According to Gadow's

(1983) perspective, the patient should be encouraged to communicate any physical problems that may be encountered with the nurse and should be consulted with regard to the care.

With reference to the 'lived body', the nurse should take into account the preferences of Gaynor and make an effort to see things from the patient's point of view that should reflect some of Gaynor's experience. The nurse should make her or himself aware of the factors that may have influenced Gaynor's perception of her illness while taking into account her relationship with her family.

With regard to existential advocacy in Gaynor's case, this would depend on the relationship that had developed between Gaynor and nurse. For existential advocacy to exist, the nurse would have taken a holistic perspective concerning the care of Gaynor and her family, therefore both the 'lived' and 'object' body perspectives ought to be employed by a nursing advocate.

The context of the above case study can be used to consider Gadow's (1983:51-55) work on existential advocacy, object and 'lived body'. For Gadow (1983), the patient is considered as the

most important person, whose existence gives reason for the employment of nurses and the application of nursing care. Gadow (1983) would acknowledge that the role of a nurse is to assess the patient with the aim of giving appropriate care that could include the administration of medication to alleviate pain. She, as other nurses, would acknowledge that a potential physiological side effect of some strong analgesics is linked to the depression of a person's respiration and as a consequence, death could occur after administration. This would be considered as a humane act to be undertaken after consultation with the patient, doctors and relatives, with the aim of treating pain of not killing the patient.

The nurse would take into account Gaynor's feelings with regard to her illness and may empathise with her position. However, the nurse is trained to save lives and to contribute to a peaceful death when a life cannot be saved. Therefore Gadow's (1983) emphasis on the 'lived body' and the experiences of the patient could not form a basis from where the nurse, as advocate, could legitimately promote or aid Gaynor's death. To do so, would be to commit an act of murder and this would be unacceptable in a

society, as in Britain or the USA. For Gadow (1983), any nurse who receives such a request from a person like Gaynor should acknowledge that a mentally competent patient has a right to make known his or her preferences concerning the ending of his or her life. Gadow (1983) would hold, that it is right that the nurse offers the patient support in his or her decision, but would also refer to the legal restrictions that are in place concerning a proposed act of euthanasia. Gadow (1983) would therefore support the idea that Gaynor should be offered analgesia for the relief of pain that may unintentionally result in death. This nursing action would accord with the legal position concerning euthanasia in Britain at the present time.

Gadow (1983) provides a framework, where the patient can be viewed from the existential advocacy perspective and treated as an individual. The nursing care that Gaynor requires can be linked to her 'object' and 'lived body'. Gadow (1983) would acknowledge that the nurse advocate's response to Gaynor's wish to die should reflect the legal position in a society. Having applied Gadow's (1983) perspective to the case study, I will now do the same with regard to Habermas' (1995) framework.

8 Habermas' Framework

I will now describe how Habermas' (1995) framework with regard to first, the application of Habermas' (1987) system and lifeworld, second, Critical Theory, third, the Ideal Speech Situation, fourth, the Theory of Communicative Action. Such an application could be employed to address the problems that a view of advocacy based on Gadow's (1983) perspective, has generated.

For Habermas (1987) the application of 'system' would refer to the type of society that Gaynor lives in, that is, a society that does not legally allow the practice of euthanasia. Habermas' (1987) 'lifeworld', (that can be considered as a similar concept to Gadow's 'lived' body), can be applied to Gaynor's experience of life prior to the onset of her illness and her experience of having the illness, informing her of her feelings with regard to euthanasia. This should be considered with reference to the life experience and consequent view held by her husband, who does not suffer from this illness, and the doctor, who acknowledges that to aid Gaynor's death would constitute an illegal act of euthanasia. The views held by the different parties involved would be influenced by differing lifeworlds that would

reflect the experiences and responsibilities of the individuals involved. I will now consider an application of Habermas' (1987) critical theory.

