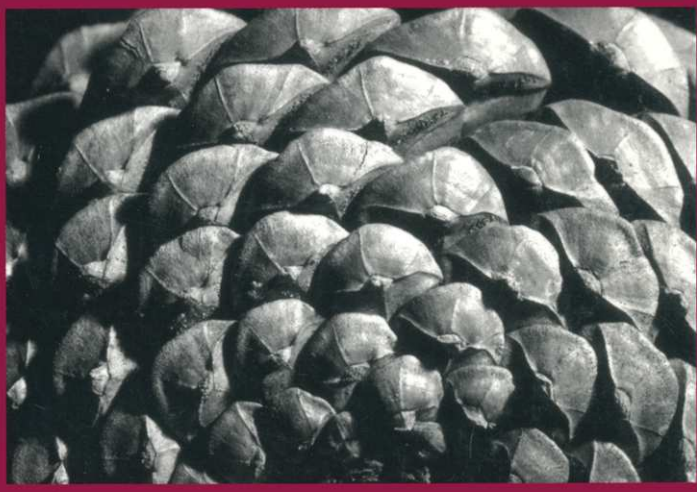

ETHICAL ISSUES IN NURSING AND MIDWIFERY PRACTICE

PERSPECTIVES FROM EUROPE

edited by WIN TADD

Ethical Issues in Nursing and Midwifery Practice

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For Vic, Beccy and Andrew,
my inspiration

Contents

Foreword

I must admit I find the idea of ethics daunting and I am sure I am not the only one. It sounds such a dry, philosophical topic, providing scholars, priests and hermits with ample opportunity for learned speculation but bearing little relationship to the real world – particularly the messy, chaotic world of health care, which to its practitioners seems more real than most. Win Tadd and the contributors she has brought together in this book clearly disagree, and perhaps they share my view that just as politics is too important to be left to politicians and medicine too important to be left to doctors, so ethics is too important to be left to ethicists.

The recent growth in health professionals' interest in ethics has been striking, and has gradually widened to include nurses and others at all levels and in all areas of practice, the target audience for this book. Far from being consigned to a dusty, unwanted corner of the curriculum, ethical issues are increasingly prominent in everyday discussions about health care. The reasons are many and varied, but undoubtedly include the changing role and greater autonomy of nurses, who can no longer hide behind others' authority but are, as their regulatory body points out, individually accountable to the public for maintaining safe standards of care. At the same time, rising demands and inadequate health care resources often force practitioners and managers into making priority choices which they find difficult or even unacceptable.

The ethical issues are unavoidable – part of the fabric of human life. In health care they arise at policy level, with governments deciding which services, professions or research should receive most funding, or devolving those tricky rationing decisions to local level. One topical example is assisted conception: should this be provided by the National Health Service

or should couples go private? Is it acceptable that availability of the state-funded service should depend on your postcode?

Even more pressing for the practitioner are the ethical issues which constantly arise in their daily work. At every turn they are required to make snap decisions about what to do for whom and how to do it. When staffing levels are low and clients' needs seem endless, how can they choose between competing, sometimes conflicting, demands? Who gets my attention first, the woman screaming in the corner or the one next to her in a wet bed? What do I say when the patient has not been given information about his diagnosis but the family has? These are real dilemmas which the practitioner often feels obliged to solve (or sidestep) in isolation, at the risk of being chided or punished for making the 'wrong' choice.

Any book which aims to stimulate debate on ethics in nursing is therefore to be welcomed. This one has a particularly innovative emphasis on the transcultural dimension. By taking a European perspective, with authors, case studies and examples from a wide range of countries, it enables us to flush out our taken-for-granted views and examine them in the light of others' experiences. It reminds us of the diversity of ethical views within our own multicultural, multi-ethnic societies: no homogeneous societies now exist, if indeed they ever did.

Comfortingly, though, there may be as much that unites us as divides us. As Tadd points out, 'transcultural ethics relies on a moral sense which originates from our shared humanity and shared human experiences... these elements of humanity all arise from basic fears, beliefs and values which are common across all cultures'. I found this to be true in my last job at the World Health Organization, where as Regional Adviser for Nursing and Midwifery in Europe, I worked with nurses from, and visited them in, many countries – from France and Spain in the west to Russia and Kazakstan in the east, all under the WHO umbrella of 'Europe'.

I observed a multitude of customs, assumptions, nuances, behaviours and attitudes, yet all of us were indeed united by shared humanity and shared experiences – and we also shared a passionate belief in the potential of nursing to cross the divides

of gender, race, age, sexuality and so on, to join hands in empathy to alleviate suffering and help each other through hard times. This book provides stimulating, thoughtful and well-informed debate to help us find our way through the moral mazes and thereby enrich our own, our colleagues' and our patients' lives.

JANE SALVAGE, RGN, BA, MSc HONLLD
Editor-in-Chief, *Nursing Times*

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1

Setting the Scene

Win Tadd

Introduction

One of the first questions posed to me when discussing the initial idea for this book was 'Is there a European perspective to nursing ethics or indeed, can there be?' Europe after all is enormous in geographical terms, comprising some 50 or so countries and encompassing a vast diversity of values, languages, cultures, races and religions. At a superficial level therefore, one might be led into thinking that the multicultural, multilingual and multi-ethnic continent of Europe is distinguished by its diversity, rather than its similarity. This, of course, is the stuff of ethical relativism which has a long tradition in philosophical literature. In simple terms it refers to the notion that moral values are relative to a particular culture and therefore they cannot be judged by the standards of other cultures or societies. In support of such a stance, an ethical relativist might argue that such a position encourages tolerance and humility, as the moral actions of a particular society should only be judged against its own standards and as we can never fully understand another culture, then will we ever able to judge it? By pointing to the fact that there is little agreement on what are fundamental moral values, the relativist might also claim that there is no credible alternative to his position.

Such arguments can, however, be challenged on a number of points. For instance, what is a culture? Do cultures approximate with geographical or national boundaries? If they do, then why do we hear of the north–south divide in our own country? How was civil war possible in the former Yugoslavia?

Second, is it only from our culture that we acquire moral values or do these arise as a result of religious following, education, family socialization and such like? If so, then one can see that relativism soon disintegrates into ethical subjectivism.

To argue against moral relativism is not simply to argue for moral absolutism which claims that there is only one, true moral code and that anyone who does not accept this is wrong. There is a middle ground provided by moral pluralism which asserts that there may be different moral theories and values which may each apprehend part of the truth of a moral life although none of them has the entire answer. It is through this stance that the possibility of transcultural ethics (Campbell *et al.*, 1997, p. 40) emerges.

Transcultural ethics relies on a moral sense which originates from our shared humanity and shared human experiences, so that although various cultures may express miscellaneous aspects differently, perhaps because of different histories, these elements of humanity all arise from basic fears, beliefs and values which are common across all cultures (Wilson, 1993). Examples of commonly held moral values, include, for example, the view that it is always wrong to take an innocent life and that incest is wrong. The basis for this book, therefore, is that as humans we have more in common than we have dividing us and that by gaining knowledge, understanding and insights into our differences, not only can we learn to respect and value those differences, but we can also learn from them, increasing our own moral repertoire by highlighting our own moral blind spots. Perhaps more importantly, we can learn to live in a moral community where everyone, regardless of culture, race, nationality, religion or gender, is afforded dignity and mutual respect. Thus although there may not be one single European perspective on the ethical issues confronting nurses within their practice, there are many shared values, such as compassion, respect and concern for the weak and vulnerable, among nurses in relation to their practice. There are also common difficulties within the nursing role. Although the nursing role is central to all European health systems, its centrality is rarely acknowledged. As Colliere (1986) identified, many elements of nurses' work, although essential to service users, remain invisible and are therefore disregarded by, for example, studies of nursing workload. In part this is due to

the gendered nature of nursing and the classification of nursing as women's work. As such, nurses are invariably excluded from the political and economic decision-making about health care, despite the fact that it is nurses (and patients) who are usually the first to encounter the grim realities which result. As Chilton demonstrates in Chapter 4, even when nurses paticipate in policy decisions they lack the authority and power invested in other professional groups to ensure that their voices are heard or listened to. As tensions increase in European health services due to increased demands, rising costs and reduced resources, the ethical challenges facing nurses will escalate and the need for increased understanding and unity will grow.

Nursing in Europe

The sentiments and views expressed above are of particular importance to European nurses, of whom there are approximately 1,700,000 registered within the countries of the European Union alone (Evers, 1997, p. 172). The pace of change in Europe over recent years has been considerable. The collapse of totalitarian regimes in Eastern and Central Europe, the conflicts and civil unrest in Albania, Northern Ireland and the former Yugoslavia, the redrawing of national and political boundaries, the economic recessions experienced in many European countries, the enlargement of the European Union – none of these events takes place in a vacuum and all of them affect health care and nurses, both individually and as a professional group, in a variety of ways. Also nurses, like everyone else, are members of society and as such are influenced by changes in their environments.

Much of the human pain and destruction caused by armed conflict is witnessed by nurses and health care personnel who try to maintain a service in conditions which most of us cannot begin to imagine. The collapse of political structures means that health services must be rebuilt, invariably in the face of material, technological and human shortages. Old reference points are lost at such times, resulting in uncertainty and the need to renegotiate relationships and rethink philosophies. Most countries in Western Europe are struggling to maintain levels

of service, in times of economic recession added to by falling revenue from increasingly ageing societies and the escalating costs of technologically advanced treatments for which the public expectation is rising. The move to market-based economies, regardless of where this is happening, inevitably results in winners and losers in the health stakes. Resources, when available, are prioritized and frequently it is the most vulnerable, the elderly, the chronically ill, the poor as well as children and women whose needs are unmet. Diseases thought to be long eradicated, like tuberculosis and malnutrition, have begun to re-emerge even in the wealthier countries of Europe. Worsening violence in our societies both as a result of crime and civil wars results not only in physical injury but psychological trauma. Illnesses and health needs whose existence was denied by totalitarian regimes, such as the AIDS epidemic and the plight of people with learning disabilities (mental handicap) in Romania, are now evident and must be dealt with. Across Europe, it is the millions of nurses who have to face these challenges and difficulties on a daily basis. It is these common challenges and experiences which not only generate many of the ethical dilemmas faced by nurses, but also form the basis of nurses' shared values and against which the topic of nursing ethics can be discussed.

In addition, nurses from the EU have the freedom to seek work in any EU country and a number of European directives mean that many nursing qualifications have common recognition. Study programmes such as Socrates and Leonardo da Vinci have created increasing opportunities for nurses to study abroad and a range of programmes designed to support and improve nursing services in the former communist countries of Central and Eastern Europe all mean that throughout Europe there is increasing scope for nurses to travel and work in countries other than their own. To a large extent nursing has always had a long history of sharing knowledge and experiences at both the European and international levels within a variety of frameworks. For example, the International Council of Nurses founded in 1899 represents nurses from diverse backgrounds and settings; the World Health Organization created in 1948; together with a number of European bodies such as the Standing Committee of Nurses of the EU (PCN) established in

1971; the Advisory Committee on Training in Nursing set up in 1977; and the European Nursing Group based on the Council of Europe with its wide membership and very strong links with the newer democracies of Central and Eastern Europe are all evidence of this tradition of sharing. There are also an increasing number of informal networks, such as the European Oncology Nursing Society; the European Association of Nurses in AIDS Care; the Working Group of European Nurse Researchers and the International Association of Bioethics, Nursing Ethics Network. A two-day seminar, organized jointly by the Standing Committee of Nurses of the EU and the European Nursing Group and entitled 'New European Structure for Nurses' was held in Niedernhausen, Germany in 1995 and enabled many of these formal and informal groups to meet each other and discuss the future organization of nurses and nursing at the European level. Since the first seminar, two others have been held, one in Madrid, Spain in 1996 and the other in Delphi, Greece in 1997.

It is hoped that this book, being prepared in the European Year against Racism and Xenophobia, will add to these efforts and aspirations and help to increase ethical and cultural awareness and knowledge among nurses throughout Europe.

The rest of this book

Nursing ethics is a growing area of concern and knowledge throughout the world. My interest began in the early 1970s as a clinical teacher in a major intensive care unit in a London teaching hospital where many personal experiences forced me to face the moral dimensions of everyday nursing practice. Since then over many years teaching nurses I was both moved and troubled by the stories which both students and qualified nurses recounted. What was particularly disturbing was that many of these nurses had carried their stories, not to mention a great deal of grief and guilt, within them for a very long time, feeling that there must be some weakness in them to feel as they did. Nurses, after all, just cope with the difficult aspects of their roles, don't they? This interest finally led me to launch into doctoral studies in the area of applied ethics and my PhD

explored the nature of moral agency in the context of the nurse's role and afforded me the privilege of collecting over 400 critical incidents from nurses around the UK and in the USA, as an International Fellow at the Hastings Center, New York.

Since the advent of the new Diploma studies in nursing education (affectionately referred to as Project 2000) the study of ethics has been given a much higher profile in nursing curricula and consequently nurses in the UK are becoming better equipped to both deal with and discuss the issues and challenges posed by their practice. The same, however, is not true in other European countries.

In Central and Eastern Europe, for example, inroads into the subject are only just being made (see the chapters by Brykczynska, Northway and Reed in this text). In Italy, a government edict has recently ruled that ethics is to be removed from nursing curricula in all but a few Italian universities as it is felt that nurses do not need a detailed knowledge of the subject (Sala, 1997). The aim of this book, which is hopefully the first in a series, is to stimulate debate on the subject of nursing ethics, by nurses at all levels in their career and in all areas of practice. Although it is not possible to provide accounts of nursing ethics from every country in Europe, most authors have explored the ethical issues relating to various client groups from the perspective of the UK and at least two other European countries, so that a considerable number and variety of insights can be gained.

In the following chapter Win Tadd begins her discussion by arguing against Hunt (1994) who claims that nurses do not need a detailed knowledge of moral principles and theories. She claims that it is only through understanding these various approaches that nurses can think through the dilemmas that confront them in a rational and consistent manner. More importantly, it is from such knowledge that nurses' ability to mount arguments, justify their actions and challenge those of others, in cases of interprofessional conflict, can be developed. She provides an outline of the major ethical theories, principlism, deontology, utilitarianism, virtue ethics and the ethic of care, which influence moral decision-making in the Western tradition while acknowledging that there are many other approaches that might well be pertinent to nursing ethics in a continent

as diverse as Europe. Finally she provides a framework for moral decision-making.

