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What is This?
Ethical conduct and the nurse ethnographer: consideration of an ethic of care

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Abstract During an ethnographic study of an Acute Medical Admissions Unit, informed consent was not obtained from some patient informants despite research proposals to various research committees stating that it would. The ethical judgement was made that not to seek informed consent was in the best interests of patients who were very ill or distressed and that to insist on informed consent would have been potentially harmful to these patients. Drawing on my experiences of collecting data whilst holding the dual roles of researcher and nurse, I argue that contextual moral judgements can enhance ethical decisions in the field and further that rigid adherence to formal bio-medical ethical guidance can lead to inappropriate ethical actions. Importantly, the ethnographer must be able to articulate arguments that reflect the contextual nature of ethical decision-making to powerful gatekeepers, such as research committees. If this does not happen then challenges to the dominance of deontological-rationalist ethics will not occur and researchers may be drawn to the use of less ethically demanding data collection methods. Drawing on insights from literature that considers feminist ethics, and in particular the concept of an ethic of care, justification for my ethical conduct whilst in the field is presented.

Key words contextual ethics; ethic of care; ethnography; informed consent; participant observation; research ethics

Introduction
This paper draws on my experiences during an ethnographic study of the role of the nurse on a Welsh Acute Medical Admissions Unit (AMAU) during which I held the dual roles of a researcher from a Higher Education provider but who was also a registered nurse. Prior to entry to the field I had gained ethical approval from various gatekeepers, including the Local Research Ethics Committee (LREC) and the Trust’s¹ Research and Development (R&D) Committee. In the research proposals pre-

¹ Groups of National Health Service hospitals are managed within what are called Trusts.
presented to these gatekeepers, I had declared that all data collection would be conducted in an overt manner and that informed consent would be gained from all participants. My intention to work alongside the AMAU nurses as a registered nurse whilst collecting data was made clear and I obtained an honorary contract from the Trust. My declared role in the field was thus to be a participant-observer (Hammersley and Atkinson, 1995) and my intention was to interact with patients, relatives and carers as well as healthcare workers whilst collecting data.

However, during data collection I provided care for many patients who were, in my judgement, too ill or distressed to be approached for their informed consent to my data collection. Seeking to find ethical justification for my actions, I re-examined and reviewed the deontological-rationalist ethical perspective that provides guidance for the conduct of research ethics committees: committees that researchers accessing an National Health Service (NHS) setting and NHS patients must satisfy (Department of Health, 2005). Drawing on Gilligan’s (1993) concept of an ethic of care and the contextual nature of real-world ethical deliberations justification for my ethical conduct whilst in the field is presented. Firstly, a brief overview of the study is presented and my participant observer role, espoused and actual, is detailed.

Overview of the study
Acute Medical Admission Units, also called Medical Assessment Units (MAUs) or Emergency Admission Units (EMUs), receive medical emergencies referred by general practitioners, other hospitals, or by accident and emergency departments (Mayled, 1998; Wood, 2000). The aim of the study was to describe and explain the role of the nurse in a Welsh AMAU and an ethnographic approach was utilized with data collection guided by initial findings in an emergent design (Hammersley and Atkinson, 1995; Brewer, 2000). Sampling was purposive in that data were sought that could provide information about the phenomenon under study (Mason, 2002). Participant observation conducted part-time over 3 years, semi-structured interviews with doctors, nurses, patients, and paramedics (n = 19), and scrutiny of documentary evidence and other artefacts were data sources. The collection of data in ethnographic studies by observation in the field and by interview can provide an emic, or an insider, understanding of the experiences of those studied (Aull Davies, 1999; Mulhall, 2003).

Participant observation
Data collection commenced with participant observation with my espoused researcher role being that of an overt participant observer in a natural setting over which no control would be sought (Gold, 1958). Participant observation is an essential data collection method when undertaking ethnography as it enables immersion and direct experience of the setting (Hammersley and Atkinson, 1995; Mason, 2002; Brink and Edgecombe, 2003). This approach to data collection mimics the human sense-making strategies of watching, listening and questioning (Brink and Edgecombe, 2003) and was used by anthropologists in the early ethnographies, such as Malinowski’s (1922/1992) seminal study ‘The Argonauts of the Western Pacific’. Modern day ethnographers no longer study ‘exotic subjects’ from an etic (or outsider perspective), but rather seek understanding of an individual’s social construction of reality by talking to and spending time with those who inhabit the area under study (Thomas,
Conducting participant observation

