A STUDY OF THE MORAL DIMENSIONS OF THE ROLE OF THE NURSE AND THE NURSE-PATIENT RELATIONSHIP

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ABSTRACT

The central question of this dissertation is "What conception of the role of the nurse, and of the nurse-patient relationship, will result in the most effective way to attain the moral aims of nursing - the provision of humane, respectful and dignified care?" The background of current pre-occupations in nursing ethics is sketched out in a review of the literature. Against this, the conceptions of the nurse as servant, advocate and skilled companion; and models of the relationship as contractual, covenantal and dialogic are respectively examined. Relevant aspects of the peculiar position of the nurse are also examined; the invisibility of nursing, the potential for informal power, and the pivotal nature of the position. Empirical evidence from both ethical and sociological studies is drawn upon to support the discussion. The conclusion arrived at is that, in the current UK health care system, the role of skilled companion affords the nurse the greatest opportunity to achieve the moral aims of nursing. It is tentatively suggested that understanding the nurse-patient relationship as dialogic may also be useful in the attempt to realise these aims. Finally, the implications for nursing, and for nursing ethics, are outlined.

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CHAPTER 1 : INTRODUCTION

Origins of the Research Question

It is clear that the woman who shaped modern day nursing, Florence Nightingale, and whose name epitomises nursing for most people, saw nursing practice as fundamentally moral in nature, rather than scientific. (Abel-Smith 1960). Gadow (1979) points out that the principal elements in nursing are persons, so human values are by definition central. In common with other professions who serve people, there is no aspect of practice without ethical considerations.

The dominant sense of nursing has to date been moral and personal, rather than technical and professional. (Bishop and Scudder 1990). There is a general idea in society, and even among nurses, that moral issues and problems in nursing practice arise from the development of technology, and are related to issues of life and death. But moral issues and problems can arise from the practice of nursing itself: where, for example, the vulnerability and dependence of those requiring nursing care can lead to imbalances of power within the nurse-patient relationship.

Nursing has been referred to as an ethical enterprise (Allmark 1992). This statement can of course be challenged: nursing can be viewed in a variety of ways - a group of cognitive, affective and psychomotor tasks, a collective experience, an organisation, an abstract tradition. But these are simply ways of viewing the activity called nursing; none of them describe the foundation on which all these accounts are built. (Yarling and McElmurry, 1986). It is the original moral commitment to health and welfare that creates the profession, not the profession which creates the ethic. (Pellegrino 1985). Fry has claimed that, if there is a distinct nursing ethic, it derives from the nurse-patient relationship: the moral foundation for nursing. (Fry 1989).

Until very recently in this country, nurses saw themselves as 'handmaidens' to the

physician. (Indeed current television drama suggests that this image lingers in the public mind, and personal clinical experience suggests in that of some nurses). This image, with its connotations of the virtues of obedience, self effacement and so on will be discussed in Chapter 3. Over the last 20 to 30 years, nurses have become more educated and nursing now lays claim to being a profession. Nurses have also become much more politically aware, and claim partnership with, rather than subservience to, physicians. A more recent trend is toward adopting the role of 'advocate' to the patient. The UKCC for Nursing, Midwifery and Health Visiting have explicitly recommended this role to nurses in the Code of Conduct, a guide for professional practice issued to all nurses on the UK register. (UKCC 1992). The adoption of this role will also be discussed in Chapter 3.

The Research Question

Gadow in 1979 saw that the most pressing and most fundamental ethical question for nurses was the question of what might be the ideal relation of nurse to client. Almost twenty years later the profession does not appear to have agreed on what this might be. Gow (1982) saw a specific role for the nurse as a humanistic expressive specialist - concerned with maintaining humanity in an increasingly technological health service. Muyskens (1982) sees the function of the nurse as providing a human dimension to technical medical care, ensuring dignity and respect in the face of both illness and technology. From these sources, I have derived the question which I have taken to be central to this dissertation:

"What conception of the role of the nurse, and of the nurse-patient relationship, will result in the most effective way to attain the moral aims of nursing - the provision of humane, respectful and dignified care?"

The Research Method

Philosophical Inquiry

Nursing has no identifiable philosophy in the way that education and medicine have. There are a variety of possibilities as to why this should be so: firstly, perhaps nursing and medicine share a common philosophy; secondly the phrase 'philosophy of nursing' is much misused in nursing to represent an ideology (Schrock 1981), which may obscure the lack of development of a true philosophy; and thirdly nurses have embraced the natural sciences with great fervour in their attempts to 'professionalise' nursing. 'While the titillating allure of clean scientific answers continues to excite nurses, the profession is inexorably drawn toward the hazier study of human experience' (Brunt 1985 p 17).

The questions traditionally answered by philosophy are the fundamental ones of being, of knowing and of values. Questions such as 'what is nursing?' 'what is the foundation of the nurse-patient relationship?' are not amenable to answer by the data or theories of science. (Ellis 1983). 'You cannot prove that empathy is useful through sophisticated statistical analysis; you do not have to'. (Brunt 1985 p 18). This is not to say of course that data acquired from scientific study is not useful in contributing to the answer of these questions.

The goals of nursing are the health and welfare of human beings. These are moral goals, i.e. the seeking of good. Therefore philosophical inquiry is needed to clarify the means and ends of nursing (Ellis 1983), to contribute to the understanding of the moral fabric i.e. common values and varying perspectives, (if any) which holds the profession together and to answer the question 'what gives meaning to what nurses are, and what they do?' (Davis 1987).

Gaut (1985) describes the philosophical task as assessing and systematically relating 'from some integrating perspective the diversity of human knowledge and experience' (p 73). Ellis (1983) suggests that philosophical techniques of analysis can be used to

improve the understanding of important human endeavours. It is the latter aspiration to which this dissertation will attempt to contribute.

EmpiricalData

Jameton and Fowler (1989) describe dual mode research where descriptive and evaluative components are combined in the form of empirically obtained data and philosophical analysis. It is assumed that empirical work can help in the discovery of important moral considerations, even if the work does not establish the truth of fundamental moral principles. For example, Hutchinson's work on rule bending among nursing (Hutchinson, 1990) or Goodwin et al's work on placebo administration (Goodwin et al 1979) can contribute to a philosophical discussion of the moral concerns of nursing, even though these have been undertaken as sociological studies. Some philosophers have also carried out qualitative research; for example Davis and Jameton's study of nurses views on autonomy, (Davis and Jameton 1987) and Self's study of the ethical foundations of nurses' decision making (Self 1987). Appropriate empirical evidence can be obtained for subsequent philosophical analysis of the moral claims of the profession. (Jameton and Fowler 1989).

It is the contention of Martin Johnson (1990) that the current sources of data (medical and legal opinion and studies using limited experimental methods) are insufficient as a basis for moral debate. Naturalistic sociological methods have considerable potential to provide data and theories from which to describe and explain moral conduct in nursing.

It is with this view of the usefulness of combining empirical data, and philosophical inquiry, that this dissertation has been constructed. Selected empirical work will be drawn upon in order to identify the moral concerns of nurses, and the ways in which they deal with them. These studies have been selected on the following criteria: they examine aspects of everyday nursing practice which are seldom, or poorly, articulated and they do not necessarily focus on what are designated as 'ethical' issues. Often

they are classed as sociological studies, but the data revealed cast light on moral aspects of nursing. They employ qualitative methods of inquiry. The literature suggests that these are appropriate methods for examining everyday work, which are open ended and suited to complexity, opening up possibilities of identifying conceptual orientations other than pre-conceived ones. (Gaut 1985).

Evidence drawn from these will be related to the discussion of the various conceptions of the nurse's role, and those of the nurse-patient relationship.

I have been influenced in my approach to this study by Brody (1990), who outlines criteria for quality scholarship in ethics. These are: empirical research identifying moral problems which are not well discussed; exploration of context and institutional factors, and sensitivity to the problem of multiple moral traditions. His concept of reflective equilibrium allows one to put all this together - moving between empirical observation and reflective thought. I have tried, in a limited way, to use these criteria to achieve quality in this work.

Scope of Dissertation

I have attempted to set the discussion in context by providing a literature review which broadly reflects the current preoccupations of nurses studying the ethical concerns of nurses. This provides a background against which the central question is asked, and possible answers explored. The discussion then moves on to how the context in which the nurse practices affects these answers. The dissertation concludes with a brief summary, and an appraisal of what has been achieved.

Limits of the Dissertation

Throughout this dissertation, the emphasis will be placed, not on moral reasoning or making decisions in moral dilemmas, but on acting morally in the course of everyday practice; what Benner calls 'skilled moral comportment' (Benner 1991). Empirical studies in nursing have repeatedly demonstrated that moral reasoning is not linked to

moral behaviour (Ketefian 1989), so the substantial body of work dealing with moral reasoning processes in nurses will not be referred to.

The area of nursing considered will be that of acute physical illness. This has been selected because the writer's clinical background, and most of the empirical studies, are located within this area. It is acknowledged that there may be aspects of nursing in other areas which are not therefore addressed here.

When referring to nurse/physician/patient, I have arbitrarily used the feminine gender throughout. I have used the word physician to indicate any member of the medical profession. I have used the word patient, rather than client, in the light of the context of acute physical illness. The meaning of the word 'client' does not seem to me to express accurately the position of the person who comes to the care of the nurse in an unsought relationship, where she is sick and distressed.

Although this dissertation addresses the situation of the British nurse, a substantial amount of the literature drawn upon is North American in origin. This is taken to be valid and appropriate, given the assumed nature of nursing, and the common history of both cultures.

CHAPTER 2: LITERATURE REVIEW

Contemporary Bioethics

Two centuries ago, the mediaeval idea of morality stemming from an authoritative external source gave way to the idea that morality could be understood as deriving from human self governance. The work of the philosophers Kant and Bentham provided the springboard for the development of this notion. (Schnweewind, 1991).The ideal of the autonomous individual as the moral agent became the focus; and this has been elaborated and defended over the last two centuries. Moral behaviour, from this perspective, is based on rationality, and in particular critically reflective or reasoned abstract principles of conduct. Moral problems are viewed in terms of abstract rights, duties and principles of conduct. The 'best' answer to a moral problem is found by appealing to universal moral principles (Johnstone, 1989). This rationalistic approach has dominated philosophy over the last two hundred years, and is a feature of differing philosophical approaches, such as utilitarianism and Kantian deontology.

This contemporary perspective is reflected in current bioethical literature, which is dominated by a principle based ethical model. This is described by Beauchamp and Childress (1989). The model relies on a framework of ethical principles, which are considered to operate on a prima facie basis. The model describes and guides the actions of the moral agent. Moral choice involves the consideration of competing principles. Reason provides the means of deciding between these: presenting and defending reasons for action, assessing own assumptions and commitments and anticipating and responding to objections. The viewpoint of the moral agent is one of objectivity, impartiality and detachment. Rights, duties and obligations are viewed as being shared by all, and all are governed by rules, norms and principles. Different types of ethical theory may be invoked during this process.

In the last 20 or so years, philosophers have begun to move away from this perspective. There are indications of a retreat from abstract principles, and a return to seeing morality as a matter of virtue. (MacIntyre, 1985). There is also a trend toward focusing attention on the behaviour of groups/communities, rather than the individual; and toward the consideration of specific problems such as managing the environment. (Schneewind, 1991).

The adequacy of contemporary philosophy has been challenged by philosophers such as Williams (1972; 1985), Blum (1980) and MacIntyre (1985). According to Williams, the unprecedented demands of the modern world cannot be met by conventional ideas of rationality. He challenges the primacy of rationality, and the decontextualisation of the individual. Blum argues that if emotionally based actions are appropriate behaviour within relationships, then philosophies grounded in rational principles only will be defective. MacIntyre sees in contemporary moral philosophy an array of conflicting moralities, which offer no guide to choosing between them, rejecting rationality and the emphasis on the individual in favour of a return to an Aristotelian notion of the virtues. In this view, the emphasis is on the nature of the moral agent, not on the moral action itself, or of its consequences. (Hursthouse 1987).

The feminist philosophers also have challenged contemporary philosophies. (Belenky et al, 1986; Baier, 1987; Benhabib, 1987; Held, 1987). Feminist moral theory holds that a substantive moral ethic should be grounded in the particular situations of experienced life, and not the detached hypothetical circumstances of the ideal. The contemporary idea of the individual agent is also brought into question (Meyers 1987). Moral philosophy has tended to neglect the areas of relationships and emotions, and has significantly neglected the phenomena of caring, concern and compassion. The ideal stance is that of a detached and impartial spectator. Feminist theorists challenge this. They see moral problems as constructed in terms of care, responsibility and personal relationships, not in terms of abstract rules and principles. They claim that currently accepted ethics have become principled at the expense of care.