In Chapter 3, Astrid Norberg gives an account of the findings of a number of international studies in descriptive ethics which she has undertaken to explore nurses' moral reasoning in ethically difficult situations. The majority of these involved nurses from across Europe. After relating the concept of caring to relational, as opposed to action, ethics, Norberg describes first a study undertaken within an action (normative) framework followed by accounts of those which emphasize approaches based on relational ethics. In managing ethically difficult situations she proposes (as does Gournay in a later chapter) that nurses can be greatly assisted by systematic clinical supervision which can help nurses to understand patient behaviour and see them in a more positive light.

Norberg closes her chapter with an account of Logstrup's ethics. This approach, as well as combining problem-solving with the apprehension of a moral sense, also emphasizes the interdependence which exists between people and thus, claims Norberg, is an appropriate approach for nurses.

Christine Chilton's chapter explores the nurse's role as a health educator in France, Finland and the UK. After defining terms such as health education and promotion, Chilton gives a detailed account of the various approaches and roles which nurses can adopt in undertaking health education/promotion. Her major concern is with empowerment and the promotion of autonomy and she argues that there is a need for nurses to be empowered if they, in turn, are to be able to promote the decision-making capacity of their patients and clients. In doing so she draws on many contemporary examples from each of the three countries.

In Chapter 5, Rosie Tope and June Smail explore the ethical issues facing community nurses in Greece, Sweden, Finland and the UK and, rather than focusing on one theme, they discuss a range of ethical issues facing nurses in each of the countries. These include: policy development and the allocation of resources; balancing interests; patients' rights; justice and inequalities in health care; interprofessional working; confidentiality and adolescents; professional duties in the context of role expansion and autonomous practice; and competence.

Chapter 6 by Helen Crafter and Cathy Rowan deals with the ethical issues in maternity care in the UK, Italy and Iceland. The issues chosen for exploration include pre-natal screening; women's right to autonomy in pregnancy and childbirth; the role of the midwife, the value placed on women's autonomy and the value placed on the midwives' autonomy. The authors go on to draw comparisons between the countries at both the levels of policy and practice and postulate possible reasons for the differences.

In Chapter 7 Gosia Brykczynska considers paediatric nursing in the context of the United Nations Convention on Children's Rights. The countries selected for comparison are Poland, France and the UK. Before embarking on this, however, Brykczynska gives a very useful account of rights theory before discussing four of the most pertinent articles of the convention in relation to paediatric nursing practice.

In the following chapter Ruth Northway focuses on the ethical issues involved in the integration of people with a mental handicap. She discusses the right to community living, the question of choice and the problems surrounding the integration of this client group into health care. The countries chosen for discussion are Albania, the UK and the Republic of Ireland. Like many other contributors, Northway emphasizes that if nurses are to improve conditions for their clients they must become politically aware.

Kevin Gournay's chapter concerns the ethical issues which arise in mental health nursing. After providing an overview of mental health services in Europe, he centres his discussion on the issues of confidentiality, sexual and personal relationships, compulsory treatment, continuing professional development and issues connected with the elderly and mental health problems. He draws on examples and illustrations from Italy, the Netherlands, the Czech Republic and Eastern Europe and Scandinavia, comparing and contrasting these with the situation in the UK.

The subject of caring for older people provides the topic for discussion in Chapter 10. Jan Reed explores the issues of difference and distinction in relation to older people and asks whether these allow their particular needs and problems to be more effectively addressed, or whether they serve merely to create unhelpful divisions which result in discrimination. These

questions are considered largely at the level of policy formulation in Denmark, Bosnia and the former Yugoslavia and the UK. However, Reed provides an illuminating account of the relationship between the political and policy levels and care delivery. She emphasizes the need for nurses to appreciate that nursing care is provided in political and social contexts and that these shape nursing practice in powerful ways.

Chapter 11, 'The Ethical Issues in Critical Care Nursing', is written by Kevin Kendrick. After arguing strenuously for shared decision-making in critical care areas, Kendrick goes on to compare and analyse the very different experiences of Swedish and UK nurses. Following this analysis he then discusses the concept of ethical advocacy and the problems associated with deciding who should determine what the patient's best interests are in any particular situation.

The final chapter by Verena Tschudin explores nursing ethics at the end of life, comparing practices in the UK, Switzerland and the Netherlands. The issues considered include neonatal care, persistent vegetative state (PVS), care of the dying, organ transplantation, euthanasia, advance directives and resuscitation. She draws particular attention to the effect of a market-led economy on the value placed on any single life, the need for skilled communication and the importance of virtues such as compassion, empathy and courage.

Nursing ethics, as a branch of applied ethics, is both exciting and expanding and it is hoped that this volume will contribute to its development by exposing new vistas, visions and directions in what is an essential field of enquiry.

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2

Ethics in Nursing

Win Tadd

Ethics in nursing

In the introduction to his textbook, *Ethical Issues in Nursing* (1994) Geoff Hunt decries the manner in which ethics is being introduced into nursing curricula throughout the UK. He states,

> many ethics courses presuppose that nurses have a need for 'help with moral decision-making' and that to satisfy this need they should be taught 'moral concepts' or 'principles' or even 'moral theory'. It is assumed nurses need yet another *procedure*, a framework of rules, which they can apply to the situations they encounter at work... In the case of ethics many appear convinced that a heavy dose of theories and principles carrying labels like 'deontology or utilitarianism', 'beneficence', 'non-maleficence', 'autonomy', 'quality or sanctity of life' will fill the moral void in our health care system (p. 4).

He goes on to claim that people entering the profession already have the requisite skills and that what they do need is the opportunity 'to freely examine from cases, preferably in their own experience, the conditions which create disparities between what their ordinary moral sense tells them and what they are expected to do without question'. He states, 'Yet surely everyone knows that student nurses do already have the responses of honesty, promise-keeping, respect for others, privacy, self-esteem and do understand these concepts' (p. 5). Hunt appears to take for granted that nurses possess a range of moral virtues and also that they seek to display them within their professional life but that the hierarchical and bureaucratic system in which nursing is practised militates against

this. He states, 'To shed one's mufti and don a uniform is to be required to shed one's moral sense and don the metaphysics of procedure' (p. 5). The effects of working in such systems are well documented (Tadd, 1995) and should not be underestimated; however, to assert that nurses have no choice about how they practise is not helpful and merely reduces them to the status of an instrument or object to be manipulated by others. Nurses, like junior doctors, administrators and other health professionals, must frequently make choices within the constraints of the system (Downie, 1984). Sadly some choose to be indifferent, rude, brusque or even cruel (Kelly, 1988; Laungani, 1992). An education in ethics is no guarantee that such individuals will practise ethically, but it can do a great deal to assist those who do have a moral sense and yet feel the effects of what can be an oppressive system. Take for example the situation when a nurse is ordered to lie to a patient about their diagnosis or prognosis. If nurses are to take seriously their role in protecting the interests of patients or clients in such situations, then they must be able to recognize good and bad ethical arguments, and be able to mount their own arguments as clearly and confidently as their medical colleagues, who frequently and with little justification assume moral leadership in addition to their appropriate clinical leadership. An understanding of the language, ethical theories and concepts and how arguments are developed is necessary to give nurses confidence to speak out and ultimately to demand accountability of those who give the orders.

Whose ethics?

Before leaving this discussion of ethics and nursing, it might be interesting to highlight a debate within the whole field of professional ethics. This debate concerns the relationship of the ethics of various professional groups to ethics generally. For the purpose of this chapter the debate turns on the relationship of nursing ethics to the entire area of bioethics or health care ethics and there are at least two distinct viewpoints. The first view is that the term 'nursing ethics' is itself questionable as 'there is really very little that is morally unique to nursing'

(Veatch, 1981, p. 17). Viewed in this way, nursing ethics is classified as a subset of bioethics in much the same way as medical ethics.

The opposing view argues that nursing ethics is not simply a category of bioethics but instead '[it] raises serious questions about the aims of theory formation in ethics, the meaning of philosophical principles of ethics, the nature of philosophical solutions to ethical problems and the modes of work necessary for progress in philosophical ethics' (Jameton, 1984, pp. xvi–xvii). Sara Fry (1989, 1992) also argues strongly that nurses need to develop their own unique theory of nursing ethics.

My own view is that as the same ethical principles apply to all professionals involved in health care there cannot be a distinct theory of 'nursing ethics', 'medical ethics' or for instance, 'physiotherapy ethics', if by distinct we are referring to a set of unique moral rules or principles to guide the nurse's actions. There are, however, considerable differences in the practices and roles undertaken by different health professionals and this can lead to variations in judgements about the morality of various actions of the different professionals. Thus although the same ethical principles might apply to all health professionals, the implications of these for the conduct of a particular individual may depend to some extent on the structure, power relationships and conventions of the health care system as it is these factors which shape moral responsibility (Tadd, 1995). It is for these reasons that 'Ethics in Nursing' must be given a significant place in the nursing curriculum and be based on a thorough understanding of philosophical ethics.

It is also at this point when Hunt's views about ethics in the nursing curriculum need to be taken seriously. After gaining an understanding of what he terms 'technical ethics', it is essential that nurses examine the 'negative ethics' or the politics of the system which prevents them from doing what they have reasoned is the best course of action. Aristotle accurately linked politics and ethics and many of the ethical issues in European nursing can be traced to the way that health care is structured and the way in which the roles of the various professionals involved are shaped. It is only by extending the study of ethics to incorporate a political dimension that hierarchies and bureaucracies will be challenged and new systems of health care which

ensure equality and afford individuals respect and dignity will be introduced. This volume is intended to contribute towards this goal.

It is also worth pointing out that if nurses wish to have a voice in bioethics or health care ethics, then pursuing a separatist approach may prove unhelpful and isolate them from the mainstream of ethical debate.

Approaches to ethical decision-making

Nurses face moral issues daily in their work and dealing with them is frequently, if not increasingly, perplexing and troubling. How exactly should we approach an ethical issue? How should we think it through? What questions should we ask? What factors should we consider? In one sense, each of us is faced with similar questions every day of our lives and indeed an important part of our early socialization involved us in learning that our actions are judged according to the moral rules that are widely accepted within our individual society. For example, as children we are taught not to steal, not to cheat, not to lie. A question frequently asked by children is 'Why?' and in order to justify particular moral rules different cultures turn to various sources.

Western approaches

Principlism

In Western cultures, the first source or level of justification is found in particular ethical principles such as that of respect for persons, the principle of respect for autonomy, the principle of beneficence or promoting good, the principle of non-maleficence or not causing harm, the principle of veracity, the principle of justice or treating others fairly. In turn, principles are justified by recourse to various ethical theories.

Many of the 'rules' found in nursing codes of ethics are underpinned by these principles. For example, clause 1 of the *Code of Professional Conduct* (UKCC, 1992), in demanding that nurses

always 'promote and safeguard the interests and well-being of patients and clients', reflects closely the principle of beneficence.

Similarly, a clause in the Finnish *Code of Nursing Ethics* (FNA, 1996) demands that the nurse 'respects the patient's autonomy and creates for the patient possibilities to partake in the decision-making concerning his/her care'. The *Code for Nurses* (ICN, 1973), in one of its clauses, emphasizes the principles of respect for persons, respect for the sanctity of life and justice, 'inherent in nursing is respect for life, dignity, and the rights of man. It is unrestricted by considerations of nationality, race, creed, colour, age, sex, politics or social status.'

Until very recently Western literature on nursing ethics has focused almost exclusively on these ethical principles rather than theories, as not only are these easier to apply in day-to-day situations, but also viewing a problem from the standpoint of the various principles can ensure that a wider view is taken than would be the case from a single theory (Edwards, 1996). A major criticism of this approach is how to judge between principles when they coincide, such as when a nurse has to override someone's autonomy in order to either promote good or (beneficence) or prevent harm (non-maleficence). Despite this, the approach has much to recommend it, in particular its impartiality. This is not to say that an understanding of the various ethical theories is unimportant, however, as it is through these that ultimate justification is found.

A full coverage of the most influential ethical theories is not possible within the confines of an introductory chapter and for detailed accounts of the various theories readers are referred to the suggestions given for further reading. It is hoped, however, that an outline of the theories will assist the reader to appreciate the various influences in shaping policies and practices in health care generally and nursing in particular.

Deontology

This theory is most commonly associated with the German philosopher Immanuel Kant (1724–1804). It is a theory which focuses on duties and obligations and one in which the rightness or wrongness of an action is largely determined by the

nature of the action itself. An approach from the deontological standpoint demands adherence to the principle of universalizability[1] and is stated in Kant's first formulation of the Categorical Imperative[2], 'act only on that maxim through which you can at the same time will that it should become a universal law' (Kant, 1964, p. 88). Kant's second formulation of the Categorical Imperative, 'act in such a way that you always treat humanity, whether in your own person or in the person of any other, never simply as a means, but always at the same time as an end' (Kant, 1964, p. 96), emphasizes the importance of the very broad and central principle of respect for persons in deontological theory. It is these formulations which result in a system of moral duties which must be fulfilled. If we consider truth telling, Kant would argue that because we are all rational beings, the universalizability of the moral rule which requires that everyone tells the truth is self-evident to a rational moral being and therefore truth telling is a moral duty. Also, the reason why we must tell the truth is not because it brings about good consequences, but because it is a moral duty. If I told you the truth because I wanted you to think well of me, rather than because of my duty to tell the truth, then I would not be performing a moral duty but would be acting from my own ulterior motives. In such a case I would not deserve any praise for being moral even though I have performed a morally right act. This demonstrates the emphasis which Kant places on the intentions and motives of the individual.

Kant links moral activity to being autonomous, as our acts are determined by our own rational will. When we act from desire or fear, or we unthinkingly follow orders, we are heteronomous as what we do is being determined by something or someone other than our own reason. For example, if I do not steal because I am afraid of being caught, then according to Kant, I am not acting in a morally praiseworthy or autonomous manner. Kant believed that each of us is our own moral authority and no-one else can dictate what our moral actions ought to be. In the same way, we must each respect everyone else's moral autonomy.

There are many aspects of Kant's theory which sit happily with our view of ordinary life. Clearly, most of us live by common-sense rules of morality and the wrongfulness of

certain actions such as killing or stealing complies with the Categorical Imperative. The central notion of respect for persons is also very compelling as a central value in morality. Kant's theory likewise provides a secure foundation for the notion of individual rights which has gained increasing prominence in our everyday lives. Yet there are some problems with this approach.

First, there is no apparent way that priorities between perfect duties can be decided should they conflict. Imagine living in a country where civil war is raging. Your best friend, a resistance fighter, has asked you to keep secret the fact that he is in hiding near by. You give a promise not to tell anyone but a short time later the ruling militia knock at your door and you are questioned as to the whereabouts of your friend. The conflict in this case is between the perfect duties to tell the truth and to keep promises and as an agent you would have to decide whether to lie and keep your promise or to tell the truth (knowing that your friend would be shot as a traitor) and therefore break your promise. In other words, Kant cannot deal effectively with conflicts of duty.

