

Promoting nurses' and midwives' ethical responsibilities towards vulnerable people: An alignment of research and clinical practice

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Abstract

Aim: To stimulate discussion and debate about the inclusion of vulnerable populations in primary research to inform practice change and improve health outcomes.

Background: Current research practices to safeguard vulnerable people from potential harms related to power imbalances may in fact limit the generation of evidence-based practice.

Evaluation: The authors draw on their experience working and researching with a recognized group of vulnerable people, incarcerated pregnant women, to provide insight into the application of ethics in both research and clinical practice. In a novel approach, the ethical principles are presented in both contexts, articulating the synergies between them. Suggestions are presented for how individuals, managers and organizations may improve research opportunities for clinical practitioners and enhance the engagement of vulnerable people to contribute to meaningful practice and policy change.

Key Issues: Ethical practice guidelines may limit the ability to create meaningful change for vulnerable populations, who need authentic system change to achieve good health outcomes.

Conclusion: Inclusive research and practice are essential to ensuring a strengths-based approach to healthcare and addressing health needs of the whole population. Health systems and models of care recognizing the diverse lives and health needs of the broader population demand practical, sustainable support from clinical managers.

Implications for Nursing Management: Practical suggestions for clinical managers to support point of care research is provided, embedding vulnerable voices in policy, practice development and care provision.

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KEYWORDS

case study, ethical nursing practice, research ethics, vulnerable populations

1 | INTRODUCTION

Nursing and midwifery practice is framed by professional codes of conduct, ethics and standards of practice. These frameworks seek to ensure the provision of care meets the expectations of the community, the professions and individuals, contributing to the best possible health outcomes for the recipient. The International Council of Nurses (ICN) and the International Confederation of Midwives (ICM) provide the overarching ethical frameworks within which all nurses and midwives must practise. Specifically, the ICN Code of Ethics for Nurses (ICN, 2021) identifies four principal elements for ethical conduct: nurses and patients or other people requiring care or services; nurses and practice; nurses and the profession; and nurses and global health (p. 3). The ICM (2014) International Code of Ethics for Midwives bases its core ethical code on the recognition of women's human rights and the role of the midwife in supporting and advocating for women. Point 1c of the code states 'Midwives empower women/families to speak for themselves on issues affecting the health of women and families within their culture/society' (ICM, 2014 p.1).

The concept of advocacy is foregrounded throughout both professional frameworks, explicitly as per Element 1.7 of the ICN Code of Ethics (ICN, 2021, p.7) or in a more nuanced manner throughout the International Code of Ethics for Midwives (ICM, 2014). Accordingly, it is expected that nurses and midwives build trusting relationships with the recipients of care, support them in their healthcare decision making and advocate for change to provide the best possible health outcomes.

People from disadvantaged or vulnerable backgrounds are over-represented in poor health statistics (Ford et al., 2021) and are often the most frequent seekers of care (Cruwys et al., 2018). For many, engaging with health care providers is fraught with challenges, including, but not limited to, access to care, understanding of need and adaptability of services (Byrne et al., 2022; Lewis et al., 2012). For many, non-engagement with healthcare providers is reflective of an overall disengagement with institutions more broadly and demonstrates a level of structural vulnerability for the individual. Structural vulnerability is a term that describes the complex social determinants that contribute to factors that result in poor health outcomes (Bourgois et al., 2017). Further Bourgois et al describes structural vulnerability as 'the outcome of a combination of socioeconomic and demographic attitudes, in conjunction with assumed or attributed status' (p. 4). Therefore, the vital role that nurses and midwives play in confronting these factors and in facilitating patient engagement cannot be overstated.