The observer role espoused for this study was that of a participant-observer in that both researcher and participant were to be aware that they had a field relationship (Gold, 1958). Prior to my entry to the field I had ensured that healthcare staff were aware of my researcher role by such strategies as attending nursing and medical staff meetings to discuss the study. I was careful to ensure that individuals understood fully that they could refuse to be involved in the study should they wish. As I intended to deliver care alongside the unit’s nurses I wore a nurse’s uniform but with a name badge indicating my Higher Education and researcher roles. When conducting participant observation the nurse’s ability to have a dual role both as a professional and as a researcher can enable access and insights that would otherwise be difficult to achieve (Latimer, 2000). Gerrish (1997, p. 27) suggests that the nurse researcher can reduce the potential for dissonance between these dual roles by offering a positive contribution to care delivery instead of being merely an ‘exploitive interloper’. I followed this advice and whilst not assuming responsibility for individual patients I helped with the nurses’ work: this served two purposes in that I was able to collect useful data and at the same time I was seen as being of help rather than as a hindrance to the unit’s work. Additionally, as a Higher Education lecturer, I was often asked for help with career advice and assignment guidance and this I gave gladly. Another issue that arose was that as this fieldwork was the first time that I had been in clinical practice for over 10 years it took some time for the nurses to accept that my clinical knowledge was limited. So when I asked questions it was because I really did not know the answer rather than a research question to catch them out. Additionally, as Holloway and Wheeler (1995) note the nurse researcher may experience role conflict as the dual roles of professional and researcher can lead to problems of identity. As a registered nurse I held a duty of care to the patients on the unit and so a professional responsibility to act should I witness poor care, however, this did not prove to be an issue. Nonetheless I found the experience of caring for ill and distressed patients and their families to be personally affecting. So any detached and impartial data-collong role was impossible for my sense of self. I acknowledged this and maintained a reflexive diary where I could note and make sense of my experiences and their influences on my developing analysis. However, the ethnographer is at risk of over-identifying with the setting and ‘going native’ and so forgoing research opportunities (Hammersley and Atkinson, 1995, p. 110). Such concerns are contested by feminist thinking that the development of field relationships should be constructed in non-hierarchical ways and that interpretative understanding involves relationship building (Williams, 1991). I agreed with Williams and considered not to develop relationships with participants would have lead to a poorer understanding of the nurses’ role and the culture of AMAU care.

Thus a key concern of the nurse ethnographer is the need to balance the researcher role with behaviour that is correct, both ethically and professionally. However, the collecting of data during participant observation in a public setting, such as a NHS ward, raises the issue of data collection that is in fact obtained covertly. It is suggested that gaining consent from all those who populate the field is not usually feasible (Punch, 1986). Whilst this standpoint may be a reasonable justification for covert
observation of the general activities of a public area it cannot offer adequate support for my decision not to identify myself as a researcher whilst in the field. Attempting to act in a moral manner dependent upon the particulars of the situation faced (Lincoln and Guba, 2003) I decided that to burden an already ill or distressed patient with information about my researcher role would not have been in the patient’s best interests. However, this approach would not have gained approval from the ethics committees that my research proposal had been taken to for scrutiny.

Gaining ethical approval
Research in the United Kingdom that involves human subjects and/or takes place on NHS premises must satisfy the ethical requirements of the LREC and the appropriate Trust’s R&D committee before any study commences (Howarth and Kneafsey, 2007). I was required to complete research proposals using the Central Office for Research Ethics Committees (COREC) application form which was completed on-line (COREC, 2004) and the NHS Trust’s own R&D Committee’s research proposal form. COREC is now known as the National Research Ethics Committee (NRES).

These committees have been subject to criticism for some time due to their poor understanding of qualitative approaches (Fallon and Long, 2007) and certainly their main work is the reviewing of medical trials. Anyone who has been involved in seeking ethical permission via these routes will be aware of the stringent scrutiny that research proposals receive and the time that seeking approval to satisfy research governance can take.