The work of Carol Gilligan, in generating a challenge to orthodox theories of moral development, also challenges the dominance of currrently accepted ethical theory, and reflects the philosophical trend away from the dominance of the individual (Gilligan 1981, 1982, 1986). Gilligan challenged Kohlberg's widely accepted theory of moral development on the basis that his empirical research was carried out on young males. When the conclusions drawn from this were applied to young females, they were categorised as being less morally developed than males. Based on her analysis and interpretation of this research, Gilligan claimed that there is a tendency on the part of males to a 'justice' (i.e. impartial and objective) orientation of morality; whereas there is a tendency on the part of females to a 'care' (i.e. involved and subjective) orientation of morality. The conclusion to be drawn therefore from Kohlberg's work is not that women are morally deficient, but are differently orientated. Kohlberg has now accepted some of Gilligan's claims and subsequently modified his theory in the light of these. (Kohlberg et al 1983). Gilligan's work has been highly influential, and there has been considerable work carried out developing this thinking. (Lyons, 1983; Adler, 1987; Sher, 1987; Gilligan and Wiggins, 1988; Gilligan and Attanucci, 1988).

The controversies within contemporary philosophy described above are also beginning to be reflected in the literature of health care ethics. The principle based framework described by Beauchamp and Childress (1989) is not universally accepted in the field of bioethics and recently has begun to attract considerable criticism. A whole issue of the Journal of Medicine and Philosophy was devoted to this criticism in 1990. (Clouser and Gert; Green; Holmes, 1990). Clouser and Gert (1990) criticise bioethical principles as conflicting, lacking systematic relationships to each other, and being unable to guide actions. They claim that it is impossible to integrate these principles as there is no theory to establish their validity and interrelationships, or guide their use. It seems therefore optimistic to expect individual practitioners to achieve something which some philosophers feel unable to do. Other criticisms of the current principle focused approach are that moral wisdom is needed, and consideration of the principles does not provide this (Holmes 1990) and that there is a heavy reliance on simply applying received principles. (Green 1990). In addition, contextual

factors, like relationships, may be overlooked, or perhaps more likely, incorporated tacitly into the reasoning process. Those who criticise the principled approach vary in their responses from suggesting it be abandoned, to increasing work on these in order to develop a unifying theory. However, not only the principle based approach has come under attack: so too has the traditional impartial and objective perspective.

Emergence of an Ethic of Care

Carse (1991) summarises the chief criticisms levelled against the justice orientation by Gilligan and other care theorists. From a justice perspective, commitment to impartiality is the moral stance. This captures our intuition that what is morally required of one individual is required of everyone. But, because the agent's view of the 'person' is an abstract one, this from the care perspective is seen as a moral problem because it is devoid of consideration of both the distinctive identity of the person, and the relationship between the agent and the person. The danger is that the agent may become unable to perceive, imagine, and therefore understand the other's position.The rejection of impartiality, or detachment as Gilligan refers to it, as a moral viewpoint reflects a withdrawal from contemporary tendencies to rely on forms of judgment that take no account of specific situations and people, and see moral maturity and skill as a capacity for abstract deliberation.

Secondly, the care orientation is characterised by a view of moral principles as being insufficient to guide moral actions. The application of principles to specific cases does not give a complete description of how we interpret situations and decide how to act. The agent has to a) recognise that the principle is relevant to a particular situation and b) realise how to act in order to apply the principle. This requires a capacity for perception not addressed by the principles themselves. There is no room in principle based ethics for sensitivity to other people, and for the capacity to perceive emotion. Gilligan argues that this 'attentiveness' is in itself a moral capacity which can be developed, and it is not principle governed.

Thirdly, from the traditional, justice perspective, emotions are viewed as hindering

judgment. But emotions play a crucial role in drawing attention to the morally relevant aspects of a situation. Emotion also plays an important part in moral actions; it is not only what we do but how we do it that makes an action moral.

The emphasis on impartial principles and dispassionate judgment which is a key feature of the traditional orientation may not provide adequate guidance in an ethic which specifically takes care as its focus. Deliberating on and upholding principles does not necessarily generate a caring response to others.

In Carse's analysis the differences between the two perspectives are not just those of emphasis; but relate to moral judgment, the nature of the moral agent, and our responsibilities as individuals to each other. For example, the care ethic emphasises compassion toward specific individuals, the traditional ethic emphasises an abstract love of humanity. (Carse, 1991). It should be emphasised, however, that it is not suggested these are two completely different moralities; but simply two differing perspectives within morality. In the same way in which, as Wilson Barnett points out, (Wilson Barnett, 1994) the recent emphasis on rights in health care has served to address previous neglect, this recent emphasis on care, in my view, is serving to redress the balance, not replace justice. On the justice orientation, people are viewed first as individuals and secondly within relationships of individual choice. On the care orientation, people are understood essentially as being in, and deriving their meaning from, relationships.

Other writers have endorsed the idea of care as a moral attribute. Noddings (1984) gives a comprehensive account of an ethic of care, deriving her thoughts from ethical and social psychology theory. The ethic is rooted in relatedness, responsiveness and receptivity (which is closely related to Gilligan's idea of 'attentiveness' outlined above). Ethical caring is the relation in which we meet another morally. Carers are guided not by ethical principles but by the strength of the ideal of caring itself.

Criticisms of an Ethic of Care

Clearly the challenges presented outlined above have not gone unanswered: considerable debate has been generated. (Hill, 1987; Montague, 1990; Almond, 1992). The gender dualism hinted at above is also currently strenuously debated. (Johnstone, 1989; Harbison, 1992; Gillon, 1992). 'Male' moral reasoning is described in terms of rational constructs and abstract moral principles; 'female' moral reasoning is described in terms of non rational constructs such as love and compassion. It is therefore very important to establish that there is no suggestion by any of the care theorists that women speak with a united moral voice, and that it is vital to reject any gender exclusivity or conflict that the language used may invite. As stated above, some male contemporary philosophers hold views in accordance with an ethic of care.

Neither of these perspectives therefore are correlated strictly with gender (Gandhi and Luther King for example possessed ideas consonant with the care ethic (Johnstone 1982); some of Gilligan's research was done with men as subjects (Gilligan and Pollak, 1988); neither are they are mutually exclusive. What is suggested is a new, combined ethic combining the moral perspectives of justice and care, each opening up possibilities for the other; and each constraining the dominance of the other. It is vital to insist that modern Western philosophy is not rejected, nor are principles, and the crucial importance of justice and rights is not denied. The demands of the care theorists are only that they be examined more thoroughly and applied more caringly.

As Carse (1991) points out, justice is not rendered unimportant in the care ethic; what is questioned is its sufficiency as a moral standard, and what is more virtually the sole standard. A more adequate, and fuller, moral theory could involve an integration of the justice and care orientations to retain their respective strengths. The strength of the justice perspective lies in the commitment to welfare, the questioning of assumptions, the refusal to be blinded by false ideas. The strength of the care perspective is the refusal of detachment and depersonalisation, an insistence on seeing and making connections between people and the insistence on attaching importance to

responsibilities within relationships.

It could also be said that a danger of an ethic of care is that a reliance on compassion may interfere with judgment and prevent rational response. In addition, it could perhaps elicit an ideal of self sacrifice, over protection, or paternalism. There are two ways in which this objection could be answered. Firstly, by appealing to Aristotle. Implicit in the idea of a virtue, (assuming one accepts caring as a virtue, see below), is the notion that an integral part of possessing any virtue is knowing 'the right level' (Hursthouse 1987) at which to exercise it. Clearly there is a difficulty here in knowing when you have 'got it right' - one of the criticisms of virtue ethics is that there is no clear guide for action. However, some writers are now returning to the idea that guides to action are not enough, without the parallel development of moral wisdom. (Andre 1992). Secondly, if one is seeking to combine the strengths of a care based and a principle based ethic of justice, then the notion of respect for autonomy also serves to act as a constraint on this possibly harmful outcome. This demonstrates the role of principles in providing us with broad norms of conduct which act as a check on behaviour. (Carse 1991).

Nursing Ethics

It is clear from the texts reviewed on bioethics (Glover 1977; Campbell and Higgs 1982; Campbell 1984a; Gillon 1985; Singer 1986; Hursthouse 1987; Beauchamp and Childress 1989; Charlesworth 1993) that the medical profession is, or has the potential to be, a major focus of attention. The issues which arise in bioethics are those which typically lead to decisions being made by physicians : for example, genetic manipulation, advances in reproductive technology, or dealing with the dying. Although many of these decisions are based on value, rather than technical, judgement, current society tends to look to the medical profession for answers, and are encouraged to do so. (Downie, 1984).[1]

It is a widely accepted tenet of biomedical ethics that physicians have a special ethic,

[1] The case for the public to explicate common values and participate in medical value judgements is clearly outlined by Neuberger (1994).

different from (at least in degree) that which binds other society members, because of the nature of their profession. (Sieghart, 1985). This assumption is accepted in this dissertation for the moment, although it should be acknowledged that this assumption has been challenged recently by Downie. (1986 a, b). He maintains that physicians (and presumably nurses) have no claim to any exclusive ethic, simply to that by which all members of society are bound. The existence of a specific professional ethic is a device to raise the status and increase the power of the profession. In this reading of the situation, if nurses seek to establish a nursing ethic, they are doing so in the interests of the profession, not of their patients. This point will be returned to in the concluding chapter. Writers such as Downie and Telfer (1969), Pellegrino and Tomasma (1981) and Campbell (1984b) explored and explicated their ideas of how a distinctive medical ethic could be described. Few writers have attempted to explicate a nursing ethic, Gadow in the USA being a notable exception. (Gadow 1983). Leaving aside the question of whether there is in fact a distinct nursing ethic, there is no doubt however that nurses have written a considerable literature on ethics as applied in nursing.

Nursing ethics is conventionally considered either as a subdivision of the bioethical model, of which the biomedical model is also a subdivision; or as a subdivision of biomedicine. (Veatch 1981), although this allocation has been challenged (Twomey, 1989). Normative discussion of ethics in nursing is usually framed in the main by biomedical ethical principles, (Rumbold 1986; Melia 1989; Rowson 1990; Chadwick and Tadd 1992; Thompson, Melia and Boyd, 1994; and codes of conduct and practice are based on these. (UKCC, 1992).

Beauchamp and Childress (1989), two of the best known writers in the field, clearly see both medicine and nursing as being part of the same overall bioethical picture. References to specific nursing preoccupations are few: reference to specific physician ones are many. The only area where nursing difficulties are addressed in detail is in relation to conflicts of fidelity. They identify nursing as the area where these conflicts are 'the most pervasive and morally troubling' (Beauchamp and Childress, p 347). They clearly identify the system within which nurses work and the role they occupy as

factors influencing these conflicts, but believe nevertheless that all health care professionals share the same principles and follow the same rules. However, empirical work suggests that the two professions adopt different perspectives on the same situations, and have different preoccupations. (Goodwin et al 1979; Sheard 1980; Uden et al 1992; Grundstein-Amado 1993). The question is whether these differences are sufficient to establish a separately derived set of rules and principles. This point will be returned to in the concluding chapter.

With regard to dealing with the 'pervasive and morally troubling' conflicts above, Beauchamp and Childress suggest that answers to these hinge on a general understanding of moral responsibility in nursing. Their discussion of this is brief, however, and relates mainly to the general trend in nursing from physician's handmaiden toward patient advocacy as the major moral responsibility. They appear to be offering a model of radical advocacy as a contemporary understanding of the moral responsibility of the nurse, justified by invoking the principles of beneficence and autonomy. They do not acknowledge either the considerable difficulties facing nurses prepared to act in this way, or the arguments against nurses adopting this as a major responsibility, suggesting only that procedural solutions might facilitate the adoption of the role.

Backing up this discussion, Beauchamp and Childress have reviewed nurse writers from 1977 to 1987. The authors are all American, and influential and well known contributors to nursing literature. They appear to have focused on how these writers contribute to an understanding of the situations of moral conflict in which nurses find themselves, but do not refer to their attempts to explicate philosophies of nursing, or describe the moral behaviour of nurses.

Nursing is touched on only briefly elsewhere: once in relation to the controversy over decisions to withdraw feeding, citing nurses as possibly holding the view that food is an ordinary part of life, not a treatment which can be withdrawn. But they do not here refer to the peculiar problems of nurses caught in what Engelhardt (1985) refers to as the 'in between' position of nursing: having to implement feeding, or caring for the

patient who has had feeding withdrawn. They offer no discussion of an appropriate role, if any, for nurses in making these decisions or how to deal with the moral distress which may occur in these situations.

Turning now to nursing texts, one might confidently expect that here the unique moral concerns of the nurse, if any, might be sought out and explored. In fact a survey of standard works in nursing ethics reveals little difference from the approach outlined above. Jameton (1984) for example sees nursing and medicine as similar health care professions, bioethics arising from the experience of both of these. His discussion is conducted in terms of principles and the major ethical theories. He conducts an analysis of a case of medical incompetence causing conflict with nursing staff, and his vivid discussion of this is consonant with Beauchamp and Childress' treatment of conflicts of loyalty (discussed above). "Since urgent good and gruesome evil co-habit in hospitals, nurses work in ambiguity and contradiction. Since they do both good and bad things to patients, nurses ask themselves whether the enterprise as a whole justifies continuing co-operation with things that in their judgement are reprehensible ..... the fact that someone else makes the decision underlying what they do does not remove the feeling of complicity in wrongdoing". (Jameton 1984, p 282). He cites as examples of this repeated heel stabs on babies who will not survive, or doctors refusing to take part in infection control precautions.

Burnard and Chapman (1988) discuss the ethical aspects of the code of professional conduct in terms of principles in very similar terms to those used by Beauchamp and Childress, and draw on the major ethical theories of deontology and utilitarianism to inform their discussion.