Contemporary healthcare practice is based on evidence-based knowledge (Boswell & Cannon, 2022). However, in order to build an appropriate evidence base, rigorous and credible research that meets a strict ethical criterion is essential. The fundamental importance of

research informing clinical practice is mentioned, albeit briefly, in both aforementioned codes of ethics. Howe

ever, despite this, the role of nursing and midwifery researchers is often overlooked. Whilst there is a strong focus on the ethics of providing quality clinical care, less consideration is given to nurses and midwives involved in research. Hayes (2006) clearly links the Code of Ethics requirement that nurses should treat all people as equals, considering individual circumstances to promote inclusivity and addressing 'hidden coercive influences' (p. 87). It is therefore imperative that nurse and midwife researchers contribute to the building of a body of knowledge in order to best advocate for all recipients of care.

The authors draw on their experiences of evaluating a project that included working alongside and conducting research with a vulnerable population of pregnant women in prison (Baldwin et al., 2018). Pregnant women in prison are considered vulnerable by their gender, incarceration, pregnancy, culture and socio-economic background (Baldwin, Sobolewska, et al., 2020). The juxtaposition of clinical practice and the importance of engaging vulnerable populations in primary research to hear the voices of those who may be silenced by complex social, cultural and political influences is explored. The authors' new insights demonstrate how practice and research with vulnerable people are aligned, enhancing outcomes for theoretical understanding and practical application. The need for primary research, centred around the most vulnerable is highlighted, and suggestions will be made for future research involving vulnerable people, without compromising the research process or compounding the participants vulnerabilities.

2 | BACKGROUND

Ethical practice in research is not a new concept. In the aftermath of WWII, the urgent need to protect the vulnerable resulted in the Nuremberg Code, followed in 1964 by the Helsinki Declaration (Mandal et al., 2011). It is beyond doubt that the events leading up to the development of these cornerstone documents dictated the need for regulation to prevent further research activity that could result in harm, maim or even kill innocent participants. Since then, formal ethics committees have become embedded into organizations that engage in research (Brown et al., 2020). Alongside the growth of ethics committees, the definition of vulnerability has evolved to recognize the many layers of vulnerability more accurately across communities.

Over time, restrictions on vulnerable people participating in research due to concerns about causing them harm have increasingly been called into question, raising issues about the exclusion of vulnerable groups from being represented in research (Hayes, 2006). For example, non-participation or exclusion from participating in research

may in fact be placing vulnerable populations at a further increased risk of harm (Juritzen et al., 2011). Using healthcare provision in prison as an example of vulnerability in context, the lack of primary research with offenders is apparent. There is an overall dearth of research about health in prisons, with most of the evidence being drawn from statistical data provided by health services or research around medical chart audits and reviews. This absence of the person and their lived experience of healthcare delivery within prison indicates a significant gap in knowledge, particularly when considered from the perspective of person-centred care.

The complexities of vulnerability are well illustrated in the cases of incarcerated pregnant women, with the recent development of formal recommendations to improve health and well-being outcomes for this group of mothers and babies (Baldwin, Capper, et al., 2020; Birth Companions, 2016). The number of incarcerated women around the world is increasing, many of which are of childbearing age, (Alirezai & Roudsari, 2022; Gibson, 2022), are from poor socio-economic backgrounds and have higher levels of emotional and mental health trauma than the general population (World Health Organization, 2014). Often women moving through the criminal justice system lead chaotic lives, involving complex social issues, resulting in prison sentences related to illicit drugs, violence and robbery (Breuer et al., 2021).

Pregnant women are regarded as a vulnerable population due to a perceived lack of capacity to give informed consent for an unborn child and thereby are seen to pose a greater potential for harm. Because of this classification of vulnerability, there has been a reluctance to undertake research involving them. Despite this hesitancy, it has been suggested that the exclusion of vulnerable populations may, in fact, cause them more harm as it further suppresses their voices, thereby contributing further to their marginalization (Aldridge, 2015). Incarcerated women have been described as 'the most vulnerable population of women' (Hayes, 2006, p. 84). Therefore, incarcerated pregnant women may be categorized as an *even more* vulnerable population.