Research governance
The dignity, protection of rights, safety, and well being of research participants are the primary considerations in any research study and research governance in the United Kingdom seeks to promote high standards in the conduct of research (Department of Health, 2005). This governance builds on existent guidance on research conduct that has been developing following the atrocities perpetrated by healthcare researchers during World War II and lead to the development of the Nuremberg Code and developed further by the Helsinki Declaration (World Medical Association, 2004). Researchers who seek to use human participants are required to be guided by the concepts of voluntariness from their research participants and full disclosure of information given about the research project: encapsulated in the term informed consent (Brykczynska, 1998). Research participants should be consulted and their agreement obtained prior to data collection and the non-coerced consent of research participants is, therefore, a primary concern for all researchers (Griffiths, 2006). The strategies detailed to gain informed consent within research proposals are examined closely as to their ethical appropriateness, especially if patients are involved. On-going consent during participant observation requires special consideration as participants, due to prolonged engagement in the field, will require reminding frequently that the researcher is collecting data (Merrell and Williams, 1994). Additionally, from a legal perspective, to touch another without their consent is actionable in law: in a civil action by the tort of trespass or indeed by a criminal action (Mason and McCall Smith, 1994). Therefore, a researcher holding dual roles, such as a nurse and as a researcher, must ensure that any consent gained from a patient relates to the true and full purpose of the action. Thus patients, in particular, should be made aware
of a researcher’s dual purpose if data were collected during an episode of care delivery. Participants’ privacy must be respected, confidentiality and anonymity maintained, and an absence of deceit upheld when giving information and interacting with research participants (Gillon, 1994). The medico-ethical principles of autonomy, non-maleficence, beneficence, and justice are the underpinning ethical perspectives for much formal research ethical guidance (Beauchamp and Childress, 2001). Gillon (1994) notes that these principles are *prima facie*, in that each principle is binding unless it conflicts with another moral principle: conflict between principles would then require a choice between the alternatives. Central to such guidance is the drive to protect the right of the individual to self-determination and to categorically state that a person cannot suffer harm to satisfy another’s research goal.

However, despite having gained full ethical approval prior to the commencement of the study, data were collected during participant observation that involved patients who had not provided consent, despite my research proposals noting the contrary. These non-consented participants were patients whose interests would be best served, in my judgement, by continuing in my participant-observer role and providing care but without disclosing my researcher function. I was concerned, however, to ensure that my conduct was appropriate ethically as my sanctioned research proposals had claimed that I would conduct overt participant observation and that informed consent would be gained from all participants. However, once in the field this then seemed a rather naïve declaration and had to be reviewed. Finding ethical guidance was not, however, a straightforward endeavour for as Punch (1994) has noted any ethical deliberations that research projects raise are often reduced to a short paragraph for journal papers or relegated to an anodyne appendix. Ethical deliberations of researchers and their considered ethical responses grounded in real research contexts are not then shared with the research community. To help allay this criticism I present examples of my ethical dilemma and the justification for my actions to stimulate discussion and debate.

**My dilemma**
The researcher role that I espoused was that of an overt observer, known by participants to be a nurse researcher interested in the organization of the AMAU, in particular the role of the nurse in the unit. Due to my inexperience in conducting participant observation I had assumed, rather unthinkingly I recognize now, that the observations made would be of the conduct of nursing and of other healthcare staff, together with general spatial observations. These initial unfocused, broad observations would be of the organization of the unit and the working day of the nurse. Patients would not be involved, or only most peripherally, until they were interviewed formally when written consent would be sought. However, my brief interactions with patients soon became key field diary entries as illustrated in the following extract:

Staff Beth had asked me to do some ‘obs’ [observations]. I went into the sideward where there was a young man of about 30 years old. I knew that he had been admitted with acute exacerbation of asthma, that he was poorly when he came in and was now ‘a bit better’ but he was still short of breath and needed ‘an eye’ kept on him. A little later he was slightly better but still looked afraid and all my intuitive systems were on edge so I stayed with him for a while and tidied up the room and got him an iced drink. After a while he pointed at
the window ledge on which a dove had landed and asked me “well, what do you make of that then?”

He looked at me and held my eye; he was obviously scared, scared of dying. I knew (and he knew that I knew) that was what he meant.