A second criticism is that the absolute nature of perfect duties such as keeping promises or truth telling appears to need more justification than he offers. In the above case, for example, most of us would argue that saving a life is more important than telling the truth. It appears therefore that Kant has either overstated the importance of certain perfect duties such as lying or promise-keeping, or he has failed to recognize the significance of certain imperfect duties such as beneficence. This can be very troublesome for the nurse. Suppose, for example, that a female patient in her early thirties is admitted for investigation and, while talking to the staff nurse one day, tells her how before she came into hospital she felt so ill that she was sure she had cancer and that the thought of this terrified her as her father had died of cancer and, in the process, had suffered a great deal of pain. The patient then asks the staff nurse to promise to tell her about the results of any of the tests which she has undergone, as she is feeling so much better she is sure that it could not be anything too serious and she is keen to get on with her treatment and return home. The staff nurse reassures the woman and promises that she will tell her as

soon as she hears anything. The following morning, prior to seeing his patients, the consultant informs the nursing staff that the patient has an inoperable cancer and that her husband does not want his wife to be told about her illness as, since her father's death, she has always expressed her dread of cancer. The staff nurse tells the consultant of her conversation with the woman and that, although she is unhappy about lying to her, she really believes that the patient will not be able to cope with the truth, at least initially, and that she may ultimately do better if she is not informed about the nature of her illness. Thus the perfect duty to keep the promise conflicts with the imperfect duty to promote beneficence and it is not clear how such conflicts can be resolved for the nurse concerned, particularly in this instance when it is unclear whether it is in the woman's best interests to know the truth.

In an attempt to overcome these difficulties, W.D. Ross (1930) provided a different account of the nature of duties by introducing the idea of prima facie duties. Ross denies the existence of any absolute duties, claiming that they are always prima facie or conditional. Unlike a utilitarian who would claim that the moral basis for an agent's duties must flow from the Principle of Utility, or Kant who claimed that it is the Categorical Imperative which provides this basis, Ross denies that duties have any such singular origin. Instead, he claims that duties arise from the morally significant relations which one has and that, 'each of these relations is the foundation of a *prima facie* duty, which is more or less incumbent on me according to the circumstances of the case' (Ross, 1930, p. 19).

In unambiguous circumstances, when an individual only has one prima facie duty then this becomes her actual duty, but where there is competition between different duties, only one can be actual. The dilemma of deciding which prima facie duty should be acted upon cannot be determined by the application of hard and fast rules. Instead it can only be resolved by carefully reflecting on which of the prima facie duties should be given priority in the prevailing circumstances. This decision-making is not simply arbitrary as some might wish to claim rather, 'each rests on a definite circumstance which cannot seriously be held to be without moral significance' (p. 20). Ross goes on to classify the various prima facie duties into duties

of fidelity; duties of reparation; duties of gratitude; duties of beneficence; duties of non-maleficence; duties of justice; and duties of self-improvement.

At first sight this framework appears helpful to the nurse in deciding which duties she should fulfil. If we re-examine our previous case for example, it can be seen that the nurse would have competing duties of fidelity and beneficence. One which demands that she keeps her promise to the patient and another which conflicts with the previous duty and demands that she does not divulge the test results, although this may cause her harm. Although Ross's framework enables the nurse to clearly identify her particular dilemma, it does not offer any conclusive guidelines as to which duty should be acted upon. Even reflecting upon the morally relevant relationships does not really appear to help. For instance, it might be argued that because the nurse shares a special relationship with the patient, special because it is one based primarily on trust, her duty to the patient should override other concerns. But what is her duty to the patient in this situation? The woman has admitted her dread of cancer resulting from painful personal experiences and yet she has extracted a promise from the nurse that she will tell her the results of her tests. Should the nurse reason that the woman only wants to know the truth as she believes she does not have cancer and that therefore her husband is correct that such news will be particularly devastating? Or should she act on the basis that the patient really wants to know regardless of what the diagnosis or prognosis is, even though this will cause great distress? For if she fails to keep her promise and thus lies, the nurse–patient relationship, along with any future care, will suffer as the nurse will be forced into avoiding the patient so as to evade being asked difficult questions. From this it is easy to see how the claim, that Ross's system of prima facie duties results in no more than an appeal to intuitionism in situations where different duties conflict, can be made.

Ross's classification of duties offers no more help, therefore, in deciding or prioritizing conflicts between various duties than did Kant's and this is a major criticism of deontology. Despite this, however, the notion of duty is significant in nursing and has been since its earliest beginnings.

Consequentialism

Consequentialist theories, of which utilitarianism is probably the best known, hold that no action is intrinsically right or wrong. Instead, they are right or wrong according to their consequences. In its classical formulation, utilitarianism is found most prominently in the works of two English philosophers, Jeremy Bentham (1748–1832) and John Stuart Mill (1806–1873), and is perhaps best known under the slogan 'the greatest happiness of the greatest number' which under Mill became known as the Principle of Utility. This Principle of Utility states that actions are right if they bring about an increase in happiness or pleasure, or a decrease in unhappiness or pain, and that actions are wrong if they bring about an decrease in happiness or pleasure or an increase in unhappiness or pain. In the example cited above about the clash between keeping a promise to a patient to divulge the results of her tests and keeping an unpleasant diagnosis from her, a nurse adopting a utilitarian approach *might* reason that breaking her promise to the woman will cause more unhappiness in the long term as when the patient ultimately realizes the seriousness of her condition she will not only have lost trust in health professionals but will have been denied the opportunity to arrange her personal affairs and say her goodbyes to her family. This is despite the fact that there will be distress and sadness, even fear, in the short term. She may therefore decide that, on balance, greater happiness and less unhappiness will result if she tells the woman the truth. It should be remembered that an example such as the one above is precisely that, an example, stripped of its context and therefore some of its reality, to demonstrate how a utilitarian might reason about a very difficult situation. In practice, dilemmas are rarely as clear cut.

To determine the amount the pain or pleasure Bentham devised a calculus which considered factors such as intensity, duration, certainty, propinquity (proximity), fecundity (abundance), purity and the extent, in calculating amounts of pleasure or pain, and this was one element of his theory which attracted a great deal of criticism as happiness and pain are subjective and therefore virtually impossible to calculate. Bentham recognized that people vary greatly in their prefer-

ences and indeed on what they classify as pain. It was this recognition which led him to declare that so long as the quantity of pleasure is equal, 'push-pin is as good as poetry'.

John Stuart Mill developed and refined Bentham's work and the doctrine of utilitarianism. Mill rejected Bentham's notion that 'push-pin is as good as poetry' by distinguishing between higher and lower pleasures. Utilitarianism was eagerly adopted by many people in Victorian Britain who were concerned with developing a practical morality through which they could judge actions, thus utilitarianism greatly influenced nineteenth-century social policy. Utilitarianism was also believed to be just as each person's happiness (or pain) counted for the same as the next person's. As most individual actions take place within the framework of a community they therefore impact not only on the actor but also on the lives of others. For example, although I may derive a great deal of pleasure from playing my music at a high volume, my neighbour's peace may well be disturbed by my actions and if taking place late at night may deprive him of sleep. Utilitarianism demands that in any calculation everyone's interests are weighed.

Bentham and Mill are often referred to as hedonistic utilitarians as they imagined utility only in terms of happiness or pleasure (Beauchamp and Childress, 1994, p. 48). Happiness or pleasure, however, are not the only values with intrinsic worth and some utilitarian philosophers have adopted a pluralistic stance by putting forward a range of values which have intrinsic worth and therefore ought to be promoted. Other contemporary utilitarians (Singer, 1979; Hare, 1981) have argued that neither the hedonistic approach of Bentham or Mill nor the pluralistic stance of Moore (1962) are adequate to determine right action objectively. Instead they claim that 'what is intrinsically valuable is what individuals prefer to obtain, and utility is thus translated into the satisfaction of those needs and desires that individuals choose to satisfy' (Beauchamp and Childress, 1983, p. 23). Preference utilitarianism demands that in all situations we should act so that we produce the greatest balance of all the individuals affected, satisfying their preferences over them not satisfying their preferences. One major difficulty with the preference approach is how to deal with people who have morally unacceptable preferences, for example those who prefer

inflicting harm or pain on others. The main response offered to this problem is that common sense, together with previous experience, are sufficient to determine unacceptable preferences and these are excluded 'on more general utilitarian grounds', that is, they would not contribute to the general good (Beauchamp and Childress, 1983, p. 24).

Another distinction frequently drawn is between act and rule utilitarianism or consequentialism.

Act utilitarianism

Act utilitarianism demands that an individual considers each action in isolation and should choose that which produces the greatest balance of happiness/pleasure/good (utility) over unhappiness/pain/evil (disutility), everyone considered. The act utilitarian therefore must look at a range of alternative actions and choose the one which brings about the best consequences.

One difficulty lies in the fact that determining all of the consequences of our individual actions is not as straightforward as it might at first appear. Imagine that my unfortunate neighbour is severely depressed when I decide to play loud music until the early hours. The effect of the persistent beat of my music is that he takes an overdose of tablets which results in a prolonged admission to hospital, loss of earnings and the breakdown of his marriage.

A second difficulty is that it is difficult to weight various types of human pleasure or satisfaction and, for that matter, displeasure, pain or inconvenience.

The major problem with act utilitarianism, however, is that it appears to allow any action whatsoever as long as this results in increased utility. This might include killing off ill elderly patients so that resources are available to the younger members of the community who contribute to a country's economic wealth. Torturing innocents, experimenting on prisoners, nothing appears to be ruled out.

A further difficulty is that this philosophy does not allow for any significant relationships which impose particular obligations and are a feature of most our lives. Such relationships might include those of husband and wife, parent and child, nurse and patient. Each person is to be counted as one and only one.

For all of these reasons most utilitarians have rejected act utilitarianism in favour of rule utilitarianism.

Rule utilitarianism

In rule utilitarianism a moral code is established by deciding which moral rules, if followed, would produce the greatest utility and the least disutility. Individual actions are morally right if they then accord with the general rules. Rules such as do not kill, do not harm innocents, do not steal, do not lie, do not break promises which, when followed by everyone, will generally produce more happiness than unhappiness.

Although rule utilitarianism addresses most of the problems that act utilitarianism raises, there remain some difficulties. First, clarification is needed about exception to rules, especially when one rule is in conflict with another. For example with our unfortunate couple above, a rule utilitarian must presumably ask, 'would the adoption of the rule with the exception (do not lie except when necessary to prevent breaking a promise) have better consequences that the adoption of the rule without the exception (do not lie)?' If the answer is affirmative, then the exception would be justified. However, rule utilitarianism does not overcome the basic difficulty which utilitarianism and consequentialism raise and that is that the majority will always tend to win over the minority, and when this type of reasoning is applied to allocating health care resources obvious difficulties arise.

Both deontological and utilitarian theories focus on the performance of actions. There is, however, another category of theories which takes as its focus the character of the agent rather than the actions which he or she performs.

Virtue ethics

There has been a resurgence of interest in virtue ethics since the publication of the first edition of Alasdair MacIntyre's book *After Virtue* in 1981, and these theories are now percolating into nursing. In a way this represents a full turn of the wheel as Florence Nightingale, responsible for the development of professional nursing in late 1800s, emphasized the importance

of good character. For her, to be a good nurse one must first be a good woman and what constituted a good woman can be found in the qualities she expected of recruits into nursing. These included sobriety, loyalty, honesty and truthfulness and, according to Nightingale, these qualities formed the foundations of moral character upon which nurse training would inculcate the habits of punctuality, trustworthiness, personal neatness and obedience.

The claim of virtue ethics is that the application of principles or ethical theories of action depends on people being of good character and sound judgement. This is not to claim that there is no relationship between action and character, as clearly, how an individual acts often provides important evidence about her character. Similarly, specific character traits lead to certain actions, for instance when a compassionate person displays her compassion through compassionate acts. For a complete picture of morality, however, it is necessary to consider the internal qualities or characteristics which are essential for moral agency and which are at the heart of virtue ethics.

The main question in virtue ethics is, 'What kind of person should I be?' and has its origins in Ancient Greece. Although Socrates and Plato were both deeply concerned with virtue, it is invariably with Aristotle's account that contemporary philosophers commence their expositions. It should be emphasized that virtue is a complex concept as over the ages it has acquired certain connotations which were not originally present. For example, today, being virtuous implies that a person is wholesome, or trustworthy, or a decent sort who puts others before herself. It also has uncomplimentary associations, such as being a 'goody-goody'. In Ancient Greece *areté* or virtue had a very particular meaning and certainly had no negative connotations. Then it was used to refer to a person who displayed excellence in whatever they did. Contemporary notions of virtue such as benevolence, meekness or selflessness are in fact the antithesis of the virtue of classical moralists and the modern word 'virtuosity' might more effectively capture the notion of excellence evident in early Greek accounts of virtue.

According to Aristotle, a virtue is a habit (*hexis*) or disposition of character, concerned with choice, which is manifested in emotions; it seeks the mean in all things relative to us,

where the mean is determined through reason; as defined by a prudent or wise man. These dispositions are not inborn or natural, but are chosen and acquired through practice and this, like the evocation of appropriate feelings, has implications for moral education which should focus on the development of the individual's character by inculcating appropriate habits or dispositions.

Virtue is not, however, merely a matter of acting in a certain way, one must also feel in appropriate ways. Thus, a virtue or an excellence of character is a settled disposition, and any action which displays virtue will also involve the display of some emotion such as desire, anger, fear, confidence, envy, joy and such like. For example, courage is an excellence of character (virtue) displayed in relation to the emotion of fear, while cowardice is a defect of character (vice) displayed in relation to the same emotion.

For Aristotle, there is no emotion which is either good or bad in itself, rather it is the state of character or disposition to display an emotion either appropriately or inappropriately which is deserving of praise or blame. What is necessary, therefore, is some way of deciding what is appropriate and for a complete understanding it is necessary to consider what Aristotle calls the doctrine of the mean.

Exercising a virtue involves the use of practical reasoning (reasoning which leads to action) in judging the mean between two extremes, one of excess and one of deficiency. Courage, for example, is the middle ground between cowardice, which is too little, and foolhardiness, which is too much. Displaying virtue involves finding the mean at the right time, on the right grounds, towards the right people for the right motive and in the right way. As to how one would determine the mean Aristotle has much to say, and he emphasizes both the role of reason and observation of those who possess practical wisdom. In particular he stresses three points.