Chadwick and Tadd (1992) take a similar approach, but offer a discussion of models of the nurse patient relationship. It is clear from the discussion that advocacy is the current major framework under consideration, and they discuss this in detail, outlining different classes of advocacy, and pointing out the limitations and drawbacks, as well as the perceived advantages. The concept of advocacy as a moral basis for nursing will be explored in Chapter 3.

Davis and Aroskar (1978) lay out traditional ethical positions in relation to issues in nursing - notably consent, rights, abortion etc. They selectively introduce philosophers' ideas they feel to be relevant to nursing - notably Rawls neo-Kantian justice based theory (Rawls, 1971) based within the rationalist tradition. [2]

Other nursing texts follow much the same line, adapting case studies to fit nursing situations, and often drawing on common nursing experience. A recent publication by Wilson-Barnett (1994) advocates a principled rights and duties based perspective, and claims that the nature of the nurse patient relationship provides a context and perspective for application of these: in a similar way in which Gillon (1994) appears to refer to scope as providing the context for application in health care. She appears to endorse Campbell's idea of skilled companionship, (discussed in Chapter 3), and Tschudin's concepts of caring, (Tschudin 1992) believing that applying the principles will allow nurses to avoid the trap of sentimentality and emotional exploitation. She later suggests that the adoption of a covenantal model might be appropriately used in order to set acceptable limits on the giving involved in the relationship. She recognises a difference between nursing and medicine in what she describes as the context or responsibilities and therefore the nature of the dilemmas, and the possibly greater opportunity of the nurse to establish relationships: referring here for support to Oakley's paper on the importance of the nurse. (Oakley 1984). Oakley, in a paper delivered to a World Health Organisation conference in Helsinki, analyses the contribution of the nurse from a sociological perspective.[3]

Wilson-Barnett, I think correctly, points out that the recent emphasis on rights has been necessary within the health service to redress the problems of institutional, routinised and depersonalised care. She too refers to the current interest in nursing in

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2 Theirs is the first instance I can find of a reference to what they call 'the great informal power of the manipulative subordinate' (Davis and Aroskar p 37). I shall return to this idea later in Chapter 5.

3 An interesting feature of Oakley's paper is her acknowledgement that despite 15 years as a researcher in hospitals, she had not really noticed what nurses did. This idea of the 'invisibility' of nursing I shall return to later in Chapter 5.

advocacy, and indirectly queries whether nurses are appropriate advocates. She claims that if autonomy were protected, advocacy would be irrelevant, but does not pursue this claim, or point out the difficulties in protecting autonomy from a nursing standpoint. Many of the criticisms levelled against the nurse as advocate could be applied to the nurse as protector of autonomy. She does endorse Johnstone's argument against advocacy, (Johnstone 1989) and considers the fiduciary relationship a more appropriate basis for nursing, with the authority to care derived from trust.

Fundamental to the nurse patient relationship (or potential relationship) is the need to understand the patient's experience. Wilson-Barnett discusses the necessity for communication and history taking skills in order to develop this relationship. She neglects however to mention qualitities such as imagination and sensitivity - both one would imagine essential to understanding others experiences. The necessity to understand patient experience by listening to their stories is also seen as a fundamental moral requirement by the American nurses, Benner (1991) and Parker (1990).

Wilson-Barnett suggests that nurses, from their particular perspective, apply and integrate the accepted tenets of ethical thinking, i.e. a principle based framework. She does not however refer to the ongoing debate as to the adequacy of this outlined above. Additionally, the values derived from biomedical ethical principles have not been convincingly demonstrated to be the primary moral foundation of nursing ethics. Some studies (Akerlund and Norberg 1985; Hutchinson 1990; Webb and Bunting 1992) indicate that nurses violate ethical principles in practice. Biomedical ethics guide most normative discussions of ethics in nursing, but little account is taken of the role and social significance of nurses, the ideal of caring and other values for practice. (Fry 1989). The bioethical framework, and the codes of practice based on it, may not accurately, therefore, represent the basis of nurses' moral judgments and actions.

Contemporary Challenges Reflected in Nursing Literature

It has been said that nursing ethics cannot simply be the application of biomedical principles to a new set of facts. (Jameton, 1984). On the contrary, nursing ethics

should describe the moral phenomena found in nursing practice, critically assess language and theoretical foundations of practice, and raise normative claims about the aims of practice (Fry, 1989). It is clear from the literature that there is a growing body of opinion that the bioethical/medical model, deriving from current philosophical stance, is inadequate for this purpose, and that a different, or at least expanded, model is required which is adequate.(Bishop and Scudder 1987; van Hooft 1990; Harbison 1992; Tschudin 1992).

The contemporary philosophical debate is reflected in nursing literature. For example, the notions of a return to Aristotelian rather than Kantian thinking have appealed to nurses. Their response varies from defending the importance of emotion and sensitivity, and their role in practical reasoning (van Hooft 1990), to advocating a virtue ethics as appropriate for discussing the moral concerns of nurses (Edgar 1993). There have been attempts to identify 'caring' as the central virtue of nursing (Brody 1988; Knowlden 1990). This movement in the nursing literature has faint echoes in the medical literature. (Toon 1993). It is clear that the work of Alasdair MacIntyre (1984) has influenced nurses. (Brody 1988, Edgar 1993). It is interesting therefore that when MacIntyre writes specifically about nursing, his concerns appear to have a different focus. (see chapter 3). However, critical responses to this enthusiasm can be found, in particular that of Salsberry (1992). She acknowledges the attractions of virtue theory to nurses, largely by providing a central place for the nurse-patient relationship as an internal good, and by acknowledging the moral value of emotions. However, there is a clear danger of decreasing self analysis - 'I'm virtuous, so I don't need to think'. She recommends that both duty and virtue be combined in the development of nursing ethics.

Gilligan's work in delineating the 'voice of care' has also attracted interest from nurses. (Gilligan, 1982). This is not surprising given the parallel between women's history, and nursing history. Nurses have taken up and applied Gilligan's thinking to their work, seeing parallels between the male/female dichotomy in moral thinking revealed by Gilligan, and the doctor/nurse tensions in health care. (Cooper, 1989; Harbison, 1992). There has been considerable interest in using Gilligan's ideas as a

framework for research in nursing ethics, displacing the previous focus on the use of a Kohlbergian framework. (Huggins and Scalzi, 1988; Chally, 1990; Millette 1994). In the USA there has also been considerable interest in what the feminist philosophers have to offer nursing, and a variety of nurses have applied the insights outlined previously to the work of nurses, clearly seeing nursing as 'women's work'; or at least work which has traditionally been the preserve of women. (Chinn and Wheeler 1985; Neil and Watts 1991.)

A theme which runs through all these challenges is that of 'care'. Since nursing is the major caring profession (World Health Organisation 1987), it has been proposed that a theory of nursing ethics should be based on an ethic of care. The ethic of caring could be the genuine core concept of the nursing discipline (Kurtz and Wang 1991), which separates nursing from other disciplines. The ethic of care is not focused on principles, but on needs and the responsibilities generated within relationships. Considerable interest in an ethic of care is a relatively recent development in nursing literature (Carper 1989; Fry 1989).

A distinctive work is that of the Australian nurse Johnstone. She also discusses principled and care based ethics, but a major concern is to point to the lack of nursing voice in bioethical debate, the lack of nursing perspectives in common texts, and voices the widespread belief that the nurse patient relationship is not morally significant. A considerable array of evidence, in the form of legal decisions and empirical studies, is marshalled in support of these claims. A particularly vivid example is that of a case where the moral distress of nurses caring for patients undergoing abortion was perceived in a study by physicians as evidence of either intellectual or professional inadequacy, or of psychiatric disturbance (Johnstone 1989 p 230-236). She tries to answer the question of why the moral burden of nursing is ignored in terms of the history of the profession and gender issues in society. I would suggest that these are only two of the factors which contribute to the 'invisibility' of nurses and nursing work. (see Chapter 5). In all, this work is a damning indictment of nursing apathy, and of the powerful influences denying nursing a moral voice. It is an Australian work, and draws heavily on that context.

Johnstone refers to American work, and there is very little UK evidence. But nothing she says seems inappropriate to nursing experience in this country.

Caring in Nursing

The Compact Oxford Dictionary (1991) defines the verb 'to care' as "to feel concern, to trouble oneself, to feel interest". To 'care for' is defined as "to take thought for, to provide for to look after; to have a regard or liking or inclination for". 'Not to care' is defined as "not to mind, regard, pay attention or respect; be indifferent." The implied definition of caring as 'paying attention' recalls Gilligan's notion of 'attentiveness', which is regarded as a moral attribute. The dictionary definition suggests that caring is a phenonomenon which has at least two aspects; a practical one, and a moral one. Benner (1990) appears to suggest that these two are reconciled in the activity of nursing, and there is some empirical work which supports this (Lutzen and Norden 1993).

Caring as a phenomenon has lately been much discussed in nursing (Watson, 1979; Leininger 1981; Gadow, 1987; Benner and Wrubel 1989; Benner, 1990) There appears to be complete agreement that it is an important fundamental nursing value, but there appear to be different emphases in the varying treatments of the concept. Watson describes caring as a human value involving a will and commitment to care, knowledge, caring actions, and consequences. In this view, the value of caring is regarded, not as an operationalised aspect of nursing work, but as the ideal to which nurses aspire in their work. Benner (1990) states that the moral dimensions of caring require attention to the local and specific, the particular and the concrete, not the abstract and theoretical, just as the practical dimensions do. Care and responsibility within personal relationships are just as (not *more*) necessary to moral behaviour as abstract reasoning, autonomy and concern for equality. Benner clearly sees the necessity to augment current biomedical ethics with an ethic of care, and her discussion reflects the wider debate outlined above.

Notions of holism are evident: according to Carper (1989), caring involves being

concerned with the whole person, and practicing with consideration and sensitivity. Gadow (1987) goes so far as to argue that the value of caring provides a foundation for a nursing ethic, which will protect and enhance human dignity. In the UK, in a text which stands out from the standard nursing ethics texts, Verena Tschudin, (1992) although addressing the principle based frameworks, concentrates on the caring relationship. Caring is not seen as a detached and rational, principle bound activity, but as an area of feeling, protecting and communicating: emphasising the reciprocity of caring. It is not a selfless act, the carer receives as well as gives. She draws on work by Gilligan and Noddings associating gender roles with moral approaches, also referring to the current 'justice vs. care' debate in recent nursing literature.

She suggests that Niebuhr's theory of responsibility is particularly appropriate for nurses. The question the moral agent asks here is not 'What ought I to do?' or 'What are the goals?' but 'What is happening here to which I should respond?' This approach is consistent with that suggested by the recent advocates of an ethic of care for nursing. It is however difficult to see that the first two questions would not also be appropriate ones for the nurse to ask.

In common with Beauchamp and Childress she identifies most of the problems facing nurses as those of constraint and conflict in the 'in between' position. Some writers seem to suggest however that instead of this position being problematic, it has certain advantages: that this position is used to the patient's advantage. (Yarling and McElmurry 1986; Bishop and Scudder 1990). I shall argue later that this view may be justified in light of the empirical evidence, but at some cost to nurses and others in the system.

The conclusion drawn by Kelly on the basis of empirical research in both the USA and UK, (Kelly 1990) is that both respect and caring are equally important, and that these are the essence of nursing. The notion of respect as a central value had already been elaborated on by Downie and Telfer in 1969, and it is interesting that this concept is explicated in empirical, but not theoretical, nursing research. Frankena (1983) in line with Kantian thinking, appears to equate respect for persons with caring. Also

interestingly, Kelly's definition of caring reflects an involved, subjective stance; the 'little, everyday things' being seen by nurses as of considerable importance to the meaning of caring.

I have found only two philosophers who have attempted analyses of the concept caring: Griffin (1983) in the UK, and Fry (1990) in the USA. Griffin identifies both moral and non moral attributes of caring, acknowledges the emotional components of caring, and agrees with Gilligan that 'attentiveness', or sensitivity and perception to need is a key attribute. The ability to perceive and respond to needs is a moral ability; what nurses do is to translate this into practical and purposeful activities. For Griffin, this is in accord with Heidegger's idea of 'attunement' and Iris Murdoch's moral vision. Griffin, I think, is aware of the variety and complexity of the concept 'caring' when she says that nurses need to identify which concept of caring they should support; and stresses that this should be to the benefit of the patient.

Cooper (1991) suggests that the ability of the nurse to see the patient from two perspectives (justice and care) may induce a creative tension, by simultaneously generating compassion and broadening the nurse's perspective, while focusing moral attention on the patient. However, she does not appear to consider the possibility that the tension created could be destructive, given the orientation of the medical profession to the justice perspective, and the traditional powerlessness of the nurse in working situations.

Fry (1990) reviews attributes and definitions of caring found in nursing literature, and groups these into a variety of models - cultural (exemplified in Leininger's work (1981)); feminist (exemplified in Gilligan (1982) and Noddings' (1984) work); and humanist, citing Watson (1979), a nurse; Pellegrino (1981), a physician; and Frankena (1983), a philosopher, as proponents of a humanistic model of caring. She suggests that elements of all of these are important in trying to think about nursing.