(Field Notes)

Following this episode, I explored relationship building and the concept of emotional involvement with patients, but this young man has no idea that he is included in my study. Informed consent had not been gained and his right to privacy breached as he had responded to me as a nurse unaware of my dual role as a nurse and as a researcher. Instinctively, it appeared inappropriate to bother this young man with information about the research and to seek informed consent to data collection. However, such an approach was contrary to the biomedical ethical principle of autonomy with its demand for informed consent from all research participants (Beauchamp and Childress, 2001). Thus the ethical concern that I faced was that this data was collected covertly and without consent. Such incidents occurred during each of my visits over the 3 years of fieldwork. The AMAU’s role was to admit acutely ill patients and the goal of care was that these patients stayed on the unit for <24 h. So there was a transient group of patients on the AMAU and sadly many patients in fact died soon after their admission:

I helped today with the admission of an elderly man with terrible melaena [passing blood in his stools indicating a severe gastro-intestinal bleed]. He was so very ill and was upset every time that he soiled the bed and kept saying in Welsh ‘mae flin da fi nrys’ [I am sorry nurse]. No one else present could understand Welsh so I stayed with him and felt slightly useful. He died before I left the ward…

(Reflexive Diary)

I will always remember this gentleman and his distress additionally he is now part of my ethnography and is an example of the physical and psychological stress that AMAU nurses face. I also consider that I have given him a narrative and this story can help understand the importance of patient dignity and compassionate caring.

On the rare occasion that patients were admitted but were not acutely ill or if they were longer on the unit due to bed shortages in the hospital then I would introduce myself fully and gain their verbal consent. However, the usual climate on the unit was one of acutely ill patients, extreme busyness and rapid throughput of patients this then lead to great difficulties in gaining consent from everyone in the field. I noted down in my field notes everything that I saw and made a report of every discussion that I had, this despite consent not being gained from all participants: I acted, therefore, in a covert manner.

There is much criticism of covert observation and concerns that it is problematic ethically (Holloway and Wheeler, 1995). Whilst researchers have been criticized for acting covertly such approaches may be justified if data were collected in settings where gatekeepers would forbid research provided that the study’s findings will lead to a future benefit (Johnson, 2007). As illustrated in the above examples, to give detailed information on the research to these patients would have been inappropriate, professionally and morally, and maybe I should have not used the information. However, not to draw on data from such situations would have silenced patients’ voices and lead to an impoverished account of the reality of nursing practice. Yet I cannot claim that findings from this study will lead to direct benefits for these patient participants as any benefits will relate only to a general potential for...
improvements in care from the study’s findings. Homan (1992) reminds us that the rigorous requirements to access patients that are in place are to protect patients against unscrupulous researchers who in pursuing their own ends denigrate the interests of the patient as being incidental. I did not wish to have such a charge levelled at me as I felt instinctively that I had acted in an ethically appropriate manner. The intention was not to deceive but rather information was withheld to avoid overburdening already very ill patients. Justification for my actions is now presented and a complimentary approach to established bio-medical ethical principles discussed.

What ethical approach?
Participant observation on an AMAU lead to face-to-face interactions with very ill and even dying patients and as a nurse educator for over 10 years every session in the field was beset with moving and insight provoking incidents. My dilemma centred on the appropriateness of using insights from these interactions with very ill patients to inform my study and its findings. It soon became obvious that reading on research methods, the guidance and approval from the LREC, and preparatory discussion with research supervisors could not hope to offer complete readiness for every issue encountered in the field. Furthermore, in a field populated by a transient population of patients and healthcare workers it was difficult to differentiate who were research participants and who were not. Johnson and Long (2003, p. 5) discuss the problem of rigid adherence to the concept of informed consent in a widely populated field and contend:

One might further suggest that despite the researcher’s best efforts, informed consent is almost impossible to achieve. It is often impractical to be completely clear to everyone who might appear in a study that they are participants of research.

I often found it to be impractical to seek consent from all participants, however, I still wanted an ethical rationale to justify the approach that I took. The ethical concept that helped my deliberations was that of contextual ethics, in particular an ethic of care (Gilligan, 1993), as will be discussed next.

Alternative ethical approaches
Morse (2000) has called for qualitative researchers to gain confidence in their research as being good in a moral sense and to have ready answers to the risk/benefit questions that LRECs raise. Researchers should have deliberated on, and have asked of themselves, what best serves the interests of people involved in the research (Hammersley and Atkinson, 1995). Sherwin (1992) has suggested that the principles of autonomy, beneficence, non-maleficence, and justice are merely a moral mantra, an uncontested worldview that does not acknowledge that practical ethical concerns are placed in real-world contexts. With their genesis in western bioethics and horror of human experimentation during World War II these moral principles, although worthy, are better suited for scientific-rational quantitative studies where physical and psychological harm is a real risk. These principles do not provide clear guidance for qualitative research; however, an ethical approach that may help bridge this discourse difference Sherwin (1992) suggests is that of an ethic of care (Gilligan, 1993).

