Skip navigation [#begincontent]

[../index.html]

Home

[../index.html] Contents [index.html]

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Teaching Argumentation in a Philosophy Course for Baccalaureate Nursing Students
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Abstract
1. Introduction

In this paper I introduce the background situation that triggered the need for a particular project offered in a senior undergraduate course in health care ethics. Background information is provided to support the rationale of the project in the course. Then, the argument that opens the challenge to the students is outlined, followed by a representative sampling of the students' responses. Finally, some tentative observations are offered, along with a suggestion for future directions that such projects might take to foster the goals of nursing education to promote the skills or critical thinking and argumentation.

When teaching health care ethics to nursing students, there is a need to encourage an integration of nursing professionals into the critical conversations occurring across the health care professions in practice. Those of us teaching a philosophy course to third year nursing students in a collaborative, context-based, problem solving focused, four-year bachelor of science in nursing degree are well aware of critical issues endemic to nursing education. There is dissonance within a program, which (quite rightly) trains people to follow procedures or orders to the letter so that there is no hesitation or time wasted when uniformity and instantaneous responses are essential to good patient care, while—at the same time—promoting critical thinking as an aspect of a professional practitioner able to evaluate situations analytically and respond appropriately on their own. I have argued elsewhere about the teaching challenges this dichotomy poses.

So, the initial task of a course giving instruction in health care ethics with a primary audience of nursing students, needs to focus on identifying, building and encouraging a critically analytical conversation based on an understanding of the skills of argumentation across discipline-specific borders in the general domain of professional healthcare service providers. That is, the domain is holistic with the idea that each professional practitioner operates from a separate, but collaborative, domain or discipline of expertise and can contribute to the best overall decision about a medical process or relationship between patient and practitioner.

This provides a basic reference to the skill that needs to be identified and encouraged in assignments designed to enhance the ability of nursing students to make good rationally defensible decisions. It is also useful to spell out these skills in such a way that novice practitioners in the discipline can efficiently integrate the skill with ethical issues raised in the practices and ethically prescriptive values Doors to Degrees-web [file:///Macintosh HD/Users/Ying/Desktop/Seneca - 01/-web stuff/Doors to Degrees - web stuff/Doors to Degrees-web.ai]identified by the profession as central to its discipline adherents. So, the second task is to identify an area of practical and ethical concern where an understanding and application of argumentation skills can be applied. A starting point for a non-nursing practitioner, is to

situate himself or herself—along with the informed public—within the Canadian Nursing Association's Code of Ethics (CNA) which is a public document meant to inform public expectations about Nursing's ethical practices. There are several prevalent themes that underscore significant differences in expectations between nursing health care practitioners and physicians, as identified in the Canadian Medical Association's (CMA) Code of Ethics. First, there is a focus on the ethos of forming caring relationships. If caring is integrated into decision making, then it should appear even at the level of micro or macro decisions about resource allocation. Second, there is clear focus on issues of social justice, in particular, the need to maintain the existing Canadian public health care system. Third, there is an identification of the nurse practitioner as having an important role to play in health care resource allocation. Fourth, there is the assumption that these social obligations of nurses are a valuable part of everyday practice, with the suggestion that the promotion of public awareness of resource problems in the health care delivery system is an obligation of nursing practitioners. Fifth, nursing practice is now encouraged to include a research-based based component, as an integral part of the justification of its existence as a profession and it's unique yet equal place in the health care system. Sixth, as noted above, nurses and nursing programs, as a way of reinforcing their professional status, emphasize nursing as a part of a collaborative group of holistic health care practitioners, each working towards the improvement of the patient's situation and the general situation of health care in society. As a member of such teams, nurses need to be able to assess, evaluate and critically analyze information from a variety of sources to make critically informed group focused decisions that will be respected and effective in resolutions that issue in well-supported collective decisions.