First, one should try to avoid the excess which is most erroneous, so that for example in relation to modesty, shyness might be less evil than shamelessness. In this way one chooses the lesser of the two evils.

Second, everyone has a natural tendency to err on one side or other of the mean and therefore we must try to steer

ourselves in the direction of the other extreme. If an agent has a natural tendency to cowardice then she ought to make a deliberate attempt to veer towards foolhardiness, thereby moving closer to the mean.

Finally, one must always be aware of, or on one's guard against, pleasure (one might wish to insert self-interest) because our judgement of pleasure is not impartial.

Despite his practical advice, Aristotle acknowledges that hitting the mean is extremely difficult and exact rules or comprehensive general principles cannot be laid down. It is more a decision which lies with perception and one has to be present in a situation to be able to judge or evaluate it. Only in this way can a person take account of the significant factors or values. Thus knowledge gained through experience which he termed *phronesis* or practical reasoning is important in knowing how to act in accordance with virtue.

In summary, therefore, according to Aristotle, virtues are those excellences of character which are settled dispositions of choice, in a mean relative to the individual, such as a wise person would determine, from the particular context, acting in accordance with practical reasoning or wisdom.

This notion of practical reasoning is important in Aristotle's account of virtue as it relates to the difference between the responsible actions of an adult and those of a child or an animal. According to Aristotle, the child or the animal are driven by passions such as hunger or anger, while the voluntary actions of a responsible adult can be influenced by his or her own internal monitoring. This internal monitoring or evaluation involves awareness of the possible outcomes within a particular situation; the awareness of choice between these outcomes; awareness of the different ends which may be worth either attaining or avoiding in relation to the possible alternatives; and a deliberate act of judgement involved in choosing and acting.

Thus, good people will have the ability to reason well about what is good for their lives as a whole and such deliberation will lead to the performance of actions in accordance with the virtues necessary for the good life. This aspect of reasoning is practical, social and political and necessarily involves others with whom we interact, influencing how we behave towards them.

For each excellence, there will be some specific emotion whose province it is and the mean is exhibiting the emotion to the right degree. If an individual displays too little or too much of an emotion then she is exhibiting a defect of character or a vice. Finally, there are no emotions that are good or bad in themselves.

It can perhaps now be seen why virtue ethics is of interest to those concerned with professional ethics but one must exercise caution as it is important to question whether it is possible, or even desirable, to identify or separate what might be termed professional virtues, from those that are necessary for everyone to live the 'good' life. Nurses, like teachers, bankers and shopkeepers, cannot leave their personal values at the entrance to their workplace and don an alternative mantle of professional values. The virtues which the majority of people come to accept during their early lives, such as honesty, reliability, compassion, integrity, courage, justice and the like, are precisely the virtues which should be expected in one's working life. Indeed this may well be part of the problem which besets many nurses, in that they falsely believe that their professional role makes demands on them which in their private lives they would not countenance. Lying to patients might be just such an example. The effect of this segregation of personal and professional virtues is a denial and disintegration of the self, which often results in feelings of guilt and alienation (Tadd, 1997). This is the point which I believe Hunt was making in his plea for 'negative ethics'. However, rather than claiming that this reduces the need for knowledge of philosophical or 'technical' ethics, to use Hunt's term, I believe it strengthens the need, as with this knowledge nurses are better prepared to argue their position and are less open to the criticism that they are responding purely on an emotional level.

Part of the reason for the perceived difficulties in relation to one's professional life lies in the fact that today the vast majority of people, including professionals, are employees of organizations and institutions and this creates various tensions and conflicts. For example, not only may personal loyalties or obligations conflict with those of one's professional role, but also there are often inconsistencies within an individual's role which seem to demand inconsistent courses of action.

It is for this reason that general rules and guidelines such as those offered by the Codes of Professional Conduct can appear to call for different actions when a nurse tries to follow their demands in a specific situation (Tadd, 1997).

It is presumably for reasons such as these that Aristotle himself highlighted the importance of context, when he said that only the baker can tell when the bread is cooked (1976, p. 120). General rules about how long an average loaf takes might be useful, but this dough, made into this size loaf, in this particular oven, burning that type of wood, may be very different from the average loaf. Nurses therefore cannot escape the responsibility of making judgements and they must consider how to do this wisely.

Also it emphasizes the fact that institutions must not only acknowledge the importance of individual virtues in their members, they must also cultivate the type of climate where people are expected, and are encouraged, to exercise those virtues. At times this might well include displaying a sincere disagreement with institutional policies. Thus, in the framework of virtue ethics, political awareness and action cannot be separated from a moral life. This again echoes the opening debate at the beginning of this chapter, but unlike Hunt, I believe that this further strengthens the argument for a thorough understanding and application of philosophical ethics to both the role and context of professional nursing, since through this political awareness can be strengthened. Professional judgement is not only knowledge of a professional nature, but also the practical wisdom as to which particular disposition, and how much of it, to display in order to achieve the particular good to which one is devoted.

On the question of which virtues nurses should display or cultivate, it seems essential that nurses are not callous or selfish, dishonest or untrustworthy, timid or cowardly. Thus, it seems appropriate to include in the list (which in the confines of a single chapter can be neither complete nor comprehensive), compassion, honesty, courage, justice and integrity as important virtues (Tadd, 1995). Also, it must be remembered that virtues do not exist in a vacuum and so the moral environment of nursing practice must be such that appropriate virtues can be both fostered and practised. This has obvious

implications for health care institutions and for nursing education in particular.

Like other theories virtue ethics is not without its critics. Beauchamp and Childress (1994) suggest that virtue ethics alone cannot adequately explain and justify the rightness or wrongness of specific actions and they rightly point out that individuals of good character are not infallible, they can and do perform wrong actions despite being generally virtuous. Such individuals can for instance 'act on incorrect information about likely consequences, make incorrect judgements, or fail to grasp what should be done' (p. 69). Thus, the major criticism is that, as a guide to moral actions, virtue ethics lack specificity.

The ethic of care

A number of nurse writers claim that nursing needs a discrete approach to resolve the moral dilemmas and issues which arise as a result of the nurse's role and the current-day practice of nursing. The ethic of care originating in feminist ethics appears to offer a very alluring proposition for a number of reasons: nursing is predominantly female and the ethic of care is frequently portrayed as a feminine ethic; by focusing on care not only are medical toes not trodden upon as it is claimed that they travel the paths to cure; but also it offers nursing a distinctive function within the health care arena.

Generally the ethic of care suggests that women approach moral reasoning and moral activity in an entirely different mode from that used by men in that, rather than relying on abstract moral principles for guidance, they tend to focus on concepts such as care, responsibility and interpersonal connections (Gilligan, 1982). Certain quarters in nursing have readily grasped these developments, for if it can be shown that a feminist ethic based on care does in fact operate, then as a largely female occupation, whose unique function it is to care, nursing not only has a theoretical basis, but also an ethical imperative on which it can establish its claims to a distinctive role and over which it can legitimately exercise supremacy (Tadd, 1997).

The ethic of care highlights the significance of interdependence in relationships where the specific situational and contex-

tual demands are given due consideration along with values such as nurturing, caring, compassion and empathy (Noddings, 1984). A detailed exploration of this approach is not possible within the confines of this chapter and readers are again referred to the suggestions for further reading. However, some criticisms have been levelled at the approach which are important for nurses to consider.

The first criticism concerns justification. It is important that when nurses are called to care, they know precisely what is expected of them. In other words that they care about the right things; that they do so effectively, and with skill; and also that they can explain and justify their actions. One important criticism of this approach is that currently the theory is underdeveloped and consequently it is very difficult to distinguish between the universally accepted notion of care in the everyday sense, and those occasions when the term 'care' is being used in a specific technical way as in philosophical writings on the ethics of care. This undoubtedly leads to confusion and a lack of clarity in the analysis of the term which makes justification of actions based on 'care' questionable by those who do not subscribe to a similar orientation. Merely claiming that each situation is contextually dependent and therefore certain actions may be wrong in one situation and correct in another is not satisfactory in professional ethics.

A further difficulty with this approach concerns how boundaries or guides to an agent's actions can be established. In their rejection of principled approaches to ethics, many defenders of the ethics of care appear to miss the point that often moral principles and rules exist precisely because we care for others and wish to live in relation to them, and without some rules and principles, such as it is generally wrong to lie, it would be difficult for society to operate in anything other than an inconsistent arbitrary manner.

The assumption, by many advocating an ethic of care, that principles are applied in a cold, calculating, abstract way can also be challenged, as can the fact that these proponents fail to see that they too are relying on principles, albeit different ones from those involved in more traditional approaches (Kuhse, 1996). For example, the importance of relationship could be claimed as a principle on which an ethic of care is

based, and like other moral principles, should be defended on universal grounds.

In relation to this debate, at one end of the continuum impartialists argue that the only justification for preferential treatment is because close relationships impose particular types of obligations on agents, but that these are strictly limited (Rachels, 1989). At the other end of the continuum, particularists, such as those advocating an ethic of care, claim that the demand for universal impartial principles is an inappropriate basis for morality. Occupying the middle ground are others who suggest that there will be times when private and public morality will collide with each other and in certain circumstances impartiality will be overridden (Williams, 1981).

It is often assumed by those claiming that an ethic of care is an appropriate basis for a nursing ethic, that the demand for impartiality requires that an agent stand back from the situation and adopt a dispassionate or disinterested view of the issue or dilemma. However, this does not mean either that emotions have no part to play in any deliberations, or that one should assume that a disinterested position (one lacking partiality) is an uninterested one.

Suffice to say that intimate relationships are different from those which are role-based. For instance, husbands, wives, children and friends would prefer to claim that they respond to each other out of love, rather than because of some particular type of duty or obligation, whereas impartial and abstract principles are necessary to a public morality where we are involved with strangers (Broughton, 1983).

In nursing it would be extremely difficult to justify a morality based on particularity. Nurses should treat patients impartially by not showing favouritism, or giving certain people preferential treatment, but this does not mean they must adopt an indifferent or disinterested attitude. Nor does it mean that emotion plays no part in the delivery of care. In many cases, the nurse will be driven by powerful emotions such as compassion, empathy, even anguish, but these emotions are not dependent on the identity of the particular patient, rather they emerge from her reasoning that when another human being is suffering, he or she ought to be helped (Kuhse, 1993).

Because the ethic of care focuses to a great extent on women's experiences of caring involving relationship, responsiveness and co-operation there is a tendency to self-sacrifice, which has long been a traditional value in nursing and which should therefore raise alarms among nurses, as rather than being a force for empowerment, an ethic of care could reinforce the social and political structures which support the dominant relations within health care.

A further difficulty is the frequent demand for exclusivity and intensity of the caring relationship (Noddings, 1984). Although it may be the case that in the intimate caring relationships to be found within the family circle, receptivity, responsiveness and relatedness pose no difficulty, one needs to take account of the fact that nurses care for many patients and it is far from certain that caring to such an extent is either possible, or even desirable. A nurse cannot achieve high levels of intimacy and mutuality with every patient for whom she must care, not only because of the numbers involved, but also the average length of stay for a patient in hospital is falling rapidly, so that nurses have little time available to get to know patients. When the nurse cannot achieve the ideal portrayed, then she is left feeling inadequate in her relationship with patients (Kuhse, 1993).

Second, one might question whether patients want nurses to be closely involved to the degree suggested. Such intrusion could for example be seen as an invasion of privacy which has little to do with merely safeguarding dignity or promoting or maintaining the person's health status. Although patients may expect sensitivity on the part of nurses and a willingness by them to carry out their duties in a caring and considerate manner, there is little evidence that patients wish or expect a relationship of such intensity. What patients do expect, however, is competent care and to be treated as people rather than objects (Morrison, 1994).

Finally, there is a potential arrogance in claiming that caring is the domain solely of nurses. Caring is a human trait and therefore is just as likely to be exhibited by other professional groups, particularly in health care, where it might reasonably be claimed that entrance into this arena is motivated largely by altruistic values.

Regardless of the above limitations, therefore, one cannot escape the fact that for nurses, and all other health professionals, to display caring behaviours towards patients is a prevalent and reasonable expectation. No-one, for instance, would choose to be nursed or treated by someone who behaves in an uncaring, cruel or selfish manner.

A pluralistic stance

From all of the above theories it should be clear that none of them alone offers an ideal framework in which to view a particular dilemma or issue. Aspects of a deontological perspective undoubtedly have a place, for as health professionals there are some actions that nurses should never undertake and in professional life the concept of duty and moral motivation is of particular importance. The consequences of what we do as health professionals, however, are also important, not simply, though obviously, for the patient being cared for at a specific time, but also for their relatives and carers, other contemporary patients and, indeed, patients who may require our services in the future. Although the justification of actions is a vital element of ethics we should not forget that moral character plays a significant part in how individuals respond. Health care systems should be such as to cultivate the development of appropriate qualities and virtues to be displayed by staff whether they are front-line, for instance nurses and doctors, or those behind the scenes whose influence has far-reaching effects within the organization, such as managers and administrators. It is this realization which is slowly beginning to dawn on more enlightened organizations and is resulting in a growing interest in organizational ethics. Caring, although an essential aspect of human behaviour and a central value in enterprises such as health care, cannot necessarily provide an adequate foundation upon which to build a system of ethics.

Other theories and approaches

Having outlined a number of ethical theories on which to base moral reasoning, it is important to point out that there are many others of which space will not permit a discussion, for example, Niebuhr's response ethics, described in some detail by Tschudin (1994). Also, the above theories will be of less importance to people from certain other cultures than they are to those of us living in largely secular, pluralistic Western societies. For instance, in countries of the former Eastern bloc, an alternative to the individualistic approaches prevalent in the West, a 'materialist communal' approach to ethics, is seen as increasingly significant (Arndt, 1997). For other groups, daily life is closely related to religious teachings.

For example, for many Jews and Muslims the ethical decisions resulting from dilemmas in health care are approached from the perspective of religious laws. According to Jewish law (Halakhah), human life is sacrosanct, thus seeking medical attention by those who are ill is viewed as a moral imperative. A patient who refuses treatment (other than for reasons of futility or great suffering) is viewed as shedding his own blood and thus breaking Holy law. Similarly, doctors are obligated to extend their skills to those in need and any doctor withholding such help is viewed as shedding blood (Steinberg, 1994). These principles were poignantly emphasized in the family division of the High Court recently, in a case brought by the orthodox Jewish parents of a 16-month-old girl, suffering from type 1 spinal muscular atrophy (Dyer, 1997, p. 5). The parents opposed the proposed treatment recommended for their daughter. Doctors caring for the child planned to withdraw artificial ventilation via an endotracheal tube, rather than subject the child to surgery to perform a tracheostomy. In the event that the child, who was not expected to be able to breathe independently, suffered a respiratory collapse, the doctors did not believe that she should be resuscitated. In a statement to the judge, the child's mother stated:

> One of the principles fundamental to our religion is that life should always be preserved. Another is that someone of our faith cannot stand aside and watch a person die where their intervention could

> prevent that death. In such a case, the person that stands by will subsequently be punished by God. Failing to resuscitate is equivalent to a situation such as this (Dyer, 1997, p. 5).