The movement toward an ethic of care has not gone unchallenged. As has been said, most writers clearly see the need for a synthesis of principled ethics and care ethics,

realising that both perspectives have much to offer nurses. Even the critics of the care ethic advocate an integrated ideal. Among these are Kuhse and Olsen. Olsen points out that the ethic of care does not provide a guide which determines what contextual factors are legitimate ethical guides, and suggests ways of dealing with this, while avoiding a return to the decontextualised approach. (Olsen, 1993). He refers to the tradition of writing which tries to reconcile friendship obligations with the moral imperative to treat others equally, suggesting that these may offer insights to nurses. (Olsen 1992). Kuhse (1993) points out that adherence to an ethic of care may put nurses in a position where, as in previous generations, they are unable to credibly justify their moral actions, and those of others; since the ethic of care is unable to provide a guide and justification for action. Condon (1992) further points out that the ethics of caring have considerable potential for describing the one to one nurse patient relationship, but nurses have responsibilities to others not known personally to them. Recourse to an ethic of principles is therefore necessary. Olson (1993) refutes the claim that nursing is founded an a tradition of caring by studying nursing records from the first part of this century. The language used by nurses in relation to patient care is notable for images of manipulation and control, not of comfort and of care. [4]

A Nursing Ethic

Nursing is widely held to be a 'moral enterprise'. (Fry 1989, Benner 1990, Allmark 1992). According to Sarvimaki (1988), the basis of nursing consists of a set of values, and the nature of these values is moral. The values are concerned with the relation with others and how to behave to others: in their specialised situation nurses have a commitment to the vulnerable. The values derived from biomedical ethical principles have not convincingly been demonstrated to constitute the moral foundation of a nursing ethic: in fact empirical studies indicate that nurses violate these ethical principles in practice. (Akerlund and Norberg 1985; Hutchinson 1990; Webb and Bunting 1992). The biomedical framework therefore may not represent, therefore, the basis of nurses' moral judgments and actions. It has also been claimed that the

[4] It could be of course that the tradition of caring is drawn from a much earlier period of time; or it could be that the idea of caring is so internalised that it is not expressed in nursing records: i.e. taken for granted.

foundations of nursing ethics are derived from the nature of the nurse-patient relationship, not from models of rights based autonomy, or social contract. The moral goals of nursing are met, or not met, within the nurse-patient transaction. (Curtin 1978; Silva 1977; Fry, 1989).

Considerable debate has taken place in the literature exploring what the moral foundation of nursing might consist of. Opinions are diverse and the debate is often heated. It is claimed by some that nursing ethics should be viewed as reform (Yarling and McElmurry, 1986; Foulk and Keffer, 1991), or empowerment (van Hooft, 1990) ethics. Bishop and Scudder (1987) oppose the view of ethics as reform, claiming that the 'in between' unique position of the nurse should be the foundation of an ethic. Packard and Ferrara (1988) claim that we need a clearly developed understanding of the nature of nursing, before we can explicate an ethic. It is generally agreed however, despite the critics, that an important part of the basis of nursing is caring. This has generated the considerable attention to caring in nursing described above. Consideration of these views suggests that caring as an ethical and personal value might be the central key in setting normative guidelines for nurses attitudes and actions. If this is the case, and if caring is consistently reinforced as an ideal by those who have the responsibility of meeting the needs of others, then the charge to care is essentially a moral injunction. (Fry, 1989). Since society charges nurses with caring for the vulnerable, then the whole practice of nursing is a moral enterprise. However, caring is not exclusive to nurses: social workers, doctors, clergy and lay people may equally claim to care. This is not, of course, a problem unless it is being claimed that caring is the unique feature which distinguishes nursing from other activities: and that is claimed, or implied, in the nursing literature. (Rawnsley, 1990; Kurtz and Wang, 1991; Pollack-Latham 1991). The World Health Organisation recognition of nursing as the major caring profession was not, I think, intended to imply that professional caring is unique to nursing, simply that nursing has the greatest contribution to make to professional caring. (World Health Organisation, 1987). What needs to be clarified is what, if anything, distinguishes caring in nursing. This will be discussed in the following chapters.

Summary

The conclusion to be drawn from a scrutiny of the literature in nursing ethics over the past few years, is that there appears to be a trend: firstly from the principled, detached approach, which is reflected in virtually all standard medical and nursing texts, and in codes of practice; toward a more responsive, involved approach (Johnstone, 1989; Benner, 1990; Tschudin, 1992) and more lately toward a merging, or conciliation, of the two. (Gustafson 1990; Tschudin 1992; Melia, 1994; Wilson Barnett, 1994; Gallagher, 1995). Empirically, Cooper's research (1990) analysing the moral experience of critical care nurses found that a justice perspective predominated in their thinking on their initial encounter with the patient; as the relationship developed so the nurses moved toward the language of care based ethics. This trend toward conciliation reflects developments in contemporary philosophy and moral developmental psychology. This of course leaves out the question of whether these two perspectives represent the full picture, or are there other perspectives as yet undescribed. This question is beyond the scope of this dissertation.

CHAPTER 3: THE ROLE OF THE NURSE

In answer to the central question "What conception of the role nurse.....will result in the most effective way to attain the moral aims of nursing.....?", Muyskens (1982) offers the concept of the nurse as advocate, as does Gadow (1990), although they appear to mean different things. The rest of this central chapter explores this image, with others, and an attempt to answer this question will be made in the concluding chapter.

The Traditional Concept of The Nurse

The Nurse as Handmaiden

For many years, nursing texts exhorted nurses to be faithful and loyal to physicians. Sarah Dock, writing in 1917, claimed that the nurse's moral responsibilities to the patient were to be subordinated to the moral responsibilities to the doctor. While that view now arouses great indignation among nurses, it is not far fetched to see elements of this attitude still in nursing practice. The fatalistic acceptance of physician decisions, whether the nurse feels them to be in the patient's best interests or not, is not uncommon. Nurses have been notoriously reluctant to accept responsibility for decision making, a trait much encouraged by traditional nurse training in its emphasis on following rules and procedures. An anecdote published recently in a major nursing journal illustrated the willingness of nurses to subordinate their concerns for patient dignity and respect to the concerns of running the system to save the doctor some time: it described the routine practice of making women waiting to consult a gynaecologist sit in a waiting room without tights and pants on.(Reid, 1992). One feels indignation on behalf of the women on reading this article: why don't the clinic nurses? The institutions which employ nurses also seem to endorse this traditional assigning of nurses' responsibilities: nurses who have challenged medical decisions to subject patients to electro-convulsive therapy, on the grounds that research had failed

to prove its effectiveness and had demonstrated some harms, or on the grounds that that informed consent had not been obtained, have been deprived of their jobs. (Beardshaw 1982; Vines 1983; Vousden 1985).

The spirit of obedience to medical orders was certainly still alive and well in 1966, when Hofling and colleagues performed their well known experiment. (Hofling et al 1966). Nurses were telephoned and asked by a physician who was unknown to them to give a patient a drug dosage which was clearly incorrect. Although several of the nurses queried it with the physician, on reinforcement of the medical order, 21 out of 22 gave the drug. I can find no trace of a replication of this experiment. One hopes that a contemporary experiment of this nature would have a very different outcome. The UKCC Code of Practice, and improved nurse education, has certainly drawn British nurses' attention to their responsibilities in relation to drug administration, but traditional attitudes die hard.

Florence Nightingale defined a good nurse as an invisible, good woman. Oakley (1984) claims this to be a strength as well as a weakness of nursing. Oakley sees the subordination of the nurse as a strength. Since nurses are not members of a professional elite, which has been the object of much criticism of late, they have the opportunity to shape a place in health care in accordance with the needs which modern patients are expressing. All that the nurse has to do is to try to make people see that while altruism is a social strength for the community, the passivity and subservience expected of nurses acting as handmaidens is much less good for those who are altruistic: their lack of status and confidence undermines their intrinsic feeling that their work is valuable. She offers no guidance as to how this aim can be achieved by a largely powerless body of nurses in the face of current society values. I think also that her claim that the general public have lost faith in the technical-curative-medical model, and the medical profession, and are consistently challenging it, to be overstated.

In common with Oakley (1984), an American philosopher, Lisa Newton (1990) defends the ideal of subordination to the physician, on the grounds that patients can only feel rapport with nurses because they are both powerless within the system:

nurses having no more control over the environment than do patients. If nurses were to acquire an equivalent status to physicians, that rapport and close understanding would be lost, and the patient would feel threatened. She sees submission to authority as an essential prerequisite for the role of 'skilled and gentle caregiver', on the grounds that the saving of life and health demands orders and procedures, which only the physicians have sufficient knowledge to generate. She also refers to patients claimed needs when she equates 'professionalism' with detachment, claiming that the public want involvement, which she clearly sees as 'unprofessional'.

Neither of these writers are nurses, and have no experience of working in the subordinate relationship, although Oakley at least does recognise the negative aspects of this. Nurses themselves have challenged these points of view: claiming that the nurses's knowledge and capabilities are being underestimated, that health care involves not only medical issues, and that being 'professional' does not necessarily equate with detachment. (Pence and Cantrall 1990). One could say that being professional does not imply a lack of emotion, but a disposition to have certain emotions.

Nurses as Women and Mothers

It is possible that nurses' subordinate and powerless place in health care simply reflects the place of women in society. Women's social roles tend to be organised around the presumption that they will serve others, and that this is the way they will be enhanced as individuals and accepted within their culture. (Oakley, 1984). However, Baker (1980) points out that there are two ways to look at the significance of the nurse/woman passive and subordinate role. Nurses may be passive and dependent because they are women, OR the nature of nursing is such that it requires the playing of a dependent and subservient role - and therefore women are channelled into it. The question here then becomes does the nature of nursing require the playing of such a role? I shall return to this point in the concluding chapter.

The role of the nurse, by virtue of its caring and nurturing nature, has been seen as

being analogous to the mother's role in the family. Aroskar (1980), points out the 'uneasy resonance' (Oakley, 1984) of the images of dr-nurse-patient, and father-mother-child. The doctor, like the father, makes the big decisions determining what the whole family will do; the mother (nurse) provides a caring environment, often acting as the pivot of the family, and the child (patient) follows the parents' instructions, in the expectation that they are acting in her best interests. This 'mothering' metaphor is an old one: 'nursing is mothering' - a 1905 comment, cited by Oakley (1984), and even today, many nurses will recognise the above pattern from their own practice.

Smith (1990) rejects the notion of the nurse as mother: equating the exercise of this role with paternalism, reinforcing dependency and passivity on the part of the patient. Taylor, however, examines the concept of maternalism. (Taylor, 1985). Paternalism is the justification of actions related to rights morality: in the name of beneficence the patient's rights are overlooked. Maternalism can be seen as the justification of action related to the morality of care: the right thing to do is that which will avoid hurt. The paternalistic parent will prescribe an action 'because this is the right thing for you to do'; the maternalistic parent will say 'the choice is yours, but here is the harm you will be causing if you do this'. Taylor argues that parentalism is a manifestation of caring, and therefore not wrong in itself, although its exercise may lead to both good and evil. However, this argument is unusual in contemporary health care.

The Nurse-Physician Relationship

Since the image of nurse as handmaiden has been so pervasive persisting to this day, (Oakley, 1984; Newton 1990), the relationship between handmaiden and superior should be examined.

Embodied in the contemporary physician-nurse relationship there is a survival from a phase in the history of medicine, when technology and cure became predominant. This has led to an inequal relationship in terms of power and status. When medicine is all powerful, care becomes the infrastructure to allow curing activity to take place, and

the nurse becomes subordinate to the physician, tied to the technical-curative model of medicine. (Oakley, 1984). The ancillary medical professions may be required to act as if only handmaidens if curative medicine is valued. This prevents the development of their own skills. (Campbell and Higgs, 1982). While there may be some justification for this subordination, in for example, acute illness, there is none at all in the field of mental handicap, care of elderly, and little in terms of long term incurable sickness. (MacIntyre, 1983). The nurse is obligated to assist the physician in her curative duty because of her duty to the patient, but the physician is not similarly obligated to assist the nurse with her caring duty. (This is not to say that many physicians do not do so, simply that there is no obligation upon them to do so).It is not logically apparent why this should be so, unless caring and curing are not equally valued. Empirical evidence supports the increased responsibilities of the nurse where no cure is possible. (Lewandoski et al 1985; Shelley et al 1987).

There are factors other than gender stereotyping and the dominance of the technical-curative model which affect the relationship. Aroskar (1985) outlines what she considers to be obstacles to ethical nurse-physician relationships. Firstly, they have different views of what health care is, deriving in the former case from a care and environment model, and in the latter from a technical and curative model, so in many ways they speak different languages. Secondly, their experiences of the world they work in are very different: these have been described in a classic article by Sheard (1980). Both physician and nurse have very little understanding of the rationale underlying each others organisation of work, attitude to resources, and assignment of patients. The rewards too are clearly very different. This is an American work, and I think the differences are less marked in Britain, but in principle I agree with Sheard. This contributes to the inequality in dialogue between the two.