A brief historical overview of the ongoing changes to the CNA document over a relatively short period of time, compared to very few significant changes to the CMA code, gives us some reason to pause over why these revisions were needed. First, the role of nurses in Canada has changed with their tasks advancing beyond previous professionals, their roles as independent practitioners not attached to health care organizations, and their growing determination to clearly identify their health care profession as distinct and separate from other health care professions. Second, their position as auxiliary to other health care professions is being transformed gradually into a role of collaboration and autonomous professional decision making. These two prominent changes will have an effect on the ethos of the profession, which accounts for the changes to the CNA document. Revisions seem designed to fill a gap between the past traditional practice of nursing and the emerging new paradigm being forged by nursing professionals. Nursing seems to be going through a process of growth and development towards the self-realization of a new paradigm of practice, one with a greater emphasis on somewhat distinctive nursing-based research. Senior nursing students are in the middle of this paradigm shift while being introduced to it, so they may be in the best situation to bridge the gap between the old and the new. Students of a paradigm can often provide more informed and determined direction to its growth and development than more traditional practitioners.

So, there should be projects in a course in health care ethics to encourage and develop the conversation about this change, provide an integration of the first consideration of revised practice and a research basis for it. Often, I find, nursing students are told that their practice must be based on fact-based research. However, I am *not* a proponent of so-called *moral realism*, because I am influenced by Hume's important consideration that a factual claim cannot, by itself, provide defensible support for a value based claim or conclusion. I need an informed and persuasive ethical imperative to raise my finger, even if doing so would save the world. Such an action is not based exclusively on any fact-based consideration. I need to take an interest or care about the outcome, which brings us back to the importance of caring relationships, noted above as unique to ethically based nursing practice. The project then needs to be one that introduces students to: research into social values that bear some relationship to identified ethical areas of interest for nursing, argumentation, the possibility of a conversation with experts in the area of health care ethics to encourage a holistic approach to informed decision making in health care venues. This is the test

criteria of the following project I designed and integrated into a third-year course in health care ethics at a small community college in Red Deer, Alberta. The course participants were composed of some students from the collaborative Bachelor of Arts program but primarily nursing students. Nursing students in the Red Deer College/University of Alberta Collaborative degree program are encouraged to work on problems in groups, identifying the need to introduce theoretical considerations to the problem solving only on the basis of pragmatic considerations of understanding.

2. Background to the Project

After some preliminary skill testing in argumentation, creating and responding to the challenges raised in the arguments of others, and an introduction to the competing claims of a privatized two-tiered health care system of distribution and a single-payer public health care system of distribution of health care resources, the students were sent to an article (now available in archives only) in an interdisciplinary on-line journal, *Medscape* (found at *www.medscape.com*). The article, *Comparing Healthcare Systems: Outcomes, Ethical Principles, and Social Values, Winte*r, 2007, by a well-respected and recognized expert in Canadian health care ethics, Eike-Henner W. Kluge, PhD, at the University of Victoria, Department of Philosophy, seemed appropriate for this audience of emerging health care practitioners. His central claim was controversial in a way that spoke directly to the professional nursing code's admonishment that nurses had an obligation to lobby for the protection of a public health care system by introducing them to an ongoing conversation or debate that "has raged over the acceptability of socialized and rights-oriented approaches to healthcare as opposed to privatized and commodity-oriented approaches" (1) and a response to the debate which was controversially denying the effects of outcome-based decision making to determine the best system between the two contrasting possibilities.

This was determined to be a good article for the students to consider since it presents an argument that challenges some commonly and uncritically accepted assumptions. Some of these assumptions which lead us to believe that (a) a rights-based view is the only basis for assessing the outcomes of a health care system, (b) the silver bullet solution of putting more resources into a health care system will achieve optimal efficiency, (c) there is no actual limit to any health care system, (d) it makes no difference what principles or values a society accepts whether the system is successful or not, and (e) it is possible to objectively measure both the needs of a health care delivery system and the successful outcomes of such a system.