For Habermas (1987) the application of Critical Theory may help in cases like Gaynor's. Critical Theory could be used to consider the historical and contemporary basis of murder and society's response to the act through for example, the death penalty. This should enable an understanding to occur concerning the reason for disagreement with regard to the act of murder and the resulting severity of punishment.

The application of Critical Theory, to cases as Gaynor's, may serve to aid people, or their representatives who are in a similar position, to question the stance taken by British society with regard to euthanasia and suicide. McHale states that:

> 'Section 2 (1) of the Suicide Act (1961) provides that assisting suicide is an offence.'
>
> McHale (1998:198)

It is therefore unlawful to assist someone who wishes to commit an act of suicide. The case can be made that in other European countries such as the Netherlands, the law has been changed with regard to euthanasia. There, killing in certain circumstances can be legally condoned, although certain restrictions and safeguards have to be applied and observed.

In this context therefore, Critical Theory may be used to question the stance taken by a society with regard to its policy on euthanasia. This can be done on the grounds that the act of euthanasia in certain well-controlled circumstances may be preferable to the alternative of a person suffering a long and potentially painful death.

Having raised an application of Critical Theory, I will now look at an application of the Ideal Speech Situation, Theory of Communicative Action, Universalism ('U') and Discourse Ethics, ('D'). The rationale for this order of application is related to Habermas' (1995) framework for the conduct of speech, where the Ideal Speech Situation can be considered as an ideal framework where all of those involved in discussion are able to have an equal participation with an opportunity to voice an

opinion. This can be considered as forming the basis for any form of communication and from this base, the Theory of Communicative Action can be applied, where those involved in communication can achieve a common understanding and harmony with regard to their communication. Universalism as previously described, can be used to evaluate norms with the aim of reaching a universal agreement. Discourse Ethics forms the conditions for a practical application of those norms.

Habermas' (1995) Ideal Speech Situation rests on the four validity claims, as previously described and he emphasizes the aim of attaining a consensus of opinion between those involved in discourse. This should lead to the formation of a consensus of opinion between people and form the basis from where those in authority may be challenged. With reference to the case study, the Ideal Speech Situation could be approximated, if the representatives of people who have a terminal illness, as for example Gaynor, are able to form a consensus and obtain support from other bodies. This could form the basis from where the law with regard to euthanasia could be reviewed and potentially changed.

Habermas' (1984) framework with regard to the Theory of Communicative Action can be applied to Gaynor and related to discourse that occurs with regard to the case study. As stated previously, his theory is based on four validity claims, namely those of the communication being comprehensible, that it should be based on truth, that it is right and that the people undertaking the communication are truthful.

The aim of those involved in communicative action is to reach a common understanding and achieve harmony with regard to a situation. This can be applied to discussions concerning euthanasia where, for example, the discussion may focus on the value of life and whether it is right for life to be ended prematurely, for whatever reason. The aim of communicative action should be to ensure that the participants are able to obtain an equal access to discussion and to form a consensus, where the outcome of communication can be agreed upon and then taken forward. It is at this point that an application of Universalism and discourse ethics will be made.

The four validity claims are the necessary prerequisite for the conduct of any communicative action and I will now consider Habermas' (1995) principle of Universalism as a way of evaluating the aim of reaching a universal agreement, free of constraints, in application to the policy with regard to euthanasia.

Habermas' (1995:65) definition of 'U', as described in chapter eight, can be used to evaluate the competing norms with reference to whether it ought to be possible, given a specific set of circumstances, that the act of euthanasia should to be legally condoned and be enacted.

The competing norms could be those relating to the sanctity of life, as with reference to the Theory of Communicative Action, and whether anyone has the right to take life or prevent people from taking their own life. This would relate to a society's stance towards life, for example, a society that condones indiscriminate murder might view life as cheap and worthless. Another example could be a society in which an act of theft might be punished with death. By proposing that euthanasia should be legally available, it could be argued that contemporary Britain is

treading a path towards the formation of a humane society. Alternatively, by continuing not to acknowledge euthanasia as a legal activity, our society could be considered as promoting an inhumane policy towards those suffering with an incurable illness. It is therefore unlikely that when considering such an emotive issue that a universal agreement can be reached, for not everyone could accept the consequences and side effects. The more likely outcome could be an agreement to disagree with the view and that the issue of euthanasia ought to be left to individuals who wish to consider euthanasia. This view would allow those who disagree with euthanasia to refrain from becoming involved.