However, while the handmaiden image is pervasive, and can be identified in some current nursing practice, there is considerable evidence that this role, while outwardly accepted, has been manipulated by nurses. An important article by Stein, written in 1967 and still much quoted in the literature, describes the 'doctor-nurse game', which is clearly recognisable to many nurses. The object of the game is for the nurse to

make and have accepted a recommendation about patient care, while appearing passive, and making the physician seem the initiator of the recommended action. The most important rule is that open disagreement be avoided. The reward is the efficient operation of the team. The game is learnt through the respective disciplines' education and socialisation processes. A nurse who breaks the rules by openly voicing disagreement, or suggesting action, is labelled a troublemaker, a loudmouth and distinctly unfeminine. The physician may break the rules by deliberately asking the nurse for advice: this physician is viewed with admiration and approval by nursing staff, and with amusement or indifference by other physicians. This game is very common in British hospitals also: a common ploy witnessed by myself when the physician appears to be in need of assistance during a resuscitation, for example, is to prepare the appropriate medication and to place it near the physician, either silently, or with the comment 'I'll leave this here in case you need it, Doctor'. This game is played tacitly, although both players know exactly what is going on, and usually achieves the desired outcome - patient good. The nurse knows that should she 'overplay her hand' the physician reaction may mean that this desired outcome may be lost. Nurses become very skilled at this game.

There is also evidence to suggest that, where it is not possible to play this game, nurses resort to manipulation of events in order to achieve what they see as patient good. Aroskar and Davis in 1978 referred to 'the great informal power of the manipulative subordinate'. (p 38). Hutchinson (1990) carried out empirical work describing what she refers to as 'responsible subversion' among nurses. This is not a new phenomenon: Olson (1993) produces historical evidence which suggests that the image of traditional passivity is a myth: nurses were routinely assessed on how they 'managed' the physicians with whom they worked.

If it works, why change it? Morally speaking, a three way relationship where two of the participants are in silent conspiracy against a third, is unhealthy and can diminish trust. Truth telling is a fundamental moral principle, and while it is possible to defend lying to someone in order to protect them, it seems very unlikely that consistent lying

within these relationships could lead to a moral good. [5] Aroskar (1985) claims that it is demeaning to drs, nurses and patients when patients interests become part of a game. It is unethical, because it denies that physicians and nurses have significant contributions to make, and contravenes the Kantian principle that people should not use others as a means to an end decided upon by them. This applies equally to physicians and nurses. Here she appeals to principle. From the point of view of the care ethicists, the situation is less clearcut. Gilligan approves attempts to maintain relationships as morally justifiable; but does not discard the role of principles. It is tempting however to believe that she would see these attempts - to serve the patients' interests and preserve relationships as morally justifiable. But the relationships themselves are based on deceit and manipulation. Some of Gilligan's feminist critics do see Gilligan's work as perpetuating the subservient role of women in relationships, and it is not far fetched I think to see this criticism being applied to this situation. Aroskar (1985) suggests that the key to eliminating these unhealthy games is by interdisciplinary education programs. However, attempts in this country several years ago to plan for multidisciplinary health care education were fiercely resisted by the medical profession, and there is no evidence to suggest this attitude is changing. There is some work being undertaken in the USA studying collaborative relationships; initial results suggest a positive effect on patient outcomes, and on nurse satisfaction. For example, Pike's study showed that the incidents of moral outrage for nurses were diminished in units which were studying and developing collaborative relationships (Pike 1991). However, to the best of my knowledge, there is no similar work in progress in the UK.

Patients' Perspectives

Zaner, drawing on Pellegrino and Rawlinson, graphically describes the experience of illness and hospitalisation. (Zaner, 1985). Daily life and its concerns are disrupted; life is no longer under our control - illness 'happens' to us; debilitating and isolating experiences distort ordinary relationships with others. The experience erodes the image of ourselves we have painfully constructed over the years, and we develop

[5] This point will be returned to in Chapter 5 in examining the position of the nurse.

unusual reliance in profoundly unequal relationships with health care professionals: we are in a position of entrusting our wellbeing to complete strangers.

Entering hospitals for those unaquainted with them is a strange experience. The environment is forbidding and foreign, and the patient is required to find a vocabulary to describe and understand brand new experiences. Zaner, citing research evidence, claims that patients believe that submission and co-operation are essential in order to allow the doctor to reach his goals of health recovery. They are remarkably resilient and forgiving, tending to stay loyal to physicians, understanding that mistakes are made, and seeking, not revenge, but acknowledgement of and apology for these. The loss of bearings and strangeness described above is often compounded by lack of information: a common complaint of patients is 'no-one told me what was happening'. Patients therefore are often constantly on the alert for news about themselves: watching staff behaviour, body language and so on.

Zaner uses the concept of 'alien territory' as a metaphor for illness. People in an alien territory quite naturally reconnoitre the terrain, and seek familiar and interpretable signs to locate themselves by. I shall return to this metaphor later in this dissertation, as I think it of importance when considering an appropriate concept of the role of the nurse. To be sick or injured is also to feel ourselves diminished in the ways which mark us as human - our freedom of action/choice, our ability to plan ahead, the control of the body by the mind and our ability to relate to other people. This too, I think, is an important factor in considering the role of the nurse.

It is this experience of being a patient which physicians and nurses must bear in mind when considering appropriate roles for themselves. The task, according to Zaner, is not to put themselves in the patient's place - the patient is not like themselves - but to try to understand what the patient is experiencing. Evidence from patients suggest that staff can make the strange more easily reckoned with, by providing information allowing orientation and understanding. The common reasons given by professionals for failing to live up to these expectations are: lack of time, fear of being insulting or presumptuous, and the fact that patients are not really in a position to for example

evaluate treatment alternatives - due to their lack of specialised knowledge, and the effects of their illness.

Those who have experienced illness and hospitalisation accord very little importance, apparently, to theoretical knowledge, technical skills, ethical behaviour and so on; placing most importance on interpersonal and communication skills, and on the human qualities and personality of the individual nurse. (Zaner, 1985). Studies in this country have shown that patients identify good nurses as those who demonstrate warmth, kindness, sympathy, emotional support and reassurance, and alertness to their needs. (Anderson, 1973; Whittet, 1994). The fundamental moral dimensions inherent to patient's relationships with health professionals are the appeal to treat and also to care, in its broadest sense. Patients are dismayed and angered at not being respected and cared for, and are grateful when they are. Mothers of sick children seem to want and need someone who will care about them. (Zaner 1985). Ersser (1991) studied the responses of both nurses and patients in relation to what is important about nursing. Nurses identified the themes of making contact, supporting, caring, being available and being sensitive to need. Patients echoed these, but placed the main emphasis on being available, appearing to care, and understanding problems. 'Caring' appeared to mean much the same thing to both, and was described in non-technicall terms - 'being there', 'giving time'. This accords with Kelly's research, where nurses defined caring as 'attending to the little things' (Kelly 1990 and 1991a and b). Ersser's research (1991) demonstrated that the most salient aspects of nursing for the patient are the personal qualities of the nurse

Oakley (1984) suggests that nurses have an opportunity to shape their role in health care according to these expressed needs. It is difficult to believe however, that patients would be well served by nurses who possess no theoretical knowledge, technical skills and reasoning power. There are clear dangers in overdoing the 'customer is always right' ethos.

It appears that the general public see no contradiction between a nurse who acts in the way they wish her to; and a nurse who is acting as subordinate to the physician.

Aroskar's (1980) examination of studies in the US revealed a public perception of the traditional feminine image of the nurse, while the professional perception was that of a neutral and professional image. Media images of nurses conflict: in most popular drama they are clearly seen as dependent on physicians, one popular UK exception being 'Casualty'. This has been acclaimed as being near realistic (allowing for dramatic licence). It depicts accurately the preponderance of nurses (in numbers), their independence of action working within a team, the range of skills required, and the conflicts faced in the course of working in the UK health care system. In general, however, although they are often portrayed as wise counsellors and caring individuals, they are seldom portrayed as independent decision makers. Physicians are the heroes, and the nurses are their supporters. Newton sees nothing wrong with the public image of subservience, claiming that an autonomous human being can deliberately choose to adopt a non- autonomous role if there are sufficiently good reasons for doing so, along the lines of those outlined above.

Nursing as a Profession

The traditional model of nursing, embodying the concepts of being a good woman, mothering, servitude, sacrifice, passivity and dependence, whatever its status with physicians or patients appears to be eroding, for a variety of possible reasons. (Muyskens, 1990). The rise of feminism has challenged sex role stereotypes (Chinn and Wheeler, 1985). Roles within the family have changed: the nuclear family with mother at home child rearing is a disappearing phenomenon. Changing technology has given nurses the opportunity to demonstrate the capacity for rapid diagnosis and treatment hitherto thought to be the preserve of physicians (in intensive and coronary care units; dialysis units etc). Changing age and illness distribution, with large numbers of patients now requiring care and sustenance as their primary needs, means that in these areas technical medicine is ancillary to these, rather than to medical cure. In the light of all of these changes, nurses now see themselves and their profession as certainly having the capacity for autonomy, and the rationale for acquiring such autonomy. Nurses have therefore striven to rid themselves of the pervasive image of the handmaiden to the physician. Nursing training has moved rapidly into nurse

higher education, the professional bodies have developed codes of conduct and practice which view nurses as independent practitioners, and different images of the nurse have been proposed, the current one in vogue being that of advocate. (discussed later in this chapter).

However, Oakley (1984) asks 'what is so good about being professional?' The medical profession are currently (she claims) suffering from a crisis in confidence - exemplified by the writings of Ivan Illich (1977), and graphically illustrated in a recent BBC television series 'The Trouble With Medicine', screened early in 1993. In this view, the profession serves to keep patients dependent and damaged: it is wrong to wish to conspire with this oppression. In addition, there is a suspicion that the desire to achieve full professional status within nursing is concerned more with the wish to enable nurses to acquire power and status, than the desire to benefit patients. Oakley maintains that the professional status of an occupation has no relationship to its importance. I think she over simplifies here: society does on the whole accord status and power to those occupations which it thinks to be of vital importance.

The Nurse as Advocate

The Compact Oxford English Dictionary (1991) definition of the word 'advocate' means 'one who pleads, intercedes or speaks for or in behalf of another: a pleader, interceptor or defender'. Extra dimensions of meaning exist - the word carries overtones of law, conflict, adversity, clear commitment to client right or wrong, and independence from the system. Melia clearly recognises this in summing these up as 'adversarial connotations'. (Melia 1994). Whether these extra dimensions are widely recognised or not, this concept of the nurse is currently fashionable, and is the topic of considerable discussion in nursing literature in the UK. (e.g. McSweeney 1990; Marshall 1991; Hubert 1993; Darbyshire 1993). This appears to follow in the train of North American interest. (Abrams, 1978; Bandman 1983; Becker 1986; Curtin 1986; Kohnke 1982 and 1990; Winslow 1984; Fry 1987; Curtin 1990; Pagana 1990; Bernal 1992). The UKCC Code of Conduct is quite specific in requiring nurses to act in this way as part of their professional obligation to the patient. (UKCC

1992).

The interest in advocacy can be seen as arising from the move away from nursing obligation to physicians, toward nursing obligation to patients. (although as we have seen many nurses make considerable efforts to reconcile the two). It reflects a changed idea of the good in wider society, from the ideals of duty and obedience to individual rights. The nurse advocate is expected to protect the patients interests and rights, and particularly the right to freedom of choice and action. However, why should the change of ideas have led to the notion of nurses adopting advocacy as their raison d'etre? Bernal (1992) suggests that this development is linked to the drive for nurse autonomy. Nurses recognise their own powerlessness and vulnerability, and transfer this conflict to patients to make it legitimate. So when a nurse overtly pleads a patient's cause, she is not only promoting patient autonomy, she is exercising her own. Powerlessness plus powerful moral ideals lead to an uncritical assent to the claims of advocacy. Nurses may also see advocacy as a way out of the situation described earlier, that of the manipulative subordinate. There exists confusion in the literature between nurse and patient autonomy - sometimes it is difficult to tell which is being argued for. But if nurses are to clarify their role in the nurse-patient relationship, they need to be clear which one they are talking about.

The claim to nursing's aspiration to serve as advocates is usually based on the fact that their position is unique - providing close continuous care, being skilled in communication and having knowledge of both the patient and the situation of the patient. There is a general assumption that nurses have a special moral perspective, deriving from this special relationship with the patient. Even if this assumption is correct, however, it does not logically follow that the appropriate role for the nurse to adopt is that of advocate. If the moral aims of nursing were to protect patient rights and ensure freedom of information, choice and action then logically these aims would be achieved from a stance of advocacy. However, there are other aims of nursing, discussed later, which are not addressed from an advocacy role. The moral primacy of rights and advocacy can lead to a diminished view of the experience of illness and the nurse-patient relationship. The usual reasons offered for the nurse adopting advocacy

as a moral ideal are those of the position of the nurse offering 24 hour intimate care. This position it is claimed allows the nurse to acquire considerable knowledge of the patient, and means she is uniquely placed to defend the patient's autonomy and so on. However, this conclusion does not logically follow. Relatives, or other members of the health care team, may have greater knowledge of the patient's position. Many nurses see this quite clearly. (Johnstone 1989; Bernal 1992; Darbyshire 1993). Additionally, patients see themselves, not nurses, as sources of autonomy, or at least there is no evidence to suggest otherwise.