The judge ruled in favour of the hospital trust to allow the withdrawal of the endotracheal tube.

For Muslims, the Sharia' are the instructions which regulate their day-to-day activities and these are derived from the Qur'an (word of God) the Sunna and Hadith (the sayings and traditions of Mohammed, the Aimma (the opinion of religious scholars) and the Kias (intelligent reasoning or analogy to rule on issues not mentioned by the others). In Islam, the concept of family is of great significance and endeavours in medicine and health care are expected to serve and protect family life. Children are perceived as God's gift to a marriage and thus adoption, sterilization and abortion are unethical unless the woman's life is in danger or the unborn child will be seriously handicapped. Temporary contraception is acceptable providing it is safe. Because the interference of any third party in conception is forbidden, sperm and egg donation along with surrogacy are not allowed (Serour, 1994).

Although within the confines of this chapter it is not possible to consider every religious viewpoint which may prevail among the various countries in Europe, I hope that the above examples demonstrate how an individual's religious beliefs can shape their responses to questions raised by contemporary health care.

Living as most of us do in multi-cultural, multi-ethnic societies, what is important to health personnel generally and nurses in particular, because of the time they spend with patients and the intimate nature of many aspects of nursing care, is that whenever possible they should acknowledge that patients may not hold even remotely similar views about the ethical aspects of their care to those of the nurse. It is incumbent on nurses, therefore, to take the time to ascertain the individual's viewpoint rather than assume it will be similar to their own.

Steps in ethical decision-making

Nurses, like others, must realize that there cannot be a guaranteed formula that, when applied to situations requiring an element of ethical decision-making, will necessarily result in ethically sound or correct decisions. A number of very useful frameworks have been identified in the nursing literature (Aroksar, 1980; Seedhouse, 1988; Husted and Husted, 1991; Brown *et al.*, 1992; Purtilo, 1993; Tschudin, 1994) and all have much to recommend them. Below is a list of steps or stages, together with some questions, to provide a focus and structure in thinking through or approaching the dubious, grey areas which take up an ever-increasing part of our time and force us to make ethical decisions on a daily basis.

Be morally alert

People everywhere live their lives within a 'general structure or web of human attitudes and feeling... which forms an essential part of the moral life as we know it' (Strawson, 1982 [1962], p. 78). Recognizing and remaining alert to these feelings can indicate when situations involve a moral component. Thus, the first crucial step lies in recognizing that a situation or decision involves an ethical dimension or 'seeing with a moral eye' (Tadd, 1994, pp. 8–9). Ethics, therefore, should be recognized as an integral part of nursing practice and not simply an add-on after clinical, psychological and legal dimensions have been explored. This also means that nurses must remain alert and sensitive to the moral dimensions of their roles and this has considerable implications for the way in which nursing is taught.

Clarify the details of the situation

Gather as many facts about the situation as possible to avoid jumping to conclusions. Sometimes there is insufficient information, for example when trying to determine what course of action a patient who is unconscious would wish to take. In such cases certain assumptions will probably have to be made. At this point it is often helpful to try to state the case with as many relevant facts that are available as this helps in the recognition of both the central and marginal factors and in addition determines the decision(s) which need to be made. It is

at this stage that all of the interested parties should be identified as there are frequently more than are apparent at first glance. Also, it is worth considering the relationships between these various stake-holders including yourself.

Determine the possible alternative actions
The next step is to identify each of the possible alternative actions.

Evaluate the alternative actions
This is one of the most important stages as it involves evaluating each potential action by considering the morally significant factors in each of them. Potentially useful questions might include: which principles does an action involve? With regard to autonomy, one might ask if others would be treated paternalistically, exploited, denied informed consent, or denied respect and dignity. In considering non-maleficence one should reflect on whether anyone would be harmed either physically, mentally or emotionally. What would be the degree of harm? Similarly, with beneficence, one might ask whether a particular action would promote good, or avoid harm or perhaps reduce harm. In terms of justice, would an action result in someone being discriminated against or treated unfairly in any way? One might invoke the principle of veracity, by asking whether an action would involve deception, lying or a lack of candour.

Having identified which moral principles are involved there are other considerations which should be included. Deontological consideration would require that a person considers whether anyone's moral rights, such as the right to autonomy, privacy or dignity, are being denied. Thought should also be given to the obligations of each person involved which might follow from the particular relationships or roles which they fulfil. Also, one should give some thought to what would happen if everyone acted in this way. Does the action coincide with one's moral duties as prescribed in codes of ethics or professional norms? Utilitarian considerations would focus on the consequences of each action for each person involved and the amount of benefit or harm produced. One might wish to reflect on whether a good person (or nurse) for instance, someone with

integrity, might choose a particular action. In addition the specific context should be taken into account. A further source of clarification and help can also result from discussing the dilemma with colleagues, other professionals, and friends and family. Often, by explaining a situation and describing the various options during an ethics ward round or patient conference, for example, one can gain insights about one's own values and the particular nuances of the situation. Sharing a dilemma or issue in this way can also reduce the 'loneliness' which frequently accompanies moral decision-making.

Make a decision

At this point one has to make a decision and having made it one has to live with it and whenever possible learn from it. Ethical reflection, like reflective practice, can lead to improved skills in making judgements. It is worth remembering that there are rarely perfect choices and with more time and more information most decisions could be improved upon. The improvement gained through spending additional time has to be offset, however, against the reduced number of options that might be available as time passes. Having made a choice it is essential that one accepts responsibility for it and uses the opportunity to grow both professionally and ethically, for as Tschudin (1994, p. ix) points out, 'making decisions can be difficult; it can also be exciting. It is certainly what real life is about.'

Conclusion

In ethics, as in any other worthwhile enterprise such as nursing or health care, there are rarely easy answers or quick fixes to the troubling dilemmas and issues which have to be faced. As we enter the next millennium it is likely that for all nurses, regardless of where they practise, such dilemmas will undoubtedly increase as technological advances become even more spectacular, resources more stretched and professional boundaries more blurred. Often, there is little time for deliberation and, like so many important decisions in life, they have to be made before an answer is fully available. This is why nurses need a sound understanding of relevant moral theories and

principles together with a decisional framework which is of assistance to them and which, over time, may become a pattern for approaching morally troubling situations. Through the study of ethics in both its 'technical and negative senses' (Hunt, 1994), along with its continual application to practice, nurses everywhere will be better placed to clarify, defend and justify the positions they adopt on matters of moral significance and firmly ground ethics in nursing. It is important to remember that 'right answers in ethics are few and far between, wrong ones are devastating for all concerned. What is important, however, is that as nurses we continually [and collectively] question our practice' (Chadwick and Tadd, 1992, p. 182). Sharing the difficulties and exposing our deliberations to the critiques of nurses across Europe, can improve our knowledge and understanding of the ethical components of nursing and increase our confidence in ensuring that health care remains an ethical and humane enterprise.

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Notes

1. Universalizability is the notion that what is right for one person must be right for anyone else in the same position. For example, if I say that you ought not to lie I am committed to saying that anyone else in your position ought not to lie.
2. A Categorical Imperative is unconditional, an order which must be obeyed as in 'Do X' and is compared with a Hypothetical Imperative which is conditional upon a particular end, for example 'Do X if you want Y'. Categorical Imperatives result in perfect duties which must be fulfilled without exception

and Hypothetical Imperatives in imperfect duties which are wider in that although they require us to pursue certain goals, such as the well-being of others, how the goals are pursued is left largely to the individual concerned providing they do not conflict with perfect duties which must take precedence.

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3

Moral Reasoning in Nursing: A View From Sweden

Astrid Norberg

Introduction

Moral reasoning, that is, the reasoning behind moral actions, is related to ethics. In the context of this chapter, a distinction can be drawn between normative and descriptive ethics. Normative ethics concerns questions about how we ought to be and act, while descriptive ethics concerns how we actually are and how we act. In this chapter the focus will be on descriptive ethics, describing how nurses reason in morally difficult situations. The basis of the chapter is the result of international studies into nurses' moral reasoning. These studies involved nurses in many European countries.

Caring

Caring can be regarded as comprising a task element and a relationship element. There is a carer who cares for the patent and a patient who receives care. The task element might concern, for example, the carer feeding the patient in a technically competent manner by ensuring that food is given in an appropriate way and contains adequate amounts or proportions of nutrient. The relationship aspect of caring involves the manner in which the task is performed, for instance by

ensuring that the patient is treated as a valuable human being and is not degraded (Athlin, 1988).

This concept of caring can be related to ethics which focuses on either actions or relationships (Lindseth, 1992). In action (normative) ethics the question is: 'What is the right and good action to choose in this situation?' In relational ethics the question is: 'How should I relate to this person in this situation?' Virtue ethics is related to both action and relational ethics. It answers the question: 'How can I become or be a good person?', or in the case of the nurse: 'How can I become or be a good carer?'

Action ethics

Within action ethics reference is often made to general ethical principles such as those described by Beauchamp and Childress (1994). This approach presupposes that ethical problems can be understood as conflicts between different ethical principles and that these conflicts must be solved by deciding which ethical principle should be given priority in a given situation. The ethical principles that are most commonly discussed in health care are the principles of autonomy, beneficence, justice, non-maleficence, sanctity of life (sometimes regarded as an axiom) and truth telling.

An example of this kind of moral reasoning is described in a study by Norberg *et al.* (1994), where structured interviews were held with registered nurses in Arizona, Australia, California, Canada, China, Finland, Israel and Sweden concerning the feeding of patients with severe dementia who do not accept food. The nurses were forced to decide whether they should use force to feed the patients or leave them to die slowly without food. The study indicated that there was a connection between the willingness to feed and the ranking of ethical principles. Nurses who were most often prone to feeding the patient ranked the ethical principle of sanctity of life very highly, while those who primarily chose not to force-feed the patients gave a high ranking to the ethical principle of autonomy. All of the nurses stressed the ethical principle of beneficence.

Within traditional ethics is the idea that we reason in a rational and detached way which leaves aside the role of emotions as these are thought to cloud the ideal process of moral reasoning (Vetlesen, 1994). However, in reality, we all know that it is one thing to know how we should be and how we should act, but it is quite another to really be good and just and act in a good and right way. In practice this is because there is a complex interplay between what we perceive, think, feel, wish and who we are and how we act. I will focus on ethics in practice.

Relational ethics

Relationships occur mainly between people. Therefore relational ethics starts with the question: 'What does it mean to be a human being?' 'What does it mean to be affected by this or that disease and to care for that person?' Relational ethics in practice is founded on the carer's outlook on life. We may regard life as a neutral raw material that we can form as we wish, or we may regard life as a 'gift which makes certain ethical demands on us and feel it is important to understand and answer those demands' (Asplund, 1991).

Moral reasoning can be approached from various angles. I will address it from the perspective of the experience of nurses when they are in situations of ethical difficulty. How does the nurse react? Being in a situation of ethical difficulty is different from viewing a situation of ethical difficulty from the outside and reasoning about it without being involved in it. Being in a situation of ethical difficulty of course involves both relating to other people and acting.

By a care situation of ethical difficulty I mean a situation where the 'good' is threatened. One where we risk promoting the evil and neglecting the 'good'. I use the term 'good' as Murdoch did (1992) when she stated that good is good, and you cannot explain it to somebody who does not already know it. In other words, in my opinion, it is not possible to define 'good'.

Moral reasoning in nursing

Being in a situation of ethical difficulty concerns being sensitive to good and evil. We must be sensitive enough to perceive that there is a risk that evil will be promoted and/or good will be neglected. There is a need for ethical sensitivity, that is, 'a capacity to recognize the moral implications of one's actions in view of the vulnerability of others' (Lutzén and Nordin, 1995, p. 42). There is a need for us to be open enough to perceive and also to be strong enough to withstand what we do perceive.

Research findings show that carers sometimes cannot endure the emotions that are evoked in their contact with patients. Hallberg and Norberg (1990) found that carers of patients with severe dementia who exhibited vocally disruptive behaviour, that is, they screamed and shouted, sometimes seemed to regard this behaviour as an expression of an unbearable anxiety in the patient, such as anxiety for annihilation and separation. Despite their understanding, the carers isolated their patients (Hallberg *et al.*, 1990) and related that they could not bear the feelings of powerlessness and inadequacy which resulted from their inability to help their patients although they strongly wished to do so (Hallberg and Norberg, 1990).

In an attempt to ameliorate the negative feelings experienced as a result of being unable to help their patients, the carers reduced their contact with the patient. This kind of behaviour shows the close connection between the ethical aspects and the task aspects of caring. By learning more effective ways of helping the patient, carers can relate to patients or clients in a more positive way. It therefore seems reasonable to see ethics as an integral part of all care activities and ethical concern cannot be separated from concerns about care technology.

Another well-known example of this is the experiment by Milgram (1975) who, after the Second World War, wished to see how people would react when they are put into a situation in which they are expected to obey orders and those orders involve hurting other people. What happened was that some of these people devalued the victim and blamed the researcher (the order giver) for what happened. Accepting that they had contributed to another's pain or suffering seemed to be more than the research subjects could tolerate.

There are many phenomena in nursing care where we have to defend ourselves against truly understanding or appreciating what we are involved in and it is in these situations when we are tempted to treat patients as objects. Being in care situations of ethical difficulty therefore concerns knowing how to act. Some ethicists suggest that we can understand how we should act by going deeply into the situation. Our moral senses can tell us how to act. Murdoch (1992) is an example of this type of philosopher for whom moral decision-making is seen as primarily being based on perception rather than on rational reasoning. Other philosophers describe moral decision-making as essentially involving a rational and deliberate choice. We choose our values and determine our priorities and this implies a choice of actions. Hare (1961) adopts such a position. In his case moral reasoning becomes like problem-solving.

What we think about this question of how to act in care situations of ethical difficulty is connected with how we perceive the world. If we perceive the world as unrelated facts and values as subjective reactions to these facts, then of course we can choose from the smörgåsbord of values that various philosophies and religions offer. The basic question becomes not what choices we make but how we make our choices (O'Connor, 1996).