The work of Carol Gilligan (1993) has been influential in the recognition of differences in approaches to ethical deliberation. Gilligan (1993), an American psychol-
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ogist, describes conducting psychological experiments using Kohlberg’s Stages of
Moral Development Scale (Kohlberg, 1976), an accepted tool to measure the develop-
ment of moral reasoning. Kohlberg’s Scale uses stories to present a moral dilemma
and participants are asked to describe and justify how they would respond if they
were put into such a situation. Gilligan describes male participants responding to eth-
ical dilemmas by the application of general and abstract rules based on rights and
non-interference. Female participants, however, sought to contextualize the story
and to understand the specific human dynamics of a situation and, by the use of
communication and cooperation, to seek resolution in relationship preserving. How-
ever, as Kohlberg’s Scale measures the application of abstract moral principles to
moral reasoning it is biased towards male approaches to ethical reasoning (Gilligan,
1993). As a result females routinely scored lower on the scale than did males of the
same age and this had lead to females being categorized as being less developed in
moral reasoning ability than were males (Gilligan, 1993). Gilligan’s (1993) insight
was that the female and male subjects studied used different approaches to moral rea-
soning and it was this that had lead to the dissimilar responses rather than any inher-
ent weakness in female moral reasoning: the Kohlberg Moral Development Scale was,
therefore, flawed due to its gender bias.

The ethical reasoning of men and boys studied was inclined to the application of
abstract universal principles in an endeavour to ensure fairness; this Gilligan (1993)
calls an ethic of justice. Whereas, female reasoning Gilligan contends centres more on
feelings, interactions, and the context of those involved, this is then named as an
ethic of care. Gilligan (1993: 19) argues that:

The conception of morality as concerned with the activity of care centers moral
development around the understanding of responsibility and relationships, just as the
conception of morality as fairness ties moral development to the understanding of rights
and rules.

Gilligan’s (1993) research has helped people, in particular women, articulate their
sense of alienation when trying to work within the predominant structure of moral
reasoning that sees moral judgement as impartial, and as essentially dispassionate
rather than passionate. Gilligan (1987, p. 24) criticizes the impartiality requirement
that distances our decisions from others as individuals and from our own relation-
ships with them and contends:

… as a framework for moral decision, care is grounded in the assumption that…
detachment, whether from self or from others is morally problematic, since it breeds moral
blindness or indifference—a failure to respond to need.

Gilligan has been criticized for this apparent gender distinction and that on the
contrary women should not view caring as a proud celebration of feminine character
but rather as a woman’s strategy for survival in a patriarchal society: women face a
paradox in that they may need to care less so that men can learn to care more (Tong,
1989). Although Gilligan states categorically that she does not wish to offer general-
izations about gender differences in moral reasoning but merely to highlight a dis-
tinction between the two ethical approaches and to provide a voice and a language
for an alternative approach, all of her research examples demonstrate gender differ-
ence. Nonetheless, Gilligan’s arguments are persuasive in asking for the contextual
nature of ethical dilemmas to be considered and the value of considering a variety
of perspectives when undertaking a moral decision. So that rather than trying to
make ethical dilemmas fit into a particular ethical theory, more situational approaches are to be valued (Sherwin, 1992). More recently, Johnson (2007) notes that insights from feminist ethical deliberations that emphasize contextual elements to ethical decision-making helps both men and women understand and critique the affects of personal and social power.

Williams (1991), also writing from a feminist perspective, describes the importance of relationships in ethical decision-making, an approach that she terms practical ethics, and argues that formal ethical codes cannot offer complete guidance on the correct behaviour for every situation encountered during research. Williams (1995) suggests that better understanding of different ethical voices may enhance the deliberations of ethics committees and offer help for qualitative researchers. Researchers who are confronted with real people with their particular needs and whom merit individual approaches that rule-based ethical principles lacking in context cannot provide. So guided by these insights I made individual judgements about the ethically correct approach when observing patients in the field, decisions that were firmly contextual and influenced by the needs of the individual patient. Such contextual approaches Christians (2003, p. 223) classifies as social ethics and notes:

Rather than searching for neutral principles to which all parties can appeal, social ethics rests on a complex view of moral judgements as integrating into an organic whole, everyday experience, beliefs about the good, and feeling of approval and shame in terms of human relations and social structures.