There are other drawbacks to the ideal of nurse as advocate. Classically, an advocate is fully committed to the client, impartial and uninfluenced by outside factors (Hubert 1993). Nurses are not able to achieve this complete commitment: often the patient is affected by the system of which the nurses are part, so they lack the independence of action required of an advocate. In addition, nurses have commitments to others, and may have to balance one patient's interests against that of another, and of the community. Who decides whose rights are to take priority, and how are conflicts with others who see themselves as acting in the best interests of the patient to be resolved? There is little guidance in the literature for nurses as to how to act in these situations. The enthusiasm for advocacy does not often extend to pointing out the considerable difficulties involved, or how to deal with these.(Bandman 1983). Hubert (1987) describes the success of the Citizen Advocacy Scheme in Leeds, where the advocates are lay people, from the same ethnic groupings as the patients. These advocates are truly independent of the health care system, and have no professional axes to grind.

The traditional moral view encompasses a commitment to equality. This is indispensable to ensure that vulnerable people are not exploited. But Baier points out that this very commitment can conceal nuances of relationships between people who possess unequal power, and can also conceal the special moral demands that weakness, vulnerability and dependence can introduce to a relationship, such as that between nurse and patient. (Baier 1987). For example, if we think of relationships as structured in terms of rights, it is possible that the right to autonomy may subtly be translated into the right of non interference. This could lead to neglect and isolation, in

a way similar to which the stance of detachment or impartiality can be transformed into moral blindness. From the justice perspective, relationships are viewed as autonomously required goods; however relationships are perhaps more accurately viewed as being acquired at birth, or, in nursing, coming into being by becoming ill and needing help.

Interdisciplinary relationships in the health care professions are often poor. To have one profession asserting that they alone can represent the patients' best interests leads to increasing friction among them. It is difficult to argue with Bandman's contention that it is virtually impossible for one discipline to function in isolation without interdisciplinary support. The logical conclusion, therefore, since patient care is a team activity, is that moral decision making (not necessarily technical) should be made by the team, all of whose members (including the patient, or her representatives) are equally qualified to do so. The reason advocacy has proven so attractive to nurses is, I think, due to the fact that this logical consequence has been overlooked by the medical profession specifically, and society in general.

The adversarial connotations of advocacy are worrying, and this is recognised by many nurses. (Johnstone 1989, Bernal 1992, Melia 1994). Pence and Cantrell (1990) find it disturbing that there is a suggestion in the literature that nurses cannot carry out this obligation without great risk to themselves and enormous personal conflict. Although there is considerable dissent and debate in the literature over the concept of advocacy, this in itself is encouraging in that nurses appear to be moving away from uncritically adopting the recommendations of others, or their own leaders.

Another pragmatic factor mitigating against the development of the continuous relationship which is said to be the basis of autonomy is the changing of working practices, for example the widespread use of bank and agency staff, which may result in many different nurses caring for short spans of time only for any one patient. [6]

The simples and most convincing argument I have found against the wholescale

6 This of course has implications for conceptions other than 'advocate'. This is discussed further in Chapter 7.

adoption of 'the nurse as advocate' is that of Johnstone (1989). She sees the rise of advocacy, not simply as a response to societal changes in ideas of the good, and power imbalances within the professions, but as a reflection of the way in which nurses are now trying to explain the moral basis of the nurse patient relationship. This, however, will only be possible if nurses and philosophers can clearly articulate advocacy as 'a moral concept containing a morally compelling force', and demonstrate its existence as the foundation of the relationship. This has not yet been achieved: no nurse has been able to satisfactorily answer the question "Why should I, the nurse, be the patient's advocate?"

The advocacy model, I suggest, is unable to serve as a complete one for nurses. While there is no doubt in my mind that a nurse has a duty to intervene if she sees action on the part of others (whoever they are) leading to patient harm, deriving from the general duties owed toward the patient, this aspect of nursing does not fully characterise the relationship between patient and nurse. This temporary relationship involves a suffering, vulnerable and unique individual, and a member of a health care team, with a characteristic professional disposition. This relationship is played out within the context of a bureaucratic system.

The limitations of advocacy appear to be recognised by nursing leaders, who seek to broaden the perspective from the specific protection of rights to a more general idea of acting in the patient's best interests. The UKCC Code of Practice carries the rider that no adversarial connotation is intended by the use of the word advocacy. However, a major criticism of this stance is that it leaves the notion of 'acting in best interests' up to the interpretation of the individual nurse, offering no guide for action.

There is little evidence that nurses do act as advocates in an effective manner. The nurses in Hutchinson's study (1990) saw themselves as acting as advocates: however, the tactics they used were those of concealment and subversion, not those of open disclosure and willingness to put the patient's case to others; tactics conventionally associated with advocacy. No empirical study reveals nurses acting in accord with a classic model of advocacy. (That is not to say however that they do not;

simply there is no evidence). There is however considerable evidence to suggest that when nurses *do* act as advocates, in the accepted sense of the word, they are either ignored or punished. (Beardshaw 1982; Vines 1983; Vousden 1985; Johnstone 1989; Turner 1990; Wright 1990; Tadd 1991; Jones 1993).

Existential Advocacy

Sally Gadow, an American nurse philosopher, has attempted to explicate advocacy as the philosophical foundation of nursing. (Gadow 1983 and 1990). She is very clear that she is not using advocacy in the sense of consumer rights. Her thinking can be difficult to follow, but I take her idea of nursing advocacy to be that the nurse helps people to become clear about what they want. This is done not just by providing information, but by helping patients to see the meaning of their experience of illness and hospitalisation and to be sure of how they wish to deal with this. Her ideas are attractive because she gives patients the credit for being able to be their own advocates (in the rights meaning of the word). She sees the nurse as having, not necessarily the deepest knowledge of the patient's situation, but the broadest: knowledge of that particular patient's experience of illness and treatment; scientific knowledge of the body, illness and treatment; knowledge of the patient's body responses to treatment and care. Although other people have greater knowledge of single aspects - doctors of the disease, relatives of the patient's personality - the nurse has a unique perspective deriving from a synthesis of these. She sees professional care as the involved synthesis of emotion, intellect and practical skill. The unique contribution of the nurse is to assist in 'unifying the lived and object body'. I take this to mean that she helps the patient understand what is happening to their bodies, thus enabling them to 'make sense' of their experiences and retain a feeling of control, but in this I may be over simplifying her ideas.

Gadow seems to have a clearly worked out philosophy of nursing: I am not at all sure that it can be considered to be advocacy. I think she has moved so far away from the original concept that another term might be more appropriate. Gadow I think takes account of what may be unique about the role of the nurse which has to be addressed

in developing an account of the moral base of nursing: the importance of the body, and the 'in-between' situation of the nurse (discussed later). Gadow's ideas are not inconsistent with those of Alistair Campbell, a Scottish theologian who has written a theology of professional care, within which he singles out nursing for consideration. The conception of the nurse which he offers, though, is that of 'the skilled companion'. (Campbell 1984b).

The Skilled Companion

What has been termed 'the ethical enterprise of nursing' (Allmark 1992) requires a theory of ethics based on the reality of what happens in everyday nursing practice. Most attention has been paid to the problems and conflicts faced by nurses; little attention has been paid to what Benner (1991) refers to as 'ethical comportment' - the way in which everyday transactions between nurse and patients take place.

Campbell (1984 b) deals with ideas which have not been popularly considered as related to the moral concerns of nursing. These include the ideas of embodiment, of intimacy, and of the emotions, culminating in his image of the nurse's unique role as a 'skilled companion', offering, in common with other caring professionals, 'moderated love'. These ideas of the nature of nursing accord well with the practical experience of nursing, as revealed by both anecdotal and empirical research evidence.

Embodiment

Medicine and nursing are essentially physical activities; Campbell, drawing from Pellegrino and Thomasma, states that they deal with the embodiment of distress. During illness, the body assumes a prominence which it normally does not have in everyday life - it becomes a hindrance to action, and not an instrument of action. When people need help with body functioning, they become patients.

In addition, good, according to Campbell, always has a bodily manifestation. In a

similar way to that in which Gilligan uses the metaphor of voice (the voice of care, the voice of justice) to describe moral perspectives (Gilligan 1982), Campbell uses the voice of the body to describe moral actions. The body of the nurse offers care, the body of the patient receives care. Knowledge and skill are required on the part of the nurse to 'tune in' to the patient's bodily needs and to adequately meet these. Care is sensuous in the true sense of the word: physical care can be carried out in a sensuous way with respect for the person. The body as a moral instrument has been significantly neglected in literature, yet it is through the body that we communicate spontaneity, care, embarrassment, distress and so on. Campbell refers to the 'caressing of companionship' (p 110) as a very basic human experience, first encountered in the relationship with the mother. He describes the intimacy of professional privileged access to the body as dangerous , and claims that a) it needs channeling by a professional ideal, and b) the professional carer must be committed to a degree of sensitivity and discretion. 'Unauthorised touching of another's body is an indignity which is to be forbidden' (Prossser, cited in Engelhardt 1985 p 77).

Both medical and nursing carers are bound by these requirements. The difference between the two professions, however, lies in both the temporal and intentional nature of the contact. (in this context). Medical contact tends to be fleeting and infrequent: nursing contact is on an hour to hour basis. Any one nurse will tend to have repeated contact, particularly physical, over a period of 8 - 12 hours over several days. Doctors have physical contact with patients with two clear aims in mind - diagnosis and therapy. Nurses on the other hand have less clear cut intentions. Physical contact can be seen as instrumental - administering medications, attending to personal hygiene, monitoring blood pressure etc. Affective contact occurs when touch is used for reassurance and comfort - hand holding, touching the face or head and so on. An empirical study by Lutzen and Nordin (1993) suggested that nurses integrate caring 'for', i.e. medications, bathing etc. with caring 'about', i.e. comforting, reassuring and seem not to see these as separate. It is this 'caring about', *as expressed through caring for the body,* which sets the nurse aside from other caring professionals. Moral dilemmas arise for nurses when these functions are separated, as when the caring 'for' involves physician ordered treatment which either nurse or

patient are unhappy with. It becomes difficult then to express caring 'about' through caring 'for'. (Lutzen and Nordin 1993). As has been previously discussed, these are the areas in which the greatest dilemmas arise for nurses. Campbell claims that medicine tends to shy away from the body. (Campbell 1984b).

The nursing orientation to the body is revealed in everyday nursing language about 'hands on' care, 'bedside' nursing, admiration for a leader who 'gets their hands dirty', and so on. The notorious reluctance of nurses to give up the 'back round' has been attributed to a resistance to change, and an ignorance of the significance of the research findings. While not discounting these it is at least possible that part of the reluctance may have been to relinquish the symbolism of the ritual.

Considering that much of nursing work revolves around the body, little empirical work has been done in nursing into how nurses deal with the body, with the exception of Australian research carried out by Lawler (1991). She explored the skills nurses develop to reduce fear and harm to patients requiring intimate physical interventions, in areas of nursing which are little discussed and are therefore 'invisible' to outsiders. Experienced nurses are well aware of how patients watch them closely for their reaction when, for example, unpleasant wounds are dressed, and they deliberately adopt an attitude intended to send the message that the wound makes no difference to their perception of the patient. She has tried to make this implicit knowledge explicit. A major aim appears to be the preservation of what the nurse sees as appropriate social relationships, and the protection of patients' vulnerability and self image. Nurses appear to use both verbal and body language to achieve these aims. These aims appear to me to be moral aims, in that their goal is to demonstrate respect for and thus achieve the good for an individual. Despite this, although Lawler did not explore this point, the nurses in the study did not seem to explicitly identify these as moral concerns. [7]

[7] (This echoes a common feature in nursing ethics research: nurses in Schrock's study identified issues such as abortion and euthanasia as moral in nature, but not issues like truth telling (Schrock 1980). Kelly's respondents (1990, 1991a and b) did not see their actions in taking care to attend to the 'little things' which mean so much to people as overtly ethical actions, although they were well aware they did not come under the umbrella of their technical responsibilities. Any explicated philosophy of nursing would have to account for these concerns: I believe that these are understandable if the nurse is seen as a companion/guide - concerned to protect the patient's sense of self on a journey through a strange place - see later discussion.)

Lawler's thesis is that nurses practise using what she calls 'somology' - 'a view of corporeal existence which integrates the lived body experience with the object body and which meets each of the essential elements for an adequate theory of the body in social life'. (Lawler 1990, thesis abstract). Nurses therefore learn strategies for managing the body in order to protect and respect the patient.

Gadow (1987) sees the preservation and enhancement of dignity as the key moral concern of the nurse. She is careful to point out that she is using the word in the broadest sense, i.e. not just preserving privacy (although I disagree with her use of the word trivial to describe this work), but encouraging and maintaining a sense of personal integrity and self esteem. I see this key concern being expressed by nurses participating in Lawler's study, although Gadow has little to say about the care of the body. Gadow's idea of caring involves attention to the 'objectness' of the body without reducing the person to the moral status of an object: a view which is consistent with the Kantian tradition of treating people as ends in themselves. Empirically, this notion has been found to be demonstrated by nurses in the course of their work. (Kelly 1990 and 1991a and b, Lawler 1991).