Students on the border of a profession, moving into a professional role from the classroom setting, not yet completely engaged in the ways of the profession, can sometimes be in a good situation to recognize and challenge faults within the system where it fails to connect theoretical claims to actual practices. Students are often eager, if the possibility is opened to them, to participate in the initiative of putting assumptions and beliefs under critical scrutiny.

The project involved the students creating their own responses to the article in the form of a counterargument. The instructor then compiled their responses, synthesized them into a set of arguments in support of a conclusion or sub-conclusion in a sustained critical response to the claims in the article. The text below is from the instructor, using the student's set of comments, with the quoted material coming directly from the student's responses or the student group leaders' responses. So, quotation marks are used to indicate these sentences are not those of the author of this paper. In this text, letters are assigned randomly at the end of each quote, respecting students' anonymity and privacy and indicating that the source is other than the author of this paper. Since several students responded with similar reactions, and there is no determination that they agreed with each other, the randomly assigned letters of the students are used at the end of each quoted piece of text.

3. The Problem

Nursing students spend much of their nursing education in the company of nursing students and instructors who share a common paradigm, foster a sense of shared community and employ the knowledge from other disciplines as a means, not a self-sufficient end, to developing a focused nursing perspective and knowledge base. Out of this situation there sometimes emerges confusion over expectations as students move from nursing courses, taught by nursing practitioner-instructors, to non-nursing courses taught by non-nursing instructors. So, the common question posed is: How will this help me as a practicing nurse? This confusion can be defused, although perhaps not eliminated, by identifying and employing problems and critical questions in the practice and ethos of nursing. Presented with a puzzle that is not framed as an irreconcilable so-called "moral dilemma," students can sometimes better understand the issues that philosophy and philosophical argumentation can help them to appreciate. So, for example, the problem is that nursing students are introduced to the conflicting notions of: (a) acting from a caring perspective, and (b) acting from the consideration of a set of rights, duties, obligations and rules: One approach is designed to identify partial, personal relationships as the basis for facilitating good ethical decision making and empathetic judgements, and the other is designed to facilitate impartial, objective decision making between strangers based on the documented authority of rules. No amount of fact or evidence-based research is going to help anyone resolve this kind of problem. What can help, however, is an approach based on developing considered argumentation designed to meet the critical challenge posed by an opposing view. I designed a project to help initiate the attitude of critical analysis in place of uncritical appeal to personal opinion.

4. The Plan

This project was designed to acquaint the students with producing critical responses to an argument that met the challenge(s) raised by the criticized argument in an acceptable and relevant counter response. They were instructed to insure that their responses could be understood by a general audience of non-professionals. It will remain an open question whether this has been accomplished or not.

> (a) To evaluate the outcomes of any health care system involves an irreducibly subjective component. Individuals perceive and understand their own health differently from how they perceive health in the case of other individuals or some set of objectified collective health outcomes. So, as one student pointed out, "it is important to understand and consider how people perceive their health K.D.
>
> (b) The indicators of any health care system are open to critical inquiry along with ongoing rational reflection, so it is suggested that this document is the opening of a dialogue not the expression of an entrenched opinion. As such, the responses should not be considered definitive, but rather indicative of a representative student nursing response. This project was designed to acquaint nursing students with journals in their area of interest, encourage them to continue to research topics in their profession, and to use this research information to continue to dialogue critical ethical and controversial issues in their profession.
>
> (c) In this project, third-year nursing students were asked to respond critically to the argument presented by Eike-Henner Kluge. They were not encouraged either to agree with the article or to disagree with its conclusion, just to formulate some reasons either against the premises used to support the argument or to provide reasons of their own in support of the argument's claims. The students were asked to provide supporting propositions as counter claims or counter arguments in response to the claims made in Kluge's article.

5. The Initial Argument that Opens up the Challenge of a Counter Argument

The following is my interpretation of the argument presented by Kluge with a focus on his actual words in most instances and a précis used in some other cases, such as P6, to simplify his statements. I have indicated, as well, my understanding of his use of connectives and implied sub-conclusions with due respect to the author's well-written and clearly expressed argument.