In chapter seven, Habermas (1995:66) offered a definition of 'D', discourse ethics; where all those who are participating in practical discourse, can (or could) approve of the norms that can be considered as valid, based on the premise that it is possible to justify the choice of a norm.

In application to the case study, the discourse should include all those who may be affected, for example Gaynor, her husband and daughter and the health care professionals who are

responsible for her care. The validity claims are considered, as a foundation of discourse and claims that the information should be comprehensible, truthful and true, are likely to be met. The claim that is open to question concerns the rightness of the discourse with reference to the current stance taken by British society with regard to euthanasia. It would be doubtful whether all involved in a discourse concerning Gaynor, could accept the consequences of euthanasia and at the same time, the consequences of maintaining Gaynor's life against her wishes. To maintain the current policy of supporting life may appear inhumane to Gaynor and her relatives, but may be perceived by the health professionals as a lawful requirement at the present time. It would therefore not be possible to satisfy everyone's interests and the parties involved may reach an agreement that they hold differing views. An agreement may be reached that society's stance with regard to euthanasia ought to be re-evaluated with the view to a possible change of policy.

The application of Habermas' (1995) framework with reference to communication can be used to offer a criticism of a society, for example, with reference to its stance on the legality of

euthanasia. By offering a criticism of society's approach to certain policies, the proponents of the criticism may be able to lay the foundations for a change in policy. Having discussed an application of Universalism and discourse ethics, I will now link the views of Habermas (1995) to Gadow's (1983) perspective.

9 Habermas and Gadow's Perspectives

First, I will describe Gadow's (1983) position with regard to a nurse who is contemplating assisting a patient with euthanasia. Gadow (1983) would hold the view that the nurse as advocate should take into account views held by a patient, such as Gaynor, and offer support for her decision. For Gadow (1983) the patient is the person best placed to make such a decision, providing that it is considered as lawful. In Britain, where a nurse's active assistance in Gaynor's euthanasia is considered as illegal, Gadow (1983) would not condone such practice, however, would support the nurse in representing the views of a patient who wishes to die. Alternatively, in the Netherlands where euthanasia is now lawful, Gadow (1983) would condone the legal action of a nurse who assists a patient in an act of euthanasia. With regard to Gaynor's pain relief, Gadow (1983)

would support the legal administration of large doses of prescribed analgesia on the grounds that it is part of a nurse's role to relieve pain, even though such a dose in some circumstances may hasten the patient's death. This would be seen as a possible and acceptable consequence of analgesia that is considered as preferable to the patient suffering for what could be a short extension of life.

In common with the majority of people, Gadow (1983) probably holds a personal view with regard to euthanasia; she has the right in a democratic society to a self-expression of this view. When considering the role of a nurse as an advocate, she has to take into account the norms held by a society, such as the USA. For example, it is wrong to commit murder and to perform acts of euthanasia even though the cases that attract such attention and discussion are often related to people with a terminal illness, who are without hope of an effective cure. The answer by a society such as the USA to a request for euthanasia would be the same, irrespective of the people involved.

Therefore, I have come to the conclusion that the concerns of a patient, such as Gaynor, can only be effectively addressed by a society reconsidering its views on euthanasia. From this perspective, Habermas' (1995) framework with regard to discourse ethics could be employed with the aim of changing the law in a society. With regard to euthanasia, this can be considered with reference to Habermas' (1987) work on 'lifeworld' when there is no hope of an effective clinical treatment for an individual's illness. For the law to be changed, an application of Habermas' (1995) framework with regard to society's stance on euthanasia and the norms with regard to the value of life should form the basis of any discussion concerning such an act.