If we perceive the world as coloured by values, the task is not to choose between values but to attend closely to the matter so that we can sense and capture the values. Johnston (1978) writes about going deeper into the ordinary, looking with the eye of love, while Murdoch (1992) writes about looking with justice and love which includes unselfishness. Murdoch also emphasizes that it is important to be realistic. Freedom presupposes realism in that if we act out of a wrong interpretation of reality, the consequences of our actions will make it evident to us that we are not free to act in that way.

When physicians and registered nurses in oncological and medical care in Norway narrated about being in care situations of ethical difficulty it was evident that they emphasized different things (Udén *et al.*, 1992). Physicians narrated their stories prospectively while registered nurses narrated their stories retrospectively. Physicians focused on disease, scientific knowledge, preserving life, survival and the patient's best interests, while

registered nurses focused on daily life, experiential knowledge, death with dignity, quality of life and patient autonomy.

The nurses emphasized relationships and care and the physicians emphasized choice of actions and justice. However, when these interviewees reflected on their narratives and penetrated more deeply their lived experiences of being in care situations of ethical difficulty, the differences disappeared. Common themes were: meeting death, balancing between being open to one's own and others' reactions and being sheltered, handling advanced medical technology and grasping care as a whole. Of great interest was the fact that the two groups disclosed different cognitive styles and types of rationality. The nurses very much referred to their personal experiences of both giving and receiving care, emphasizing the process of care. The physicians, however, referred to science and proven experience, emphasizing the result of care (Lindseth *et al.*, 1994).

In an earlier study, physicians, registered nurses and enrolled nurses in northern Sweden narrated their experiences of being in situations of ethical difficulty in intensive care units (Söderberg and Norberg, 1993). There were some differences in the accounts that seemed logical consequences of the fact that these professional groups have different tasks in care. The physicians mainly described the issue of over-treatment resulting from the difficulties in deciding about withholding and withdrawing treatment. The registered nurses primarily discussed their experiences of realizing which decisions might lead to meaningless over-treatment. Enrolled nurses more commonly spoke of relationship problems with patients and patients' families and the difficulties they faced in having to explain and defend decisions that they sometimes neither understood, nor had any power to affect.

It seems reasonable that the various tasks in care lead different people to experience different things. A closer analysis of the narratives disclosed similarities as well. Physicians, registered nurses and enrolled nurses all described situations that could be understood as tragedies (Söderberg *et al.*, 1996). Good solutions or outcomes were not possible and there were no easy answers to questions about the interpretation or the meaning of the situation. Patients and their families appeared as unjustly stricken victims. A difficulty identified in the physicians' stories

was that of knowing what would be a realistic course of action, as it was important for them to perceive difficulties as well as realistic possibilities. The registered nurses predominantly talked about preserving patients' dignity in difficult situations, while enrolled nurses' versions described the difficulties of consoling patients and their families in situations without any hope.

The interviewees narrated how they created a silent space between themselves and their patients and the patients' families (Söderberg, 1997). They kept themselves and their values in the background to enable the patient and his or her family to express their experiences, values and perceptions of the situation without interference. They were attempting to be silent and attentive to subtle cues from the patient. Attention in a tragic situation helped them see, feel, understand how to act and perceive the possibilities that were available in the situation. This need for a silent space to enable an understanding of how to act was emphasized as early as the fourteenth century by Meister Eckhart who wrote about the relation between man and God. It seems that this is an analogous way of expressing the need for a deep involvement in order to be able to understand the demands of the situation.

By going closer into care situations of ethical difficulty, people are able to penetrate deeper, not only into the ordinary, but also into the unusually difficult matters. They look with the eye of love and create a silent space where the other can appear. Often this results in the discovery that they do not have to make a choice any more. This experience can be expressed as 'I saw', 'I felt', 'I knew'. Carers expressing these types of experiences often face difficulties in explaining their convictions. The experience is like the one that Martin Luther expressed as: 'Here I stand, and cannot do otherwise!'

Being in a care situation of ethical difficulty means acting in a way that individuals believe that they should act. As the Bible indicates, since the time of St Paul – and probably even earlier – people have asked themselves why they do not do the good that they wish to do and why they do the evil that they do not wish to do (Romans 7:13).

Wyschogrod (1990) suggests that people can learn something about the question of how they can act as they think they ought to, by studying those people who do that, for example,

the saints. She discusses Christian, Buddhist and political saints and describes several characteristics that they have in common. I will mention a few.

The saints do not apply abstract theories to practice. They relate their lives to great narratives such as Jesus' life, Buddha's life or to a vivid picture of the society that politicians wish to create.

The saints have an open mind, they are deeply engaged with other people, that is, they are other directed. Saints are often connected with suffering. Wyschogrod emphasizes that this does not mean that they search for suffering, but rather, their open minds make them vulnerable and exposed not only to suffering and compassion, but also to joy.

The saints are directed forward. They do not go over their experiences repeatedly. They live in forgiveness, they forgive and accept forgiveness. Therefore they progress all the time.

The saints have a special perception of time. They experience time as the time left and not as that which has passed. It is their time, their due, the time they will have to take responsibility for. Therefore, it becomes utterly important how they spend their time. The saints know their priorities and can differentiate between what is important and what is less important.

The saints' actions hang together demonstrating integrity. They form a wholeness and express a message. The saints do not choose their actions as one chooses articles in a store. They do what the situation demands. This reminds us of what Murdoch describes when she suggests that when someone attentively goes deeply into a situation then there are no more choices to make and this means freedom. This freedom is, however, freedom to and not freedom from. In other words it represents an ability rather than a situation of coercion or constraint.

Wyschogrod describes saints as selfless, meaning that the centre of their personality is their values. As the Bible states, a Christian can explain it as: 'Now I do not live by myself, but Christ lives in me' (Galatians 2:20). In more prosaic words one might say that these people are well integrated with their values. This indicates that their moral actions are very much more spontaneous than is often supposed and not the result of moral reasoning as an example of detached problem-solving.

Although nurses, like most people, are not saints they can however learn from the saints. They can learn that the most important question is not what they do, but who they are. The question is less: 'How can I do good things?' But rather, 'How can I become a good person?'

Being in a care situation of ethical difficulty means needing support from co-workers. The saints certainly get support from their faith and nursing research has shown that support from co-workers can help carers to act in accordance with their conviction of what is the good thing to do.

In previous interviews experienced nurses stated that their decisions about ethical matters depended 'on the situation at hand' (Jansson and Norberg, 1989, 1992). In order to understand the meaning of that expression, experienced and good cancer nurses were interviewed (Åström *et al.*, 1993), and were asked to relate situations they had experienced in which it was hard to know what was the right and good thing to do. The situations described were interpreted step by step from two questions: 'What do nurses experience when being in ethically difficult care situations?' and 'What does the expression "it depends on the situation as to what I decide", mean?'

In such complex situations the nurses experienced many ethical demands, some of which were impossible, while others were possible, for them to meet. That is, the situations were regarded as either overwhelming or possible to grasp and the nurses either exhibited a type of loneliness or a form of togetherness.

When narrating about overwhelming situations the nurses mostly used the term 'one' about themselves and the term 'they' about their co-actors. When talking about situations which were possible to grasp, the terms 'I' and 'we' were mostly used. The most important situational factor in these narratives was whether the nurses had a group with whom to share their thoughts and draw on for support. If this was not the case then they had problems acting in accordance with their ethical reasoning and feelings.

In narratives about overwhelming care situations the nurses did not make a conscious interpretation of whether the patients' demands were also the ethical demands of the situation (Åström, *et al.*, 1994). In these situations there seemed to be distrust and destructive interdependence between the co-workers, and

the patient was not seen as a unique and valuable person. In narratives about situations which were possible to grasp, the nurses made a conscious effort to interpret the demands of the situation and acted in accordance with their interpretation until a new interpretation was necessary. The interdependence among the co-workers was used constructively in order to care for the patient who was regarded as a unique and valuable individual.

It seems important, therefore, to change care-givers' perceptions of the patient in a positive direction. This can be done by providing them with the opportunity to discuss their spontaneous reactions to the patient and help them to understand the patient's sometimes seemingly bizarre behaviour. Hallberg and Norberg (1993) showed that carers, who got systematic clinical supervision and were able to discuss their patients and their own reactions towards them during supervision sessions, changed their perceptions of patients with severe dementia. They were able to see the patients more easily as human beings displaying behaviour that is a meaningful reaction to a difficult situation.

Moral reasoning in accordance with Lögstrup's ethics

Being a good person, however, does not mean that one does not have to reason in a problem-solving way. The question is how this kind of reasoning, which utilizes problem-solving, can be combined with spontaneous action. The work of the Danish philosopher Lögstrup seems to provide some ideas about a possible way of combining moral sensing with cognitive moral reasoning (Lögstrup, 1971; Bexell *et al.*, 1985). Lögstrup's account of ethics is ontological and relational. It verbalizes human experiences that are usually unconscious.

Lögstrup regarded life as a gift which has to be put to good use. Situations within our lives frequently present ethical demands which we must consciously interpret. Thus, Lögstrup described a human ethics based on a phenomenological analysis of life.

When we meet another human being, Lögstrup states that we may become embraced by what he termed sovereign or spontaneous utterances or experiences of life, such as trust, sympathy, openness, mercy and joy. These positive phenomena cannot be controlled. If attempts are made to produce and use trust and mercy, for example, then they will be destroyed and turned into mistrust and cruelty. What is possible, however, is to develop an understanding of how we can avoid preventing the occurrence of these spontaneous utterances and how to avoid their destruction. He also suggested that it is possible to create situations that allow for and nurture these spontaneous utterances. As we are part of the situation at hand and take part in the creation of ourselves, we should try to create situations that allow for and nurture these spontaneous or sovereign utterances. In other words we should participate constructively out of freedom. Every situation is both 'singular' and 'unique' at the same time as it is 'typical' and 'similar' and thus it increases our understanding of other singular situations (Armgard, 1993).

It is basic in human life that individuals meet each other with trust. Trust just occurs and Lögstrup emphasizes that this does not have to, nor indeed *can* it, be explained. What has to be explained are the situations where trust does not occur and the same is true for other sovereign/spontaneous utterances such as mercy, sympathy and joy. For example, when another human being is hurt, those involved may be engulfed by feelings of sympathy and mercy. This does not have to be explained. It is situations where this does not occur which require explanation.

When A relates to another human being, B, this means that A has power over B. A can, for instance, hurt or even kill B. B's life is in A's hands – in a literary or metaphorical sense. Equally, B has A's life in his or her hands. Thus everyone is interdependent, different parts of the same situation and of each other's lives. We have, therefore, to respond to this; either we take care of each other or we capture and destroy each other. To be interdependent does not mean that we lack independence but that we are free and independent when we accept the fundamental features of interdependence and subjectivity and accept our responsibility (Lögstrup, 1983). We have a free choice and a duty to act in accordance with the ethical

demand embedded in the situation (Lögstrup, 1962). We must take an active personal part in the situation in accordance with our interpretation of the ethical demand and cannot simply remain a neutral spectator (Lögstrup, 1997).

When we are not embraced by spontaneous utterances of life and feel uncertain about how to act, we must consciously interpret the ethical demand that the other person represents. This unspoken demand is embedded in the human situation and Lögstrup emphasizes that the ethical demand is one-sided. We have to answer the demand without asking what the other person is demanded to do. The ethical demand is radical – we can never do enough – and it is unspoken. We cannot ask the other individual what it is but instead have to interpret the situation at hand. We can never be sure that we have interpreted the demand correctly, we simply have to take responsibility for its interpretation.

When interpreting an ethical demand, we sense the situation that we ourselves and the other individual are parts of. In order to sense, we must be open to receive and share experiences with the other person. This assumption that going deeply into a concrete situation means finding the good and right way of acting reminds me of Meister Eckhart's writing about a silent space (see p. 48). The interpretations of what is sensed are made against a background of prior understanding. When interpreting the ethical demand we are also guided by norms and values – important parts of our prior understanding, for example the norm about love for one's neighbour. When crises and conflicts occur, spontaneous/sovereign utterances of life might become verbally formulated and thus guide the development of norms and duties. The norms and values are in this way part of our outlook on life.

Lögstrup's account of ethics has been used in nursing science, for example by Saveman (1994), to reflect on formal carers' experiences of witnessing abuse of elderly people in their homes. Her interpretation of interviews with formal carers, for example district nurses, was that the abusive situations could be interpreted as situations where the sovereign/spontaneous utterances were destroyed and the carers had problems interpreting and acting in accordance with the ethical demand. They could not use their power in a constructive way. It is evident that Lögstrup's

ethics cannot be used as a system of rules or principles that can be applied to a situation of ethical difficulty. It is, instead, an outlook on life and a way of reflecting on situations of ethical difficulty. Each individual must make his or her own interpretation of the situation at hand and take responsibility for acting in accordance with this interpretation. There cannot be any guarantee that the interpretation is correct. An open and serious attention to the situation and reflection about norms based on spontaneous/sovereign utterances of life are needed.

Interdependence

Lögstrup stressed the fact that people are interdependent and this aspect is very apparent in dementia care for example (Norberg, 1996). In interviews with carers it was found that those who said that caring for a patient with severe dementia represented meaningless work got nothing back from the patient. These carers talked about the patient as an object or as being socially dead. They expressed the feeling that they only 'work' in dementia care.

Other carers stated that caring for patients with severe dementia represented extremely meaningful work. They got so much from the patient. They talked about the patient with the respect deserving of a valuable human being and they appeared proud of their work.

It appears therefore that the perception of the patient is of the utmost importance in ethical nursing practice. Good carers have difficulty expressing why and how they find the patient a valuable human being. They sometimes use religious metaphors such as, '[when you care for the patient] you are caring for Christ. He is the one who is hungry, naked and sick' (Norberg, 1996, p. 105).

Conclusion

Finally, I come to a reflection related to virtue ethics. How did the good carers become good? In interviews, good carers often related experiences that could be labelled as broader experi-

ences. Examples such as 'Before, I thought and felt so and so, but when my [mother, father, child] died, I understood. After that happened I see and feel and think in another way.' Thus carers frequently relate experiences that made them touch something 'holy' and that made them change their outlook on life.

In nursing, we cannot give students and carers these kinds of experiences but when they occur we can help them reflect on them so that they acquire positive paradigm cases. This is important because such situations can also lead to fear and defence and result in negative paradigm cases (Åström *et al.*, 1995).