Physical care is important in symbolic ways; an importance founded on the phenomenon of touch. (Gadow 1987). Gadow sees touch as a way in which to counteract the tendency to turn patients into objects. The nurse's touch can reduce the patient's isolation, and can allow participation in his/her experience, thus increasing the capacity of the nurse to fulfil the role of companion/guide discussed elsewhere. In this society, intimate touch is associated with sexuality - Lawler has shown how nurses can use touch in a way which suggests friendship and sensuousness, rather than sexuality. The significance of this physical contact is increasingly being realised in nursing, with nurses studying the therapeutic use of touch (Bottorff 1991, McMahon and Pearson 1991) in order to realise the moral aims of nursing.

In this culture it is impossible to handle the body of a stranger without having to acquire particular attitudes. Nurses who learn the technique of performing the last offices are being taught an emotional attitude as much as a technical skill. (Campbell

and Higgs 1982). This attitude appears to be one of respect for the body: the student nurse is taught that the nurse has a duty to provide care after the moment of death in the same way as care was provided in life. The deceased is treated by careful handling, provided with fresh linen (even in the face of shortages) and close attention is paid to the environment in which her relatives will see her.

The evidence then suggests that Campbell is correct in his emphasis on the importance of the body in the nurse-patient relationship.

Emotions

Campbell describes the powerful emotional associations attached to the image of nursing, equating these with mothering (or parenting). The body is cared for, growth is respected, independence is promoted, potential and needs are perceived, and goals decided on. Drawing on Tillich, and in accord with Callahan, he sees the emotional element in professional care as of central importance. This is in direct opposition to the prevailing ethos in health care; of offering patients a service which can be costed, based on scientific evidence of the effectiveness of various types of procedures, techniques etc. However, the emotional reactions of carers to suffering and distress lead to the reactions of sympathy, empathy and fellow feeling. This, according to Scheler, upon whom Campbell is drawing at this point, prepares the way for the action of love.This emotional reaction may be blind to rules, outcomes and principles, but may in fact lead to moral good.

Drawing again on Scheler, he maintains that one must be able to let go of the self in order to allow participating in and identification with the other's experience, and that the loss of this capacity allows the development of an instrumental and dominational view of the professional-patient relationship. This capacity, to emotionally engage with another individual, it is claimed, offers a mediating position between the body and the mind. (Perhaps dealing with the physical body predisposes to this capacity.)

The conventional professional response to the place of emotion is that emotion should

be discounted: detached and analytical responses to situations are in the patients best interests. But emotions can lead to moral good as well as bad. Blum (1980) maintains that the moral emotions are as valid and reliable as the rational constructs. Treating moral decisions as a set of computed moves is to dehumanise them and render them immoral. This is not to say however, that emotion should be the sole determinant of action. Emotion has to be tempered with reason, and vice versa. The drive for action comes from the emotion; the decision as to what the action should be comes from reason. To achieve the good, the balance has to be right. This is at odds with current thinking in nursing texts, with one or two notable exceptions, where the requirement for detached reasoning is clearly reflected in nursing texts and codes as previously described. These in the main do not take account of the emotional side of nursing. In fact, detachment and lack of emotion is seen as a moral good. However, there is a trend recently, especially in American nursing, toward viewing emotional detachment as a moral fault (discussed in literature review Chapter 2.) Gilligan and Pollak (1988), working with doctors, found that they were more concerned to protect their objectivity, and less concerned to protect their involvement with the patient. The indications from the literature are that nurses would be concerned to protect patient involvement rather than objectivity. However, there is evidence that health care professionals may use detachment and indifference to protect themselves from the discomfort caused by allowing emotional involvement with their patients, rather than to protect their reasoning abilities (Benoliel 1967). Where evidence suggests that nurses become detached, this is done in order to protect themselves emotionally, not preserve their objectivity.

The role of the emotions has long been discredited in professional life: the aim, strongly in keeping with Kantian ethics, is to maintain objectivity and detachment in order to prevent the emotions from clouding perception of the issues at stake. This former attitude is very familiar to practising nurses: I have on occasion witnessed medical decisions being taken on the grounds of 'we'd better do something about this chap's pain, the nurses are getting emotional'. This said with a tolerant and understanding smile. But perhaps it is equally true to say that only by allowing oneself to experience emotion can the issues at stake be truly perceived. Johnstone

(1989 p 228-235) reports on research in the early 1970's by Char and McDermott into nurses working with women undergoing abortion. Although the nurses had no religious objections to abortion, and understood the needs of the mothers, they experienced considerable distress at having to deal with delivery and disposal of the foetuses. This aroused considerable conflict within them about the 'rightness' of what was being done. This moral distress was interpreted by the researchers as a psychiatric problem stemming from the nurses' own sexual difficulties, an astounding conclusion from the presented evidence. In 1981, Davis felt free to report research results, demonstrating the inability of nurses to articulate their ethical stance, with the rider that these young female employees' sentimental or emotional reaction to situations tended to discredit them and allow others not to take them seriously. It is for this widely perceived reason that so much research emphasis especially in America has been directed toward finding ways of educating nurses to think critically and objectively about ethical problems. There is no doubt that nurses require to be able to do this, but there is a danger that this ability, and the capacity to experience emotion, are seen as mutually exclusive. In pressing nurses to rid themselves of emotional responses, the danger is that moral perception or sensitivity may be reduced. Ideally, the nurse should be able to harness powers of critical reasoning to emotional responses to situations and people.

Campbell raises the notion of 'critical distance'. The professional is distanced enough to exercise objective judgment and to offer support, but not so distanced that response to the sufferer is prevented. This difficult balancing act may be enhanced if the nurse remains clear about what the aims of the relationship are. This will be discussed in the closing chapter.

The Expression of Emotion in Nursing

It is customary in today's health care system to view patients as customers, or clients, and the nurse as one who provides a service to them. However, as has already been discussed, patients are vulnerable, sick and in distress. As Bowlby and Weiss have shown (cited in Ersser, 1991) an increase in attachment behaviour is seen as normal in

these conditions. Nurses appear to recognise and reciprocate this, while also recognising the usually short duration of the attachment. Considerable anecodotal and research evidence exists in relation to the emotions experienced in nursing. Smith (1992) describes the 'emotional labour' of nursing. Her work suggests that both positive and negative aspects of emotional labour experienced by nurses have a profound effect on patients. [8] Goodwin et al (1979) studying the use of placebos by both physicians and nurses suggested that the issue is not simply one of honesty, but that emotional issues such as anger toward patients are involved. Brown and Thompson (1979) revealed the actions of nurses in delaying or preventing resuscitation by physicians, based on emotional responses to the situation. Ersser (1991) also explores the concept of emotional labour. This study suggests that nurses deliberately use their own emotions to influence patient welfare. He describes this deliberate use in terms of 'trust' work, 'composure' work, and so on.

Those who work with people are human, and so will experience feelings of disgust, anger or resentment toward some of them some of the time. (Gow 1982). This is accepted by social workers, psychiatrists and psychologists. Time and effort is required to learn how to cope with these: which is why these practitioners study to degree level, and begin their work in sheltered areas where they are given few clients and intense supervision. Nurses do not have this degree of preparation; plus they also have full 8 hours continuous contact - not one appointment. In addition, they are required to carry out physical care which is often hard and unpleasant, they are required to be armed with considerable knowledge, and they are required to be able to cope with emotionally charged and demanding situations. It can be argued with validity that all of this places far more strain on their capabilities in interpersonal relationships than any other profession. As previously discussed, most patients require nurses to care. Caring involves emotion and it has to be sincere, most people are able to tell if someone really cares or is just acting. In addition, as the relationship between nurse and patient/relatives develops, it is unlikely that the nurse could continuously 'act' emotions, without people realising that they were not sincere.

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[8] (The subjects of this study were student nurses: Lawler's work (1991) on experienced nurses suggests that experienced nurses may be more able to limit these effects on patients).

(Darbyshire 1990).

The nurse therefore has to try to be better than her natural self: i.e. the professional role requires her in certain situations to be more than just herself (Gow 1982). If the moral ideal of moderated love which Campbell describes (see chapter 4) is a true description of a professional relationship, then emotional involvement of some degree is inevitable. The question then becomes, are nurses clear as to what moral aim the emotion is directed toward.

Nursing needs to be very realistic about this, and to be very clear on both the demands on, and the possibilities for, the emotions of the nurse. As previously discussed, nurses can develop character armour to deal with these huge demands, and may learn detachment as a protection. However, there are signs that some nurses at least are well aware of the therapeutic effects of their emotional labour. Gow's respondents (1982) appeared to believe that what made the difference between helping and not helping a patient was the way the nurse's inevitable emotional response was expressed and directed.

In comparing the emotional work of nurses with air hostesses, Hochschild (cited in Darbyshire 1990) argues that most emotional labour is invisible. This may be the case in nursing, but many patients and relatives do demonstrate awareness of nurses emotional work, and feel that it is important to them. (Darbyshire 1990, Gillan 1994).

The data suggest that though nurses deliberately use their own emotions it is not always in the form of bedside 'armour'. Ersser (1991) draws on Strauss in explaining the use of emotions as 'sentimental work'. This could be for example 'composure work', aimed at helping during fear or pain; or 'trust work', aimed at displaying concern and competence. There is considerable evidence, therefore, that for nurses and patients, the emotional component of their work is important to them . This is in accord with Campbell's ideas of the central importance of the emotions in a professional ethic. The evidence, however, also suggests that the institutions and the physicians with whom nurses work either ignore or ridicule its importance.

Companionship

The companionship which Campbell describes is a 'bodily presence which accompanies the other for a while'.(p 49). He recommends the image of a journey undertaken by two chance met companions, who then separate. What happens during the period of companionship may affect the length of the journey, and how it is remembered. The relationship may also encourage a striving to reach the end, or may discourage to the point of giving up. He describes three ways in which nursing can be said to be this kind of companionship. Firstly, there is the presence of the body (already discussed). He speaks of the sensitivity of one companion to the other's needs, idiosyncrasies etc. Secondly, the journey has a goal; the companion alleviates the hardness of the journey by looking toward to the goal. Nursing skills and knowledge help them to see that goal. Thirdly, the companionship involves being with, not just doing to; entailing the sharing of risk, and the difficulties such a demand makes on the companion. And lastly, the commitment is limited, parting is essential. (Campbell 1984b). In Campbell's companionship, there is personal involvement and a giving to the other which transcends skill or technique. [9] Illness disrupts peoples lives, and impairs their capacity to deal with the journey. They therefore become unusually reliant on the companion.

Campbell also offers the idea that the knowledge of the good in the relationship stems from the meeting of the world of sickness and the world of the patient. This is reminiscent of both Zaner's (1985) and MacIntyre's (1983) idea of the meeting of two worlds. It seems to me therefore that the image of the nurse here is not simply that of companion, but that of guide and interpreter, taking some responsibility for the journey being made. Note that it is some responsibility, not total responsibility. It is the traveller who knows where he wishes to go, and the companion/guide who tries to ensure this happens, but the relationship is unequal in the sense that one partner is more than usually reliant on the other.

[9] Here he implies that the two parties are equal, but later says the two do not stand in the same position. But surely companions do stand in the same position?

MacIntyre suggests that the current relationship of nurse-physician purports to be but is not functional. Concentrating on the conceptual division between care and cure may hide this. Currently there is a function waiting to be performed which he claims is not: that of interpreting the patient to the physician and vice versa. The most obvious person to take this role is the nurse, and I would suggest from my own experience that many nurses do undertake this: for example, 'sister's rounds' taking place after medical rounds with just this purpose in mind. MacIntyre sees the nurse as emissary or interpreter between two cultures. However, this description seems to imply passivity on the part of the nurse: the evidence suggests that there is more active manipulation of the interface of the two cultures by the nurse. (Davis and Aroskar 1978; Hutchinson 1990). A persistent theme which arises from talking to patients is that they want to know what is happening. (Zaner 1985). The intricacies of diagnosis and therapy can be complex and difficult for the physician to understand; for the patient who is compromised by the experience of being ill it can be impossible. To be a patient is to be constantly on the alert. They grasp at encouraging things, and magnify bad things. They want their carers to tell them what they know, and to do so in a way which demonstrates their perception of them as a person.

The forbidding and foreign environment of both illness and hospital is a culture shock which requires patience to endure. (Zaner 1985). People have difficulty in articulating new and strange experiences, often describing themselves as having lost their bearings. The nurse acting as companion may make the strange more comfortable, better able to be reckoned with and contribute to the restoration of confidence. Perhaps the nurses described by Kelly (1990 and 1991a and b) as placing importance on 'taking care of the little things' e.g. making room amongst technical equipment for personal photographs and belongings, maintaining the patient's normal routine of bathing instead of forcing her to adopt an institutional routine, ensuring favoured food is ordered, and so on, are attempting to reduce the strangeness for their patients. Suffering of any kind is a threat to the sense of self. If the patient is allowed to remain suffering, when this can be avoided, then they have been abandoned. It is the task of the companion to ensure abandonment does not occur.