P1: "There is no social service that will ensure a happy, harmonious and successful society." (1-2)

P2: "Healthy people have the *potential* for happiness, harmony and success." (2)

P3: "*Whether that potential is realized still depends* on the people themselves." (2)

P4: "Whether that potential is realized depends on whether the structures that are in place are consistent with the resources that are at society's disposal." (2)

So,

P5: [Sub-conclusion from P1-P4] "Whether that potential is realized depends, above all, on the values and principles that are integral to the moral fabric of that society." (2)

P6: A society that values (i) autonomy, equality, human rights will ethically differ from a society which values (ii) a utilitarian distribution of social utility, which will in turn differ from a society which (iii) "has an egoistic ethical orientation." (2)

So,

P7: [Sub-conclusion from P5-P6] Each society, according to what principle drives its ethical model of distribution, P6(i) P6(iii), will reject the other possibilities and distribute health care services according to its own preferred model.

So,

P8: [Sub-conclusion from P7] "[T]here is not right model of healthcare." (2)

Therefore,

C: "There is only a right model for a particular society's ethical orientation" (2) and no right model for every society in general as a universal standard of measurement.

Sub-Argument 2

P1: Some preventable health conditions are linked to lifestyle.

P2: Some hopeless cases stretch health care resource limitations while guaranteeing less than optimal outcomes for other, less funded, better outcome interventions.

So,

P3: Not all healthcare claims have equal merit.

C: With no mechanism "to evaluate the appropriateness of certain procedures or to evaluate the moral legitimacy of health care claims for self-induced conditions (5)," all claims will be treated equally to the detriment of an efficient distribution of health care resources.

Sub-Argument 3

P1: There is "no consistent and usable definition of health (6), which has received "general acceptance," which is what outcomes of a health care system are supposed to do.

P2: To measure a healthcare system the components must be clear, unambiguous, and independently relevant to effectively support the principles and values of any particular society.

P3: There is no quality of life measure.

So,

P4: Not all health care claims have equal merit, since "some preventable health care conditions are linked to lifestyle," and "some hopeless cases stretch health care resources." (5)

C: There are no measures to determine whether a given health care system is performing optimally.

Sub-Argument 4

P1: There are factors that are independent of any particular "health care system but that nevertheless determine whether an otherwise appropriate system functions optimally and produces ideal outcomes." (4)

P2: Resource allocation determines whether an otherwise appropriate system functions optimally.

P3: The attitudes of health care practitioners and patients (evaluated as satisfaction levels) determine whether an otherwise appropriate system functions optimally.

P4: "If one is interested in longevity, morbidity, and life expectancy, then the thing to do is to invest resources in nutrition, public housing, sanitation and diverse other public health measures not in acute care medicine." (4)

C: Any society whose principles and values are rights-based, like Canada, has not "failed in its social obligation nor chosen the wrong health care system just because overall health status, like life-expectancy, morbidity, and other health measures of its citizens—including their satisfaction ratings—fall below a certain level. (4)

Sub-Argument 5

P1: Delivery or distribution of health care, by public or private means, is independent of whether a society's approach to health care is consistent with its principles and values. (3)

P2: It is the obligation of any society to provide only the opportunity to access health care services to its population by different means: vouchers guaranteed annual income, and so on.

P3: How the opportunity, in P2, is made use of is the citizen's or individual's responsibility, not society's responsibility.

So,

C: No society is obligated to follow a health care delivery system that is consistent with its principles and values in order to achieve an efficient or optimal distribution of these resources which means that a privately operated system may be as efficient as a publicly funded system differing only on ideological grounds, principles or ethical values.

6. Construction of the Argument from Student's Critical Responses

The following premises (P1-P13) are my construction based on my classification and interpretation of the students' responses. I have indicated how the students seem to have responded in ways to qualify or challenge by counter consideration some of the claims presented in the original argument.

SP1: Employing argument by analogy, the failure of any social system is not determined by its failure to achieve its *ideal outcomes alone*, because if this were the case then we would be justified in equally condemning other social systems, like the justice system as a failure because it failed to successfully combat crime in an *ideal outcome*, but this seems impractical.