Moral reasoning in nursing is therefore a type of problem-solving but it is one that must be based on carers going deeply into care situations, tuning into them, taking an interest in them and being affected by them (Vetlesen, 1994). This basic mode is an important basis for any rational problem-solving.

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4

Nurses as Health Educators: The Ethical Issues

Christine Chilton

Introduction

Autonomy, or the right of the individual to self-determination, while taking into account responsibility for one's actions towards others, is an ethical principle that has gained wide acceptance within democratic societies. The extent to which an individual has or can exercise autonomy is relative, as no-one has absolute autonomy. It will depend on a person's capacity to reason and make rational choices, as well as having the opportunity or freedom within one's environment to both make and act upon informed decisions. Creating and respecting the autonomy of an individual are two of the goals of nurse education and are values which are increasingly emphasized as the profession embraces developments in health promotion and moves towards a 'new nursing' philosophy (Salvage, 1990).

'New nursing' is a philosophy which has evolved during the past two decades from developments in nursing theory. Whereas 'old nursing' focused on the physical aspects of illness and task orientation, the essential feature of 'new nursing' is a holistic, interpersonal concern in which the nurse–patient relationship is seen as the key aspect. One assumption of this philosophy is that patients want to enter a relationship based on choice and shared decision-making. Putting this philosophy into practice requires an expansion of the traditional role of the nurse as expert and carer, towards one which encompasses the role of facilitator in health promotion. The holism which is empha-

sized in 'new nursing' arises from the incorporation of psychological, social and biophysical dimensions into the health model. This new philosophy of nursing has grown in popularity, alongside developments such as the individualized care and primary nursing and the wider social and cultural acceptance of individual freedom.

Incorporating the principles of this new approach into practice, however, is both complex and problematic. Recent nursing literature (Jewell, 1994; Trnobranski, 1994; May, 1995; Antrobus, 1997) describes the features of the new nursing philosophy and discusses the disparity between theory and reality. The ethical issues which arise in relation to this philosophy, the concept of patient or client autonomy and the nurse as a facilitator, will each be discussed within this chapter.

The World Health Organization (WHO) refers to health promotion as a 'mediating strategy between people and their environments, synthesising personal choice and social responsibility in health care to create a healthier future' (WHO, 1984, p. 73). Empowerment, or the creation of autonomy, is the goal of health promotion and in the Ottawa Charter health promotion is defined by the World Health Organization as 'the process of enabling people to increase control over, and to improve their health' (WHO, 1986, p. 1). 'Self-empowerment' is the philosophical basis of health promotion, and involves possessing the ability, authority or power to make decisions about one's own health-related behaviour and lifestyle without fear or coercion.

The development of health promotion

Health promotion and the new nursing philosophy have evolved during the past two decades, as part of the move away from the biomedical view of the causation of ill health and the associated dependence on medical care for disease prevention. These changes arose from the recognition that the major causes of premature death and disease were more often a result of social and environmental determinants together with individual behaviour and lifestyle patterns (Lalonde, 1974). As a result, the emphasis on both disease prevention and dependence on medical care in developed

countries is being replaced by a more positive approach towards health and public health policies.

The role of lifestyles and the environment as important determinants of health status was further developed by the WHO, beginning with the Health For All 2000 (HFA) strategy launched in a declaration at the international conference on Primary Health Care, held at Alma Ata in the former USSR in 1978 (WHO, 1978). This vision was later transformed into a framework for health promotion programmes in the *Ottawa Charter for Health Promotion* (WHO, 1986). Outlined in the framework are five principal action areas: building healthy public policy; creating supportive environments; strengthening community action; developing personal skills; and reorienting health services. Health promotion has grown, therefore, from the formerly prominent health education by refocusing on building healthy public policy, but it still relies on these two components working together. There has been a tendency for the concepts of health promotion and health education to be used interchangeably. In reality they are quite distinct although nevertheless interrelated, as they both have empowerment as their goals.

Bunton and Macdonald (1992, p. 9) suggest that 'mediation, enablement and advocacy' are the 'process methodologies' of health promotion proposed in the Ottawa Charter through which 'people could begin to take control over their own health'. To ensure that a nation's health promotion programme safeguards the autonomy of the individual, that is, the freedom to choose and make informed decisions about one's health status, it is necessary to acknowledge that its two main interacting components, healthy public policies and health education, take account of the social and economic determinants of health as well as individual responsibility to maintain one's own health.

The World Health Organization has referred to health promotion as a 'mediating strategy between people and their environments, synthesizing personal choice and social responsibility for health to create a healthier future' (WHO, 1984, p. 73).

Health promotion may be thought of as a collective responsibility which takes into account the social and economic factors that determine the health status of individuals and communi-

ties. As a strategy, health promotion relies on two main approaches. Bunton and Macdonald (1992) explain that one is structuralist, encompassing political and environmental action and the development of healthy public policies. The second is lifestyle, which focuses on individual behaviour change and which is mainly concerned with health education. Both approaches interact with health protection measures, such as immunization and screening, and a useful and more detailed explanation is provided by Bunton and Macdonald (1992).

Building healthy public policy

This chapter will feature Finland, France and the United Kingdom as 3 of the 38 signatory nations of the Ottawa Charter. Moving at their own pace, these three nations are making the transition from traditional approaches towards health policies and health education that at present facilitate, to various degrees, the ability of the individual to manage his or her own health. Their governments have all recognized, at least to some extent, the contributions that nurses are able to make towards the health of their nations through health promotion and health education.

Since 1982, Finland has been the pilot country for the WHO's HFA strategy development and in 1985 it became the first country in Europe to issue a national strategy for HFA. This has a strong emphasis on lifestyles and combines both behavioural and public policy approaches to health promotion and disease prevention. However, the deep economic recession of the early 1990s, leading to high unemployment, has slowed down the implementation of some targeted projects, especially those aimed at the adult population through occupational health services and those planned to reduce the socio-economic differences in health (Eskola, 1995).

The United Kingdom, in accordance with the principles of WHO's HFA strategy (WHO, 1985), issued four national health strategy documents *The Health of the Nation* (Department of Health, 1992). The strategy for England emphasizing the need for individual lifestyle changes of identified high risk groups and the meeting of specific targets has been criticized for not

adequately taking into account the social and economic factors that determine health (Hagard, 1995).

In France, the biomedical model remains dominant in the perception of the general public, professionals and policy-makers. In the literature, public health issues tend to be viewed in epidemiological terms rather than as an evaluation of health promotion interventions. There is relatively little discourse which defines and analyses the concepts of health promotion and health education, as is apparent in the United Kingdom and Finnish literature. However, on a practical level, a variety of health education and health promotion structures exist at the state, municipality public sector and the voluntary sector levels so that these twin concepts are brought together in health service action. Since 1994, health priorities and measurable objectives have been identified and a framework for a comprehensive and co-ordinated health promotion programme is being developed (Demeulemeester and Baudier, 1995).These will be transmitted through existing health promotion, health education and health service structures within the public and voluntary sectors at regional and local levels (Tessier *et al.*, 1996).

In reality, as each nation moves at its own pace towards the achievement of HFA, ethical issues arise in relation to the autonomy of patients and clients and the extent to which nurses are empowered to enact their role as health educators. These issues, in the context of Finland, France and the United Kingdom, will provide the main focus of this chapter. It is necessary first, however, to consider the concept of health.

Health

Health is an ambiguous and subjectively understood concept whose range of meanings stretch from that of the narrow biomedical model to one that is broad and holistic. Nordenfelt, in his book *Quality of Life, Health and Happiness* (1993), gives a detailed analysis of the range of philosophical accounts of health, disease and illness, commencing with Boorse's narrow biostatistical theory and concluding with a detailed description of 'subjective health'. What Nordenfelt's work demonstrates is that health is an 'essentially contested concept' (Gallie, 1955–56) which

means that whenever statements about terms such as health are made questions of value are raised which seem to prevent agreement on a conclusive definition or indeed appropriate usage of the terms. According to Gallie, essentially contested concepts have three main characteristics. First, they are 'appraisive' (p. 171) in the sense of not only naming the concept but also ascribing a value with respect to it. Second, essentially contested concepts are 'internally complex' (pp. 171–2), in that their characterizations entail reference to several dimensions. Third, an essentially contested concept is 'open' (p. 172) so that participants in the debate are able to interpret it in a number of different ways. These difficulties have led to problems in gaining agreement on what constitutes health with the result that proponents frequently talk at cross purposes. One way to overcome these problems is to accept that there is only one concept of health but many different conceptions of it (Lindley, 1986). 'A conception is a particular interpretation or analysis of a concept... An adequate conception must fall within the scope of the basic concept' (Lindley, 1986, p. 3) so that whenever an abstract concept such as health is expanded with different content, it can be said that there is a conception of the concept. An illustration may help to clarify this particular use of these terms. Imagine, for example, two individuals who have acquired the concept of a dog, an animal with four legs, a tail and which barks. However, if one had experienced only pit bull terriers and the other only chihuahuas, their individual conceptions of 'dog' would be very different (Tadd, 1995). In the case of health, therefore, its definitions are based on value judgements, whether these are the goals and beliefs of health professionals or the 'common-sense' views of lay individuals. A gap between professional and lay concepts of health can give rise to problems of communication and co-operation. Thus an open-minded approach to determining people's views of what it means to be healthy, or to lead a healthy lifestyle, is needed by health professionals.

Health definitions have 'polarity', that is, they can range anywhere on a continuum between a negative definition, as in health being the absence of disease or illness, to one that is positive, such as health as a state of well-being. The World Health Organization acknowledges that health is a holistic and dynamic concept of interdependent, internal dimensions which

act together or separately and are affected by the social, economic and physical environment. Its own historical and rather idealistic definition of health as 'a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity' (WHO, 1948, p. 1) has, since its original appearance, undergone further development.

As proposed by WHO (1984), being healthy should have a purpose and instrumental value as a resource, rather than simply being an end in itself of perfect well-being. At the 30th World Health Assembly in 1978 the WHO adopted a resolution that the main social goal of health according to the WHO 'should be the attainment by all the people of the world by the year 2000, of a level of health that will permit them to lead a socially and economically productive life' (WHO, 1985, p. 1). As a result of this resolution, a unanimous commitment to the HFA strategy was made in the Alma Ata declaration (WHO, 1978). Thus the achievement of health ought to be a means to an end which exists within a political context and relies upon healthy public policies at national and local government levels.

From a global view of health to one that is meaningful to the individual, it can be seen that no single, universal definition of health exists. However, while it may be impossible to predict an individual's view of health, differing views associated with social class and cultural groups should be acknowledged. These views often concern beliefs about the amount of choice and power available to individuals and these in turn shape the decisions individuals make which influence or determine their lives and health.

Health education and the role of the nurse

Health promotion and health education are integral to nursing, but there has been a tendency for nurses to use the terms interchangeably (Latter *et al.*, 1992). They are, as has been discussed, quite distinct, although necessarily interrelated, activities with empowerment as their mutual goal.

Health education is a planned activity intended to provide knowledge and assist understanding about health issues as well as enabling people to incorporate their health choices into

their own lives. Current approaches invite the active participation of individuals and communities in all decision-making.

As Delaney (1994) suggests, health education is the most easily distinguishable element of health promotion in which nurses and midwives participate. In the majority of cases health education undertaken by nurses and midwives focuses on the individual and Delaney (1994) defends this by arguing that it is unreasonable '...to expect any group or individual to operate at all levels of health promotion'. It is for these reasons that this chapter will focus on the narrower role of the nurse as a health educator. In this role a range of individually focused approaches can be used, each defined according to their goals, activities and underlying values. These approaches may be used singly or in combination and Ewles and Simnett (1992) suggest that there is no one 'right' approach, but rather the choice should depend on an assessment of individual/community needs as well as the values and code of conduct of the health professional. It must be emphasized that, in all cases, health education should involve voluntary change and not have to rely on persuasion, coercion or indoctrination.

Behaviour change approach

In this approach individuals are encouraged to take responsibility for their health by changing health-damaging attitudes and behaviours in favour of healthier lifestyles as defined by experts. Acting in a manner perceived to be in the best interests of the individual and with the aim of achieving compliance, persuasive interventions are frequently used. These may include one-to-one advice, information and mass media campaigns. The powerful persuasiveness of health-damaging influences such as cigarette advertising is frequently cited as a justification and these interventions often target behaviours such as smoking, excessive drinking, lack of exercise, unhealthy eating and unsafe sex. For example, *The Health of the Nation* (Department of Health, 1992) strategy for England includes targets such as a reduction in the number of people who smoke cigarettes and encouraging individuals to adopt healthy behaviours is proposed as a legitimate activity of health profes-

sionals. One problem with this approach is that a failure to achieve the targets set can result in victim blaming while the social and economic factors that affect people's choices and decisions are ignored. A further problem is that such strategies place little value on individual autonomy and can be seen as moralizing.

Educational approach

In this approach the aim is to improve knowledge, develop skills for healthy living and ensure understanding so that individuals can make an informed choice about their health behaviour. The approach respects the right of individuals to choose their own health behaviours. Information is provided through one-to-one teaching or in small discussion groups, with the content often being influenced by clients' expressed needs. In addition individuals are helped to explore their values and attitudes and to carry out their own decisions. The approach is particularly suitable for antenatal and child care, school and workplace programmes as well as individual patient education concerning specific disease, treatment and rehabilitation procedures. Written information is often given to these individuals and their families to read; however, patient/client education has been found to more effective and acceptable when it is designed specifically to meet the needs of those concerned through follow-up discussions which provide opportunities for asking questions and receiving supportive explanations from nurses and midwives.

A review of the literature indicates that this approach is used in Finland for family training and support of couples in their transition to parenthood (Vehvilainen-Julkunen, 1995) as well as to achieve active and responsible self-care in adolescent diabetics (Kyngas and Hentinen, 1995). In France, Marty and Macaux (1997) have adopted an educational format for written information offered to breast cancer patients undergoing surgery. Included in this information package is advice on the nurse's role in health education and the women are invited to seek further explanations from nursing staff. Through group discussions and the publication of a newsletter, a team of occu-

pational health nurses in France have been able to successfully advise on the prevention of chemical hazards (Manicot, 1991). In the United Kingdom, this approach, often termed teaching and information giving, has been identified in the surveys of Davis (1995), McBride (1994) and Noble (1991).

Client-centred approach

This approach relies on professionals working as equal partners with individuals to help them identify their concerns, the aspects of their lives that require change and the choices that are available to them. Individuals are then helped to gain the skills of informed decision-making and the confidence to act upon their decisions so that they can take control of their lives and health. The approach is centred on the individual and, with its goal of self-empowerment of the patient or client, may involve one-to-one counselling. In Finland, for example, an examination of the client-centred approach demonstrated that the relationships between mothers and public health nurses during visits to health clinics supported self-confidence and participation through negotiation, information sharing and advising (Vehviläinen-Julkunen, 1992).