The paradox of this situation is that pregnancy alone should not be considered the causation of increased vulnerability as it is considered a state of well-being rather than illness. Therefore, it could be argued that it is in fact unethical not to undertake research with vulnerable populations, such as pregnant incarcerated women as the need to elicit meaningful findings is paramount with enormous potential benefits (Alexander, 2010; Krubiner & Faden, 2017). Further, current evidence suggests that the prison environment may contribute to improved birthing outcomes and being pregnant whilst 'inside' provides the incentive for a woman to transform her life with positive birthing and effective parenting experiences offering an opportunity to interrupt the cycle of recidivism (Shaw et al., 2015).

3 | DISCUSSION

Our experience foregrounds the often-avoided topic of doing ethical research with vulnerable people (Gordon, 2020). Recognition of a population such as incarcerated pregnant women as a vulnerable

group contributes to the lack of evidence-based understanding of their situation, from analysis of primary data rather than the more commonly used data sources of document review or research with people who are not the primary concern. We support the view that it is unethical *not* to undertake research with vulnerable populations (Alexander, 2010; Krubiner & Faden, 2017) as the need to elicit meaningful findings is paramount to those concerned. In fact, the exclusion of this group may, cause harm as it represses their voices, further contributing to their isolation (Aldridge, 2015). Vulnerability is not static, its levels fluctuate in response to the environment and other physical and emotional factors that are at play at any specific time (Biros, 2018).

Usually, there is a distinction made between research ethics and clinical practice ethics. However, our experiences demonstrate the necessary links that nurses and midwives must make between research and practice in order to operationalize best evidence, contribute to new knowledge, provide high-quality care and align with ethical clinical practice. Our novel approach to this complex situation is illustrated in the following table. Table 1 shows how our methodological approach addressed all four basic ethical principles for research and how those concepts may be operationalized in the clinical environment.

The application of the ethical principles in both contexts is a novel illustration of how ethics underpins all aspects of nursing and midwifery. Further, it demonstrates the inextricable links beyond that of evidence informing practice. It shows that the ethical conduct of research could be considered a natural extension of ethical nursing and midwifery practice. There is scope for nursing and midwifery managers to support the conduct of research, involve clinical staff in research and extend the concept of woman-centred care by placing vulnerable women at the centre of new understandings as well as at the centre of their care.

Contemporary strategies implemented by all levels of government around the world centre on the concept of inclusivity. It is our assertion that these strategies promote inclusion on multiple levels: one, to actively engage clinicians in research and two, to design research to uphold the ethical principles allowing for both protection and participation with vulnerable groups. Our insights demonstrate a need for these same organizations to extend inclusion strategies to ensure that all voices are heard. It seems reasonable that, whilst upholding the ethical principles, nurses and midwives are well positioned to seek out and embed ways of engaging the disenfranchised and marginalized in research studies. Engagement and inclusion may increase self-worth and perception of self within the broader community and thereby increase power status for those who have the least. As outlined in Table 1, building relationships is fundamental to creating a research culture in practice, and these relationships should be across disciplines, contexts, organizations and regions, drawing on the formal and informal networks that nurses and midwives are part of. Adopting a research-engaged culture and providing support for clinicians to be actively involved in research are essential elements to increasing nurses' and midwives' ownership of the evidence for their practice. Redesigning old strategies such as journal clubs is one way in which