1. "A nation which believes in a right to healthcare has not failed in its social obligation because health indicators such as overall health status, life expectancy, morbidity, and mortality fall below certain levels or has a poor public rating. Outcomes such as these do not effectively determine the success or failure of a certain healthcare system. If the outcomes mentioned above determine a particular system's failure or success, then one could accurately say that the same should be applicable to all other systems in a society. For instance, one could say that a particular country's justice system is unsuccessful or inadequate because of its inability to combat crime." A.B.
2. "A healthcare system which is structured such that the burden of payment is on the citizen tends to illicit more negative outcome because poor individuals who usually need healthcare become poorer as a result of the burden placed on them by the healthcare system." A.B.
3. "The government decides on whether or not to allocate funds towards healthcare or whether those funds would be better spent in other areas such as military spending or building infrastructure. In some countries the amount that they spend on military exceeds that of what they spend on the health of their peoples – for example in the United States of America. (Colby & Corbett) Many people look towards the USA and believe that because they have enormous power in medical advances and state of the art facilities that their private system is better than their public system. However when you look into the system you realize that the state of the art hospitals with the best equipment serve very few of the population. (Colby & Cornett) Those who do get served have the money to get themselves to the front of the line." A.P

SP2: There is an irreducibly personal connection and subjective perception of health, which renders generalizations about a system's success or failure questionable.

4. "…it is important to understand and consider how people perceive their health…" K.D.
5. "The health of a society as a whole is dependent on the health of its members, regardless of ethical orientation." M.O.

SP3: Following P2, there is an overriding right to equality of access in the allocation of health care resources which is not based on merit or desert as the foundation for the distribution.

6. "….a private system with money being provided to the individuals is not a particularly good way for society to honor its commitment to level the healthcare playing field…." C.M.
7. "….by a system being operated by the public it is easier to make sure all the checks and balances are in place and in turn everyone will receive the same care." C.M.

8. "The author suggests that not all who access the healthcare system have "merit," and that individuals who are chronically ill and/or dying are a drain on the financial resources and services provided by the system, and that those who have self-inflicted illness fall into this category. I would disagree with this premise in that it puts a price on life and denies the individual their fundamental right to be treated equally and their right to life as outlined by the Universal Declaration of Human Rights (1948). It is inhuman to suggest that a life has a dollar value and if there is no chance for recovery then why waste resources that could be more positively used to treat someone who has a high chance of survival?" C.C.
9. "I (also) do not agree with not giving full treatment to those with palliative diseases. In my opinion that is choosing death for people which goes against the Canadian Charter of Rights…." A.P.
10. "….access to healthcare should minimize health-based differences. Providing the members with money does not minimize the health-based differences, when the money could instead by put directly into the healthcare system, therefore providing more equal access to healthcare with more ability to minimize the health-based differences. This has been demonstrated in several societies such as Britain and France; in these systems, healthcare is provided to every member of society equally and is available to everyone. In Britain if there is a cost incurred to the individual there is no variance in prices, such as with prescription drugs; every drug has the same cost. When a society provides appropriate healthcare to its members they will be healthier and more productive and more goes into the society." C.M.

SP4: It is a mistake to claim there is dissatisfaction with the failure of a system when the failure is in one aspect or area of the system, namely for example, long waiting lines for certain important health care services.

11. "…with wait times being the main reason of dissatisfaction…its not realistic to say that low satisfaction rating necessarily means failure or that the health care system is less than ideal." K.D.
12. "It is not just to state that belief in the right to health care has completely failed; it may just need to be restructured or organized." K.D.
13. There has been the long wait time for specialized exams such as MRIs which can be up to a half a year wait." M.B.