Such an ethical discourse should be based on the four previously identified validity claims and ought to be conducted with regard to the previously described conditions, as according to Habermas' (1995) framework. These are, that those involved should have the aim of achieving a mutual understanding and harmony, that there ought to be equal access afforded to the individuals concerned and that those involved should work toward achieving a consensus. The framework could then be

used as a basis for a criticism of society's stance towards euthanasia with the aim of changing social policy and the legal position of society with regard to proposed acts euthanasia.

Habermas (1995), through 'U', is able to create the conditions for the conduct of discourse, where competing norms can be evaluated. This can be considered as a useful basis from where discourse can be conducted with reference to the norms of a society, for example, with reference to nursing and the National Health Service. Gadow (1983) would agree with the need to evaluate competing norms and she would consider the conduct of discourse as relevant to the interests of patients and that of the Health Service.

Habermas' (1995) 'D' refers to the practical application of discourse and can also be applied to nursing and the Health Service. Gadow (1983) would consider that the patient's decision and preferences are important as these reflect the wishes of a patient should be the best person to make these decisions, therefore Gadow (1983) would take the view that these wishes should be respected. A change of policy by society with reference to an act of euthanasia should allow Gadow's

(1983) perspective on advocacy to be considered as credible. It should embrace the potential that a patient may wish that an act of euthanasia should be performed and Gadow (1983) would then be able to condone such an act.

10 Summary

It has been my aim during this chapter, to demonstrate that the described perspectives of both Habermas (1995) and Gadow (1983) can be considered as relevant to nursing. An application of Habermas' (1984, 1987 and 1995) work on communication has demonstrated that a theoretical basis can be made for communication, in an applied setting. Gadow's (1983) perspective of existential advocacy, taking into account the 'lived' body can be readily applied to the case study and Habermas' work on 'lifeworld'. The work of both these writers adds to an understanding of the basis for advocacy, in terms of acquiring an understanding of a patient and their problems. It would now seem appropriate to offer a conclusion.

CHAPTER 11 CONCLUSION

Having considered the five advocacy perspectives, and the applied work of Habermas (1995), I will now offer a conclusion to the thesis. An introduction to advocacy has been identified and I have described the work of two British writers on advocacy, namely those of Gates and Teasdale. The British view facilitates the occurrence of a broad perspective with regard to advocacy and refers to 'independent' or 'citizen advocacy', as described in Teasdale. This allows for the involvement of a third party, for example, the services of an experienced person who is able to act as an effective advocate, or alternatively, an advocacy body and may include an involvement of a person or body of people in addition to a nurse–patient relationship.

This can be considered as a contrast to the views offered by the three United States authors, namely Gadow (1983), Kohnke and Curtin (1979). These views are based on the exclusion of a third party; instead they focus on the relationship that exists between a patient and health care professional, as for example, a nurse. An emphasis is laid on the right of patients to make decisions concerning their treatment and welfare.

Having described and considered the work of the five authors on advocacy, I have come to the conclusion that of these authors, Gadow (1983), through her account and concept of existential advocacy and the 'lived', 'object' body, is able to offer the most convincing and sound foundation for advocacy. The criticisms that can be made of Gadow (1983) can be easily answered when taking into account her advocacy philosophy and this can be applied in a variety of situations, i.e. to all areas of nursing. I find that her perspective is able to offer a deep, sound and coherent academic basis for advocacy.

Gadow (1983), in common with other authors suggests, that the foundation for advocacy should rest on the decision made by the patient and that any nursing action ought to be based on this. The difference between Gadow's (1983) account of advocacy and those of the other four authors lies in her description and justification of existential advocacy in terms of the 'lived' and 'object' body, which can be linked to Habermas' (1987) perspective of 'system' and 'lifeworld' This provides the foundation on which Gadow's (1983) account of advocacy can be considered as having been carefully thought out and is hard to criticise, on the basis that the patient's preferences and

decision reflect his or her circumstances. Gadow's (1983) philosophy, with regard to advocacy, can be applied worldwide. The philosophy can be considered as creditable, as it reflects the wishes of the patient or client, rather than that of any other person. It therefore follows, that for Gadow (1983), the patient's decision-making should be considered as the most important aspect of advocacy.