TABLE 1 Ethical principles in nursing and midwifery research and practice

Ethical principle	Ethical research design	Ethical clinical practice
<p>Autonomy—Seeks to uphold the individual's right to self-determination without bias or influence</p>	<p>Relationships built between researcher and participant</p> <p>Researchers are not employed by the government or by corrective services</p> <p>Information sheets and consent forms will be worded to an agreed literacy level</p> <p>All consenting participants will be invited to participate in all aspects of the study</p>	<p>The ethical principles for nurse and midwives are visible and embedded into organizational policy and clinical practice expectations</p> <p>Considerations and respect for different ways of knowing and understanding are foregrounded in organizational and clinical practice</p> <p>All recipients of care are given the option to make informed decisions and if they choose, decline or redefine their care</p> <p>All clinical decision making places the recipient of care at the centre and prioritizes their individual choices, empowering them to be active participants, rather than passive recipients</p> <p>Professional relationships between the clinician and the recipient of care are established and nurtured, supported by nurse and midwife managers and organizational governance processes</p>
<p>Justice—Research outcomes must be fairly and equally distributed</p>	<p>Findings will not be disseminated without full consent from the participants</p> <p>Transcripts of are the collective property of the participants and research team</p>	<p>Full and accurate explanations of care management options are given, clarified and confirmed with all recipients of care</p> <p>Equity in access to appropriate services is enhanced by individual and organizational practice</p> <p>Clinicians ensure that current evidence is embedded in practice to ensure consistent, quality care across settings for all recipients of care</p> <p>Nurse and midwife managers, in consultation with all staff, ensure that adequate resources are available to meet the standard-of-care expectations</p>
<p>Non-maleficence—No harm comes to those who participate in the research or in the broader community</p>	<p>Fact checking with the participants conducted prior to final publication and dissemination of findings</p> <p>All precautions will be taken to protect confidentiality, privacy and identity of participants with ongoing review during the research process</p> <p>Data collection methods promote the creation of safe spaces</p> <p>Researchers will adopt a reflexive stance</p>	<p>When providing education, clinicians clarify understandings with the recipient of care, redirecting or explaining where required</p> <p>All recipients of care are offered the opportunity to participate in research and policy development where appropriate. Similarly, all recipients of care can decline or withdraw participation without impact on their care</p> <p>All nurses and midwives, across all levels of practice, including nurse and midwife managers, engage in reflection and reflexivity as part of their continuing professional development</p>
<p>Beneficence—Research must be conducted with the intent to do good</p>	<p>The research team are already known to the potential participants and have built relationships over a period of time</p> <p>All researchers will demonstrate reflexivity in their research practices and keep a journal during the study</p> <p>Opportunities will be provided for participants and researchers (separately) to debrief</p> <p>Findings will be disseminated to the academic community, funding/supporting agencies, and the participants with opportunities to discuss and debrief</p>	<p>All healthcare professionals involved in the provision of care establish respectful relationships with recipients of care</p> <p>Clinicians at all levels, and across disciplines, will support each other and provide regular opportunities for debriefing in safe environments</p> <p>Nurses and midwives, at all levels, will engage with and contribute to policy development and implementation</p> <p>Nurses and midwives, at all levels, will engage with and support the ethical conduct of research to improve health outcomes and reduce risk. This may include actively seeking out opportunities to be involved in research</p> <p>Nurse and midwife managers will create a supportive environment that promotes research as a practice improvement and continuous professional development opportunity</p>

organizations (and managers) may contribute to the shift in clinicians' thinking (Cooper & Brown, 2018; Leonard et al., 2022).

4 | CONCLUSIONS

The conduct of research with vulnerable populations remains the subject of much debate, despite many now believing that to exclude vulnerable cohorts from research participation contributes to the perception of them as vulnerable and further perpetuates their sense of powerlessness.

This paper has provided experiential understandings upon which to build and support future practice, policies and procedures in research and clinical practice. It is imperative to conduct robust research to provide the evidence for continual practice improvement. Whilst serious ethical consideration must be given to support studies that promote the voice of the vulnerable in research and consider the circumstances in context, they should not be excluded on the basis of their vulnerability. The justification for such considerations by nurses and midwives in practice is apparent when the ethical principles are shown to be embedded in both professions across both research and practice contexts. This highlights that the divide between building evidence and operationalizing it may not be as wide as previously thought.

5 | IMPLICATIONS FOR NURSING MANAGEMENT

This paper provides a rationale and guidance for nursing and midwifery managers to support research at the point of care ensuring that the voices of the most vulnerable are heard in policy and practice development and care provision.

ETHICS STATEMENT

Ethical approval was gained from the CQUniversity Human Ethics Committee for the project that this commentary was based upon (approval number: 0000021132).

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DATA AVAILABILITY STATEMENT

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