SP5: The failure of a system is not a reason to necessarily abandon it for another alternative; rather it is a reason to pursue a restructuring or re-organization of the system, a re-thinking or reallocation of the resources in the system, in light of the priority given to human rights over systems and in this case the priority given to a right to health care

14. "Everyone has the right to life, liberty and security….Illness can also be seen as slavery, as it may dominate the ill person. So if healthcare is unattainable, these premises are at risk of being violated." K.D.
15. "Is society's ethical orientation determined by the government ruling the nation or the members of the nation?" M.B.
16. "There is an obvious right model of healthcare which is one that delivers health care based on the fundamentals of the *Universal Declaration of Human Rights*." M.B.

SCP6: Kluge's use of outcome based objections is supported by other considerations of variables in: life expectancy, consumer dissatisfaction and so on.

17. "This argument is reasonable because there is no healthcare system or method of healthcare delivery that will ever achieve 100 percent satisfaction from its consumers, or have the ability

to increase life expectancy, health status, and morbidity rates that are desirable, as long as there are external, uncontrollable limitations being placed on the healthcare system itself." C.P.

However,

SCP7: [Counter premise response to CP6] There is a way of assigning and determining responsibility for health care outcomes.

18. "Within the healthcare system, there is a responsibility of officials to determine appropriate allocation of resources. This allocation of resources, whether they are staffing, material, or monetary resources, is a large factor in the health outcomes of citizens treated within the healthcare system. Granted, individual income and ability to pay for other treatment will factor into this equation. Adjustment in allocation of resources within the current healthcare system would likely be a less challenging feat that restructuring a society's whole healthcare system." C.P.

SP8: The emphasis in Canadian society on a publicly funded health care system cannot be compared to the system of allocation in the United States, where the latter does not affirm access to the system by all citizens.

19. "(They) [Canada and the United States] are different in the way they fund and deliver physician and hospital services." M.B.
20. "An identified strength of this healthcare model (Canada's) is that (all) citizens have access to care, (which affirms) the principle of inherent dignity and equality of all persons.
21. "It appears as though the people of the United States need to care more about their society." M.B.

SP9: While some public health care procedures, like immunization, which could be privatized in a free market type distribution, the choice of immunization remains an individual's decision which if not legislated is not any more effective in either a public or private distribution.

22. "The author does not discuss the very important fact: even if there is enough funding to immunize everyone, not everyone will choose to become immunized. Thus it is important also (with allocation of resources)to ensure most individuals choose immunization; there must be education and increased public awareness which includes giving resources to health professionals to teach to make sure there are resources to advertise in the media the important of being immunized." J.P.
23. "It is also key to mention that the choice cannot be mandated in any way by governments as it would be a violation of human rights to force immunization." J.P.

SP10: While allocations based on healthy life style choices might make more effective use of available health resources, the public decision remains controversial about who will be *authorized to decide* which diseases are essentially or primarily self-induced, and which are only accidentally so induced, especially since the science is unclear about the demarcation.

24. "The author fails to discuss how this determination of who gets what healthcare should be made. The author mentions that resources should be given out on the basis of whose illness is self-induced and whose (illness) is not self-induced. The author does not mention anything about the acuteness of the illness." J.P.
25. "It can also be argued that this type of system is very inappropriate because science is unclear as to whether smoking or genetics has caused the person to suffer from heart disease. There

would be no appropriate ethical measure to ensure that the healthcare system is passing out access appropriately." J.P.

26. "I however do not agree that some people should be denied healthcare due to their poor lifestyle choices. In my opinion this is not an acceptable way for the government to try to save money in the healthcare system. As well as being morally unacceptable it goes against the fundamental rights of the constitution that a person has freedom of choice. (Department of Justice of Canada, 1982) Also on a genetic standpoint not everyone solely chooses their port lifestyle since genetics can predispose them to be more likely to fall into the trap of addictions. If we punished everyone who chooses a poor lifestyle we are depriving people who are contributing to society in other ways." A.P.

SP11: An efficient health care distribution has to take account of the following conditions: (a) the need for a peaceful and comfortable death for everyone, and (b) the most efficient global distribution of health care services, with (a) providing the condition that takes priority over (b).