In the thesis, I have described the work of Habermas (1995) with regard to discourse ethics, his work has been applied to the Pink case and the view of advocacy, as offered by Gadow (1983). Habermas (1995) has set out a theoretical framework that can be used to identify the required conditions for the conduct of ethical discourse. He allows for the deployment of a methodological approach to discourse, where competing norms can be evaluated and as stated earlier in the thesis, he has created a framework where statements can be tested for their validity and effectiveness. I have taken an opportunity in this thesis to link Habermas' (1995) theoretical principles to the Pink case, where the framework of 'U' and 'D' are applied to the actions of Graham Pink, his colleagues, and the hospital's management.

I have also constructed a case study, with the aim of forming a link between Gadow's (1983) perspective on advocacy and Habermas' (1995) framework for the conduct of discourse ethics. I have been able to demonstrate that it is possible to link the two perspectives with the aim of providing a sound account for the basis of advocacy with regard to a situation that may occur in any clinical area. The employment of the perspectives has enabled me to demonstrate their usefulness when considering the circumstances that could lead to the need for advocacy and a requirement that one should consider the factors that lie behind these.

I feel that I am now able to offer a final comment with regard to the thesis. Habermas' (1995) work on discourse can be used as an academic framework that can be employed to identify the necessary conditions for the conduct of ethical discourse. This framework can then be used to evaluate competing norms with the aim of allowing the participants in ethical discourse to come to a conclusion that can be acceptable to all. The thesis has given me an opportunity to apply Habermas' (1995) view of discourse ethics and his 1987 view concerning 'system' and 'lifeworld' to advocacy, through a link with and an application of

the work undertaken by Gadow (1983) on the 'object' and 'lived' body.

For Gadow (1983), the patient is considered as the person who should make decisions with regard to his or her treatment and welfare, and the nurse ought to respect the decisions made by the patient and her actions as an advocate should reflect this view. The application of Habermas' (1984, 1995) work on communication and ethical discourse to advocacy has not been previously attempted. This application has a special significance in that, as demonstrated by the Pink case study, there is an obvious need for advocacy in health care, and this has never been greater. In this thesis, I have applied Habermas' (1995) perspective in the context of the provision of a health service, to form a deeper understanding of advocacy. It is my hope that this understanding of the implications of advocacy should act as an aid for nurses, when they consider whether to take on an advocacy role.