Total reliance on deontological ethical principles can lead to decisions being made that inhibit the contextual understandings that should influence ethical decisions. Throughout the study I ensured that any action on my part would not detract from the patient’s good and in fact any interaction would enhance the patient’s experience. The ethical response I utilized sought to place those patients observed, those who consented and those who had not, in their specific contexts and by doing so demonstrate an ethic of care ‘bound to the particulars of time and place’ (Gilligan, 1993, p. 59). To subject ill patients to hearing information about my research to gain their consent would have been unethical and uncaring given their conditions whereas not to include them would have found that their voices would have remained silent. It has been suggested that if consent cannot be gained at data collection then the researcher may seek retrospective consent (Denscombe, 2002). However, the short time that many patients spent on the AMAU would make this approach impractical and untenable. Furthermore, many patients did not recover and died either on the AMAU or soon after. Likewise Madjar and Higgins (1996), whilst researching elderly residents in a nursing home, found that the discourses of the research ethics committee and the clinical field differed. Many of the residents were blind or had lost the habit of reading, so to seek a signed consent before interview would have been stressful or impossible for most of the residents. Following this experience Madjar and Higgins (1996, p. 130) then argue:

While accepting the need for adherence to guiding principles of duty based ethics, we have found that practical moral decisions in the field require that, as individual researchers, we needed to exercise discretionary judgment, informed by the ethic of care and the concern for the well being of research participants

So I also made discretionary judgements about the ethically correct approach when observing patients in the field, decisions that reflected contextual issues and that
served best, in my opinion, the patients’ true interests. It is my concern that research committees’ strict adherence to deontological-rationalist ethical principles may lead to less research involving clinical settings due to the impracticable obstacles that the researcher may face. Furthermore, if researchers cannot present arguments for alternative ethical approaches then the conduct of participant observation will increasingly become ethically prohibitive and may result in researchers avoiding this most valuable method of data collection.

**Conclusion**

Punch (1994) notes that in large organizations with considerable numbers of people engaged in constant interaction that it is a physical impossibility to seek consent from everyone and seeking it will kill many a research project stone dead. When conducting participant observation on a busy AMAU there were scores of patients, healthcare workers, and visitors who entered the field and it was not feasible to seek express consent from all. However, within this paper I have discussed my particular concern to understand the correct ethical approach when collecting data whilst caring for ill or distressed patients. Finding the answer to my ethical question was difficult for as Punch (1994) suggests too frequently published research reports offer inadequate discussion of contextual ethical dilemmas. To separate the ethical conduct from the published research account serves researchers, especially neophyte researchers, poorly and may lead to a perception that ethical conduct is of secondary importance to research findings. By discussing publicly the ethical deliberations and decisions made in the conduct of a research enterprise can require courage if others disagree with one’s actions. However, it is only by such debate that we can we learn from each other and contribute to the ethical development of qualitative approaches.

Nurse researchers who can take multiple roles when in the field have privileged access, however, maintaining analytical distance whilst acting with ethical and professional appropriateness then takes on special meaning. The researcher cannot hide behind permission from ethics committees or professional codes when dealing with human beings as each situation will require an individual response. The researcher must act morally and this requires the capacity to reason morally (Homan, 1992) but as Gilligan (1993) has shown it may be time to reconsider the dominant moral mantra of deontological-rational ethics as the sole response to ethical considerations. Qualitative research is not controllable like a laboratory experiment or a randomized controlled drug trial would be, it is complex and messy and thus the subsequent ethical dilemmas do not have clear-cut answers and must be deliberated on in their specific contexts. An understanding of an ethic of care alongside an ethic of justice may help inform this reasoning. If the abstraction and generality of traditional approaches to research ethics offer inadequate guidance, or indeed inappropriate restrictions, then the concept of contextual reasoning, and in particular an ethic of care, may help us when faced with moral dilemmas in our research conduct and help provide coherent ethical arguments to justify decisions made in the field. If ethnographers cannot do this, there is a risk that research grounded in clinical practice will be avoided due to the inflexible demands of research committees and this would be detrimental to the development of practice-based research.
Key Points

- Ethnography enables cultural insights into the reality of nursing practice.
- Participant observation conducted in a clinical setting can raise complex ethical dilemmas.
- Rigid adherence to deontological-rationalist ethics can lead to inappropriate ethical actions.
- Insights from feminist ethics should inform the deliberations of ethics committees and the conduct of researchers.

References

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