27. "It is the ethical responsibility of the healthcare professional to insure a peaceful comfortable death for all individuals in their care." J.P. [insane equity of treatment of the individual?]
28. "…. In a shrinking global village requiring frequent international travel, an increasing number of persons are potential recipients of healthcare services in many different countries." M.O.

SP12: There is a problem in the use of language, language which is unclear and in the approach followed in the article there is an inconsistency between the claimed approach and the anticipated results, while the author is committed to a realistic solution, the basis for his claims are hypothetical and not real.

29. "Throughout this article, expressions such as "let's suppose" and "let's assume" are used liberally to describe hypothetical situations and yet the author states a desire to not confuse the ideal with the real. (Kluge, 2007) If the author truly believes that the delivery of healthcare should be based on societal ethics, real world examples should have been used to support the claim, rather than hypothetical or imaginary examples." M.O.
30. "Kluge also seems to imply that a healthcare funding is static, but this is not necessarily so. Banting and Corbett state in their comparison of healthcare systems that the challenge of funding can be met when there are at least two levels of government involved in decision-making and when officials are willing to re-evaluate and re-design systems as the needs of the populace change." (2002) M.O.

SP13: The failure of health care in Canada is the government's responsibility in terms of how much money it allocates to the system and how it prioritizes its overall set of social resources.

31. "….the government of Canada has to take sole responsibility for the downfalls as it runs the healthcare system and the provincial and federal governments are the main monetary contributors to the healthcare system." (Fierlbeck) A.P.
32. [Re: health promotion and prevention education] "This method of preventing or decreasing the chance of disease has not been 100 percent effective, but it has markedly decreased the frequency of demand for acute healthcare services." C.P.
33. "First, in order for a healthcare system to achieve and maintain optimal levels of health outcomes, there needs to be a clear definition provided as to what 'optimal' outcomes are. Second, there needs to be methods by which changes to the healthcare system can be made." C.P.
34. "If the government is heavily in debt, then there may be difficulties with paying for healthcare, and therefore there would be fewer hospitals, or because the government is controlling the healthcare, there would be more hospitals and clinics." J.H.

35. “They are willing to pay for the service directly or indirectly through voting-in the right government that supports the healthcare they need or taking (money) out of their own pocket.” S.M.
36. “If the healthcare system is not achieving optimal outcomes, it should not be replaced; it should be changed. Societies are adaptive and so too should the healthcare system that services the individuals in it.” C.C.

7. Concluding Considerations

The outcome of this project was a critical conversation which started with the article by Kluge, moved to a number of third-year nursing students in a health care ethics course at a college in central Alberta, and finally included the instructor of the course who was faced with providing a structure to the conversation—as a kind of informed scribe—to the engaged discourse of the group. Was this an indication of success or not? Not all the students’ reactions to this project could be included, so it was necessary for the instructor also to make a considered judgement about what was to be in and what was not to be in, which is itself an indication of the power of the scribe in such situations. First, because the students were faced with convincing someone other than the teacher of the course, there was a pronounced movement away from unsupported opinion or belief to developing an argument. Second, because there was an on-going discussion in other nursing courses about the public-private health care delivery systems controversy, students already had an advanced interest in delving deeper into the issues. Third, nursing students did a good job of integrating material from their core nursing program texts and class discussions into their responses for this project, which I supported and was pleased to see helped many of them to understand an important connection between their core nursing program and the critical approach of my philosophy course. Finally, it is hoped that this initial, yet crude, map can be used by others to design their own more sophisticated projects to include students in public debates about significant issues in applied and professional ethics—not as spectators but as full participants.

Not surprisingly, nursing students in general were not intimidated by the task of critically evaluating an article by a recognized expert in the area of health care ethics, but rather they felt free to engage in a fully critical challenge. Students informally indicated that the article prompted further discussions outside the class about the nature of a fair and just health care delivery system, one that matched the ethos of nursing. Continuing the critical conversation is the best indicator that a course in philosophy has had a lasting and important effect.

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Contents [index.html]