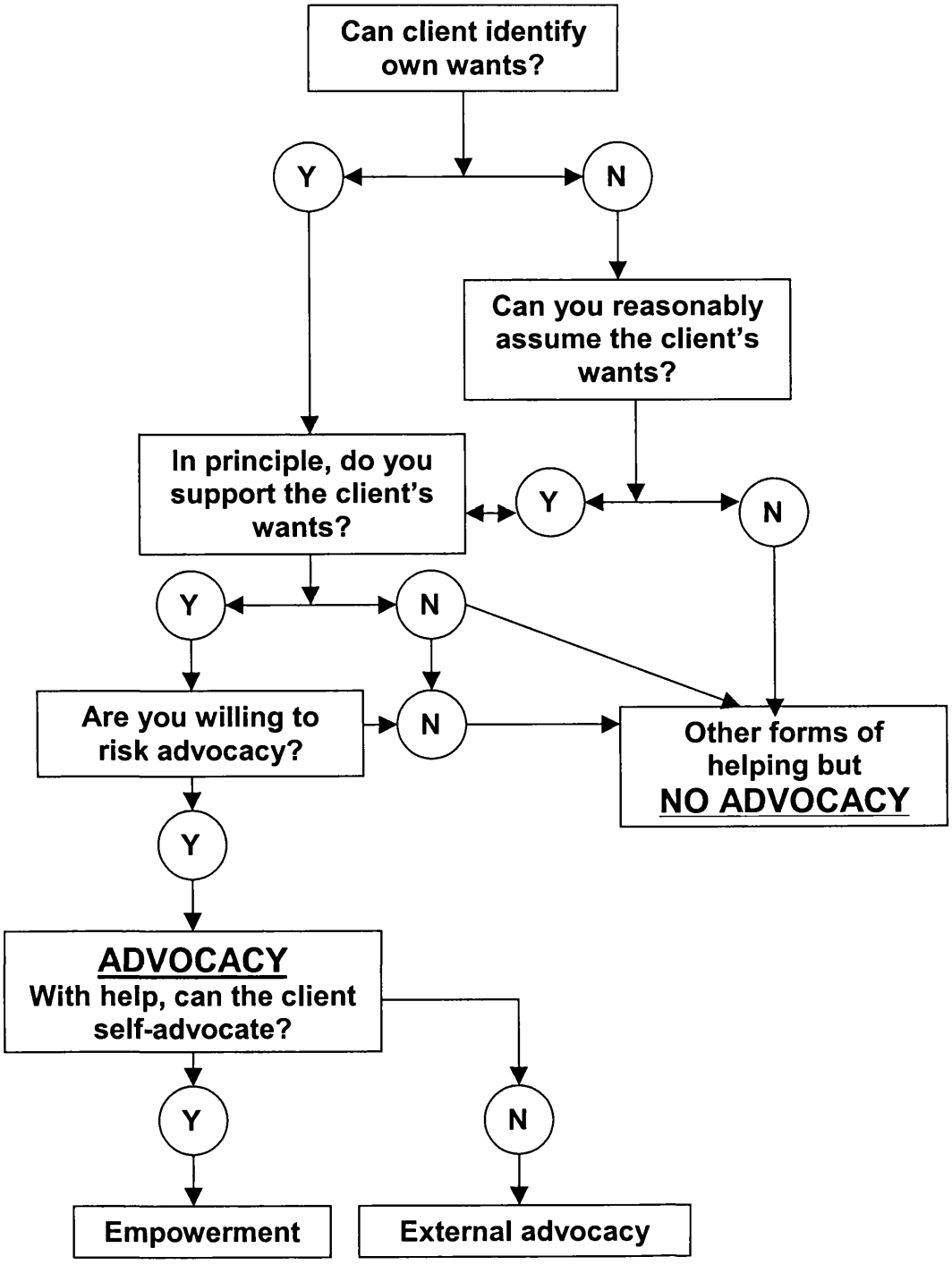
The application of the work of Habermas (1995) and Gadow (1983) has been facilitated as required, through the use of case studies and these have enabled me to apply the relevant

principles to examples that are related to potential problems encountered in nursing practise. The application of these principles has demonstrated Habermas' (1995) relevance to Gadow's (1983) work on advocacy and through this application it is shown that Habermas' (1995) perspective has direct relevance to ethical discourse involving the National Health Service and advocacy. Having written this thesis, it is acknowledged there is scope for further application of Habermas' (1995) views on discourse ethics and it is hoped that this will provide the basis for future work.

APPENDICES

APPENDIX 1

AN ADVOCACY FLOW CHART AS ACCORDING TO TEASDALE (1998:33, fig. 4.1)



APPENDIX 2

NURSING AND MIDWIFERY CODE OF PROFESSIONAL CONDUCT (2002)

- As a registered nurse or midwife, you are personally accountable for your practice. In caring for patients and clients, you must:
- Respect the patient or client as an individual
- Obtain consent before you give any treatment or care
- Protect confidential information
- Co-operate with others in the team
- Maintain your professional knowledge and competence
- Be trustworthy
- Act to identify and minimise risk to patients and clients.

These are the shared values of all the United Kingdom health care regulatory bodies.

For further details with regard to the above code, please see the Nursing and Midwifery Council Code of Professional Conduct (2002:3-10).

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