The nurse's role as a health educator can be described according to two main styles of intervention ranging from authoritarian (nurse as expert) to negotiator (nurse as facilitator) (Ewles and Simnett, 1992). The ethical implications of these roles are discussed below.

Nurse as expert

This traditional image of the nursing role is one in which paternalistic action features strongly. It tends to be popular within the health care professions as it is so clearly defined. The nurse is a source of knowledge who provides information, advice and guidance to clients or patients in order to bring about a change in their behaviour which will include taking responsibility for their own health. The chosen activities rely on the nurse's assessment of the need for change, the

appropriateness of the individual's lifestyle and the most effective means of communication. It results in a one-way flow of information which may not always be relevant to an individual's particular needs or circumstances. The acceptance of the health message may rely on the nurse's status, her credibility and trustworthiness. However, persuasion or coercion may result if nurses impose their own values, solutions or instructions as a way of dealing with a client's problems. This necessarily denies the individual the right to freely choose their health-related behaviours and therefore is unethical.

The model ignores the social and environmental dimensions of health and as with the behaviour change approach discussed above, assumes that individuals have equal resources thereby ignoring the complex relationship between individual behaviour and social and environmental factors.

By the patient or client adopting a passive role, compliance is expected. This can be reassuring to those who are vulnerable, such as children or those who are very ill and have rather limited levels of autonomy. The disadvantage of such an approach is that by fostering dependency on medical knowledge, rather than encouraging autonomy, individuals neither develop the ability, nor acquire the resources, to accept responsibility for their own decisions and actions. Although adoption of the role of expert has been successful in patient education when it is necessary to avoid distress, such as providing information prior to or after surgical or investigatory procedures, it has not been effective in changing the long-held, health-related behaviours which affect lifestyle. It is these which often pose the greatest challenge for nurses working in primary health care settings such as schools and workplaces. The ability to communicate is simply not enough. It is necessary to take into account not only an individual's stage of development and emotional condition, but also his or her social and cultural background.

Ethical issues also arise because of the assumption that everyone has equal resources and abilities to comply with the directives given. When compliance is not achieved then victim blaming may occur, even if it is not deliberately intended. In other words, individuals are held solely responsible for the factors which have put them at a disadvantage, but over which they may have no control. Similarly, health problems attributed

to particular groups may also lead to victim blaming. Perhaps nowhere was this more obvious than in the early days of the AIDS outbreak. Mothers and fathers attending family training in Finland evaluated the role of the public health nurse and midwife as an important expert (Vehviläinen-Julkunen, 1995).

Nurse as a facilitator

In adopting this role, the nurse seeks to enhance the autonomy of the patient or client and it is this image which many nurses aspire to within the new nursing philosophy. The model lies comfortably with the client-centred and educational approaches that invite the participation of individuals. Examples are cited in the literature by Vehviläinen-Julkunen (1992) and Kyngas and Hentinen (1995). In this role, nurses utilize activities and methods that are planned in consultation with the individual, using stages similar to those of the nursing process. Through the process of negotiation, a careful assessment of the individual's needs are made.

As a facilitator, the nurse should enact her role with warmth and empathy, building confidence, sharing skills and knowledge and encouraging the individual to enter into a relationship of trust and openness. Through the individual's choice to actively participate in negotiation and shared decision-making, their autonomy is not only respected, but may also be enhanced. In this way individuals learn to trust their own judgement.

The nurse is required to respect informed decisions made by the individual, even if these are not ones with which she would concur or that will lead to a healthy outcome. This can create a dilemma for nurses whose intent is to 'do good', where 'good' is defined in some sense of 'health'.

Nurses aspiring to the role of facilitator must be aware that although educational approaches aim to enhance autonomy by providing knowledge that will enable the individual to make an informed choice, unlike client-centred approaches, they may ignore both the restrictions that social and economic factors place on voluntary behaviour change and the complex nature of health-related decision-making. Self-empowerment enables

individuals to act in ways that influence these factors within their own communities.

The new nursing philosophy, with its aspirations for self-empowerment, assumes that patients or clients want to be active participants but this should be seen as their choice. There are of course various types and degrees of participation which may vary over time according to the needs of the individual. If nurses are inflexible and assume that all patients or clients should be encouraged to become active participants in decision-making, regardless of its appropriateness to the particular individual, then coercion and compliance may occur. To avoid this, patients and clients should be asked if they wish to become involved (Waterworth and Luker, 1990). On the other hand, the provision of information is a fundamental need and according to European Union regulations, it is a legal right. Furthermore, there is an ethical obligation that the quality of information provided should enable individuals to understand the medical aspects of their condition or state of health and to participate in decisions which will have consequences on their well-being (Posko, 1993).

In the UK nursing literature descriptions and discussions of this style of role enactment can be found in the work of Waterworth and Luker (1990), Jewell (1994) and Trnobranski (1994) but similar topics are not apparent in the Finnish and French literature.

The need to empower nurses in Finland, France and the United Kingdom

To achieve the goal of self-empowerment the relationship of patients and clients with the nurse must undergo a transition of power and control by moving away from the nurse's traditional role as expert to that of facilitator. The patient's or client's autonomy is enhanced, while the nurse's authority, in her role as a health educator, is reduced. However, to fulfil a professional role that facilitates empowerment and encourages collaboration and active participation in both self-care and decision-making, nurses need to have both the authority and

therefore the autonomy necessary to enable patients and clients to enact the decisions they have made.

Finland

Finland has a long and distinguished history of public health nursing providing an extensive service in municipal health centres. Although reforms over the years have altered this service, the public health nurse, together with the doctor, still remains a key person in primary health care as Tope and Smail discuss in the following chapter. She is able to work directly with clients and has the authority to initiate contacts and consult expert members of the health care team (Siivola and Martikainen, 1990). Public health nurses undergo four and a half years of education (including three years of general nursing education), but the authors admit that 'developing the quality and content of public health nursing continues to pose an educational and managerial challenge' (p. 107). The role of health educator is also incorporated into the role of registered nurses working in the hospital sector.

Within the hospital setting in Finland, gaps have been identified between the government's recognition of the role of the nurse as a health educator and its implementation. Suominen (1993) assessed the extent to which breast cancer patients' information needs are met and found that nurses' perceptions of their health education role are unclear. In some cases, nurses believed information giving to be a 'medical issue' and therefore the responsibility of the doctor. This lack of clarity of the nurse's health education role was confirmed in a further study among a similar group of patients by Suominen *et al.* (1994).

The need for nurses to adopt a holistic approach to patients as individuals, supporting their active participation in a close and equal partnership and enabling the process of self-care through responsible health behaviour, was also identified by Kyngas and Hentinen (1995). This need was found to be fulfilled by nurses who perceived themselves to be empowered (Raatikainen, 1994). In her study, these empowered nurses were more often found to hold senior positions (nurse specialists or assistant head nurses), rather than to be working as 'registered

nurses'. It was concluded that a more advanced level of nursing education, continuous professional development, the possession of a wider sense of responsibility, clearer principles and the ability to work in collaboration with others were the distinguishing features of an 'empowered' nurse. However, the study did not make clear whether or not these senior nurses were attempting, or were sufficiently empowered within the hierarchies of the five hospitals surveyed, to create supportive working environments for their junior nursing colleagues, which would in turn be empowering.

'Self-care' health educational programmes in Finland are predominantly based on counselling during individual patient contacts, by both registered nurses and public health nurses, in the hospitals and municipal health centres respectively. These programmes have been criticized for their tendency to rely on the application of a 'universal package', rather than being based on an appraisal of individual needs (Suominen, 1993; Miilunpalo *et al.*, 1995).

France

Historically, the role of nurses in France has been regulated by the content and omissions of several decrees. Since 1984, nurses have had the legal authority to assume a role in health education and health promotion but it was not until a decree in 1993 that nursing became an autonomous profession with its own explicit values and principles. Prior to this nurses were legally subordinate to a dominant medical profession by whom their work was prescribed, rather than being a complementary profession working in partnership. Lacroix (1992) described the struggle she experienced as the only nurse in France at that time to become President of a Departmental Committee for Health Education. She also emphasizes the considerable difficulties faced by nurses in gaining rightful recognition for the valuable contribution they can make as health educators as they remain under-represented and undervalued.

In 1992, a revised public health module, consistent with the principles of the Ottawa Charter for Health Promotion, was included in nursing education programmes leading to the

French State Diploma in Nursing. The goals of this module are to prepare nurses for multidisciplinary collaboration and their role as 'agents of health' and to enable them to participate effectively in the development of a real public health policy which, in the future, 'will have to be structured around a reflection on patient education that will drive him [the patient], little by little, to take some charge, by himself, of his illness' (Alozy, 1993, p. 29).

During this decade, there has been much discussion about nursing ethics and the autonomy of the patient in France. In relation to the role of the nurse as a health educator, there appears to be more of an expression of the right sentiments that endorse the self-empowerment of patients than practical strategies for overcoming some of the very real obstacles that separate nurses and patients. As in Finland and the United Kingdom, there is little written about the effect that the lack of autonomy has on the nurse's role as a health educator. Despite legal recognition of such a role and an education which provides an appropriate knowledge base, as well as teaching and communication skills which should, in theory, give nurses the necessary competence and confidence, external barriers to the performance of the role still exist. For example, Posko (1993), in a small survey of cancer patients' satisfaction with the information they were given, found that part of the problem in providing patients with the information they wanted was caused by insufficient communication between medical and nursing personnel. From the author's experience, the public hospital sector is generally understaffed by *infirmières* (first-level nurses) who, in their highly skilled, extended roles, are bound by an inflexible task-oriented organization.

Within such a system patients are denied the individualized assessment and care which is at the core of the new nursing philosophy, although when working with empowered patients and clients, nurses welcome the opportunity to encourage an active partnership. However, in a society that is conscious of consumerism, the self-employed community nurses (*infirmières soins à domicile* and *infirmières libérales*) may not always take opportunistic health education initiatives in relation to smoking, sensible drinking or practising safer sex, for fear of offending and losing a client and consequently reducing their income.

The exception may be when clients have a chronic disease or long-term disability and their partnership in care has become 'bonded'. In their role as health educators then, community nurses seem to represent a vast, relatively inexpensive (reimbursable), accessible, but greatly underutilized and under-recognized resource, both by the public, the policy-makers and the professionals themselves.

The United Kingdom

Some of the above comments may strike a common chord with the experiences of nurses working as health educators in the United Kingdom. Health education has been a well-established element in the role of community nurses and still comprises a large part of their health promotion work (Sourtzi *et al.*, 1996). These authors found that health education was largely based on traditional one-to-one activities. In the UK, the term 'community nurses' refers to practice nurses, health visitors, midwives, district nurses, school nurses, community psychiatric nurses, community mental handicap nurses, indeed any nurse working in primary health care settings.

Although the United Kingdom's 'Health of the Nation' strategy (Department of Health, 1992) recognizes the role of nurses in health education and health promotion, the recognition is a somewhat limited vision of what the role could be. For instance, one implication of this strategy in practice, through its targeting of high-risk groups and inadequate recognition of the socio-economic determinants of health, is the expectation that nurses will adopt a behaviour change approach. The strategy is not sufficiently supportive of the nurses' role as a facilitator of health education whose goal it is to empower patients and clients. Many opportunities are lost through, for example, statutory duties, case load size, collecting information on patients' health status and health surveillance, in fulfilment of the Health of the Nation targets.

Although in the United Kingdom hospital nurses exist in vast numbers, have close and continuous contact with patients and are knowledgeable about health education, Delaney (1994, p. 833), referring to two unpublished studies (Richardson, 1992;

Glossop, 1993), concludes that 'there is little evidence that it [health promotion] is rigorously and readily related to everyday practice' and this may also apply to health education. In hospital settings this is partly due to nurses' socialization into traditional practices such as ward organization and the expectations of colleagues, as well as the demands of the bureaucratic and hierarchical system in which they are employed.

Educating patients for health and self-care is seen as a priority in the recently reformed nursing education at Diploma level, commonly referred to as Project 2000 (Noble, 1991). These courses encompass holistic views of health, but as Delaney (1994) observes, a theory–practice gap is evident due to the lack of attention given to how abstract conceptual issues, such as enablement and empowerment, can be translated into the actual behavioural skills of the nurse.

Trnobranski (1994, p. 735) commented that a 'nurse needs to be empowered and have the freedom to make decisions as an autonomous practitioner, in order to be an agent of the patient's freedom of choice'. Nurses should be accountable for any professional decisions that they make. The UKCC in its *Code of Professional Conduct* (1992) expects practitioners to possess these attributes of autonomy and accountability. The extent of their realization within nursing in general, as well as in the 'facilitator' role of the nurse as health educator, is still, however, debatable (Trnobranski, 1994).

Conclusion

In Finland, France and the United Kingdom, the overall health of these populations has improved in recent years, for as people are more articulate and socially and economically advantaged, they tend to adopt healthier lifestyles. The goals of the Health For All 2000 strategy and its more radical Ottawa Charter for Health Promotion identify the need to reduce or eliminate differences between socio-economic groups and overcome health-damaging lifestyles. Throughout Europe, however, there remains a considerable problem aggravated by the economic recession of the 1990s.

The approach towards better health and the social and economic fulfilment of patients and clients through self-empowerment provides considerable challenges for nurses in their role as health educators. This, not surprisingly, may seem a daunting task for any individual or group of nurses although the process of achieving autonomy of the patient or client must have a beginning.

Based on the available literature, the extent to which nurses in all three countries are able to practise their role as health educators and perform it in an ethical manner is impossible to assess as further evaluative research is required. Existing evidence, however, indicates that lack of knowledge, patient assessment and communication skills, confidence and support from those who control their activities and employment may reduce the likelihood of effective health education if it is practised at all.

Disparities exist in all three countries between the aspirations of facilitating patients and clients towards the goal of self-empowerment and the realities of existing health education practices. These practices are more likely to exist somewhere along a continuum between the roles of expert practising activities within a behavioural change approach and that of facilitator whose approach is client-centred. Neither role is right or wrong in itself, but should be determined by the needs and wishes of the patients and clients involved, and realistically take into account the social, economic and political factors that influence their everyday lives.

The issues involved in respecting and promoting patient or client autonomy are closely related to and concern the degree of autonomy which nurses themselves possess. If health education is to be an ethical enterprise, there is a clear need, not only to empower patients and clients, but also to empower nurses in their role as health educators.

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