Zaner's image of the 'alien territory' of illness and suffering lends itself very well to the idea of a companion/guide, familiar with the terrain and equipped with the skills to lead the patient through it. Campbell's metaphor of the nurse as skilled companion, extended to include the ideas of interpreting and guiding, seems to be one which meets this need. The nurse's 'in-between-position' (discussed in Chapter 5) makes her the obvious candidate to fill this role. Because of the physical intimacy and continued contact of nursing described above, nurses have the potential to be very aware of the patient's body and feelings, and at least to a limited extent of the patient's own particular world. Their knowledge base and experience also gives them awareness of the world of sickness and therapy. The moral aspiration here, I believe, therefore is to synthesise these awarenesses in order to inform, interpret (in both directions) and guide their patient through the world of distress and suffering. This aspiration may be more easily achieved if the nurse is working from a position of involved reasoning and disciplined emotion as described above. Illness seems uniquely capable of awakening a special moral sense that is usually dormant but that on special occasions can be brought to the surface. (Zaner 1985).

Gow's research identified three main helping responses of the nurse: providing moral support, acting as a sounding board, and providing explanations. This empirical finding fits well with the image of the nurse as guide/interpreter/companion. (Gow 1982).

In thinking about what makes the role of the nurse unique, the traditional view is to consider care versus cure; the nurse cares, the physician cures. With the changing focus of health care, this boundary is becoming blurred. But what is certainly true to say is that where no physician assistance is possible, there is a very important role for the nurse as companion. Care of the dying, care of the elderly, care of the mentally handicapped are all areas where the major focus of health care is a nursing one. No other member of the team is in a position to fulfil this role. The role is taken seriously by nurses, but seldom articulated. It is customary practice, even in acute care settings, however, to allocate a nurse to stay with a patient when death is anticipated, and no relatives are present. Many nurses make considerable efforts in the face of staffing and

work pressures to provide this companionship, regardless of whether the patient is or is not apparently aware of it. This idea of companionship extends often to the relatives. Even when relatives are present, considerable efforts are made to maintain continued and frequent contact with them, even at times when no physical care has to be provided for the patient. Care and companionship are often transferred to the relatives, a fact which has considerable impact on them (Gillan 1994).

Campbell, is therefore, not alone in seeing the role of the nurse as that of companion. The evidence suggests that both nurses and patients regard companionship as at least part of their role. Influenced by MacIntyre (1983) and Zaner (1985), I suggest that this conception could be usefully extended to include that of guide and interpreter.

Engelhardt (1985) maintains that the only differences between nurse and doctor are in social roles and power, and claims that there is no conceptual core unique to nurses. Nurses only fill niches where there is no competition from physicians. Even if this is so, and being a companion is a role brought into being by the structure of society, this does not preclude it having a moral foundation. The relationships brought into being by the adoption of the roles are different in nature, and as Campbell and Higgs point out, it is necessary to evaluate the nature of the relationship in any moral assessment (Campbell and Higgs 1982).

CHAPTER 4: THE NURSE - PATIENT RELATIONSHIP

In order to fully characterise the concept of the nurse, it is necessary not simply to examine the role which the nurse might fulfil, but also the relationship within which the role is played out.

It is generally agreed in the literature that in any health care relationship a moral obligation arises from the special relationship between the carer and the one seeking care. (Pellegrino and Tomasma 1981, Campbell 1984, Fry 1989, Tschudin1992). The presence of an afflicted person seems uniquely capable of awakening ' a moral sense that is usually dormant, but that on special occasions can be brought to the surface'. (Schweitzer, cited in Zaner 1985 p 102). Nurses and doctors therefore have the opportunity to regard every meeting with affliction as a 'special occasion', bringing forth this moral sense. This view has not gone without challenge (Downie1986 a, b). It could be said that these moral responsibilities are neither more nor less than those which any service profession holds. How we wish to be treated by for example a car mechanic is analogous to how we wish to be treated by a doctor or nurse: with respect and courtesy, efficiency and a concern for doing the job well. Up to a point this is certainly true. This relationship differs however in two important ways: firstly, we are not required to allow the car mechanic access to our bodies or intimate concern to allow him to carry out the service he is performing; and secondly, if we do not approve of the estimate, or the way in which the mechanic deals with us, we are in a position to leave and seek another; in other words we are able to maintain control. We may be dismayed and upset by his actions, but a) they are much less threatening to our sense of self than they would be in a doctor or nurse and b) we have much more control over them.

We are all vulnerable to how others treat us; but much more vulnerable to some than others. The increased vulnerability of sickness and distress, I would suggest, places a correspondingly greater responsibility on anyone charged with the job of alleviating suffering. (I include in this category anyone who deals with the distressed, not just

doctors and nurses; simply they are two of the occupations who do this on a regular basis).

Why is it important to consider the nature of this relationship? A theme in Campbell's work which is of particular interest is his emphasis on assessing actions by evaluating the nature of the relationships between the agent of care and the recipient of care, rather than on the results of the encounter or by the rules of a particular code, or set of principles, (although he does not deny the usefulness of these). It is in the evaluation of relationships that 'we most urgently need criteria for moral judgement'. (Campbell and Higgs 1982 p 10). This is surely correct; well established methods exist to evaluate outcomes of action (Dowie, 1994); codes of practice have been developed to assist us to follow principles for action. We also have access to the considerable discussion which has taken place over how those principles should be addressed in professional life (Gillon 1985; Beauchamp and Childress 1989). Review of the literature suggests that the focus of contemporary morality is seen as the right of the individual to choose his actions. However, as Campbell and Higgs point out, the ability of the individual within a helping relationship to choose is affected by the nature of the relationship (Campbell and Higgs 1982).

There are a variety of models, both descriptive and prescriptive, proposed to describe the nurse-patient relationship. Within these relationships, the nurse can occupy a role such as advocate, companion, surrogate mother and so on. [10] The following are the main ones considered in the literature.

Contractual Relationship

The characteristics of a contractual relationship are described by Thompson, Melia and Boyd (1994). Like a commercial contract, the relationship is governed by the demands of justice, rights and duties. The patient voluntarily seeks help, and access to the nurse's knowledge and caring skills. There is a formal or informal contract to care.

[10] Although it seems intuitively correct to say that these two must be interdependent, it is possible to imagine a nurse acting as, for example, an advocate both within a contractual and a covenantal relationship.

The patient accepts the need to co-operate, and the nurse accepts the duty to care, repaying the patient's trust by providing competent service.

This analogy appears limited in its power to capture the nature of the relationship in that the two partners are in an unequal position, and that usually neither is in a position to terminate the contract, unlike commercial contracts. This view of the nurse-patient relationship is one which regards patients as consumers and health as a commodity. It assumes that the patient is capable of determining his own best interests. There is a belief that the ethical responsibility of the nurse is determined by rights. (Smith 1980). According to Brock, an American writer, the nurse *can* opt out of the relationship, citing the special case of abortion. (Brock 1980). However it is difficult to see how nurses can reconcile this stance with the duty owed to their employer, and to their patients, apart from this special circumstance. According to Brock, the key to this model is the patient's freedom to determine her relationship with the nurse. Brock's nurse-patient relationship is essentially the same as that of the physician patient relationship. But Smith points out the nurse has an extra obligation to the physician because of patient agreement, thus altering the quality of the nurse-patient relationship.

Brock's account of the clinical contract claims that the rights and duties in the relationship become explicable only in terms of a contractual model. While nurses often act as advocates, surrogate mothers, physician assistants and so on, the duties involved in these roles can all be explained with reference to this model. He answers the objections outlined above by saying that the nurse is an indirect party to an implicit agreement between patient and health care system. She becomes committed to the relationship by virtue of the contract with the hospital.

He does not say anything about the extent to which nurses are aware of this indirect and explicit commitment, or whether this distanced view of the nurse-patient commitment is desirable.

May (1975) criticises contracts on the grounds that they promote self interest, and

confine the response to needs to those which are outlined in the contract.

Covenantal Relationship

The most detailed account of caring relationships as covenantal relationships is given by May (1975). According to him, truth telling is the basis for the relationship in the sense that the doctor needs to be true to promises (he is considering primarily physician-patient relationships). The covenant is primarily based on a promise, and fidelity to that promise. It is characterised by an anticipated exchange of gifts, labours or services, and this covenant is responsive in nature - not one sided. Thompson, Melia and Boyd (1994) define a covenant as a commitment of mutual fidelity, grounded in respect for persons. The patient offers trust freely, and the carer accepts the duties freely. The covenant is based on the Judeo Christian ethical tradition. It has three elements: a gift (the presence of the patient), a promise based on the gift, (to provide care) leading to an experience of altered being, which engenders a set of obligations (the duties owed by the carer). The covenant is initiated by the patient.

Cooper (1988) argues forcefully for a covenantal view of the relationship as a basis for a nursing ethic, drawing on Gadow, Veatch and May. She endorses May's claim that the covenant arises from the moral principle of fidelity. However, as this principle is implicit in other relationships e.g. physician-patient, it is difficult to see why she advocates it as the basis of a *specific* nursing ethic.

Campbell (1984b) proposes that his 'skilled companion' offers 'moderated love' within a covenantal relationship. He endorses May's claims and draws on Ramsay to emphasise the importance of fidelity in the professional helping relationship. The covenant he envisages promises a much more active concern on behalf of the patient than the restrictive contract. Unlike other writers, he explicitly acknowledges the importance of physical action in the relationship: "The covenantal relationship which promotes trust and mutuality requires bodily mediation in order for its true value to be appropriated by helper and helped alike" (p 111).

'Moderated Love'

Campbell draws on the work of the sociologist Halmos, who claims that some forms of professional care can be seen as the offering of love. The orientation is nearer to religious faith than scientific detachment. Campbell, drawing on his knowledge of the caring professions, including nursing, develops this idea, offering parallels between Christian values and professional values (Campbell, 1984), although he says that a Christian belief is not essential to professionals.

Campbell's main thesis is that 'moderated love' is the moral ideal for professional practice to aspire to. The relationship between love and benevolence he takes to be crucial for any moral theory. Hume also takes it to be central; Kant to be irrelevant. Nursing ethics texts in general appear to follow a Kantian line, although there are signs that this is changing. Kant, although he has nothing to say in relation to the emotions, does equate his 'respect for persons' with the Christian idea of 'agape', the injunction to 'love thy neighbour as thyself'. Love is defined as a spontaneous emotional response, transformed into a therapeutic technique. There is a commitment to the welfare of others, transcending personal advantage and professional advancement.[11] It is this love which Campbell says is moderated and offered by professional carers. Moderating love is a skill - balancing involvement and detachment, and also a symbolic role - representing society's concern and hope for the ill and distressed individual. Moderation of love is understood in three different ways: firstly, the ethic of agape is drawn upon, and the emotional response is tied to the command to respect all humans equally. Secondly, moderation tempers the relationship - there are not extremes and sudden changes which characterise personal love. And thirdly, the moderation of love symbolises an attempt to reach an impossible ideal - it is therefore the embodiment of hope. Campbell identifies features for each caring profession which form the basis for love - brotherhood in medicine, and companionship in nursing. Three features are singled out as essential to

[11] Campbell does not deny that many professionals do act in their own self interest: he appears to be saying only that there is the potential to achieve this good, and that professionals should aspire to this ideal. The power and influence that the relationship confers upon practitioners should be borne in mind and curbed by them.

the relationship: particularity, incompleteness and mutuality. [12]

Particularity

Caring professionals all require to apply general principles, acquired from their knowledge and experience, to unique individuals. The general principles are necessary in order to address our understanding that there are universal ways in which people should be treated. The application of principles in individual situations is not always easy, and demands time and attention - which is not always available in sufficient quantities. Doing this can also be threatening, in that people's responses are unpredictable, leading to feelings of loss of control on the part of the professional. But if this moral ideal is being aspired to, this challenge cannot be avoided. An example may make this clearer. It is a generally accepted principle that telling the truth to someone is a moral good; showing respect for the person's rights to know and to make choices based on that knowledge. It may be however that in a particular situation, the nurse or doctor decides not to tell the truth at that particular moment, judging that it is in the best interests of the patient. Telling the truth may for example cause distress which the carer judges that the patient might deal with better at a later date. The carer is walking a tightrope: well aware of the results of avoiding truth (lack of trust, respect and so on), and with only an estimate of how the patient will respond to their actions. This I think is what Campbell means by the threat to the professional of treating people as singular individuals: it's much easier and allows actions to be more easily defended if you go by the book.

Incompleteness

Another challenge to the aspiring idealist is the need to acknowledge defects and uncertainties in the care being offered to the sufferer. Although technical knowledge may be of a high order, the professional's idea of what constititutes the good is no better than any other's, but she can open up possibilities from their particular stance,

[12] I have tried to distil the essence of Campbell's meaning into a short account: however it should be acknowledged that I may in doing so have oversimplified and lost nuances of meaning.

and be open to possibilities which other disciplines, or the patient, are able to open up. This notion of the professional's role accords very well with that of Donald Schon's 'reflective practitioner', where the professional acknowledges the incompleteness of their knowledge, and uncertainty of outcomes: using these as an impetus to learning (Schon 1991). It is an aim of current nursing education curricula that reflective practice, in Schon's sense of the word, should be encouraged.

Mutuality

This is defined in the Compact Oxford English Dictionary (1991) as "mutuality: of ....actions/sentiments/relations performed/entertained/possessed by each party towards or with regard to the other: the quality or condition of being mutual (reciprocity)". "Reciprocity" is further defined as a "condition which is felt or shared by both parties: a mutual action: expressing a mutual relationship". To "reciprocate" is to "give and receive mutually". [13] Communion of feeling is possible between total strangers because human experience and emotional expression are very similar from person to person. (Campbell 1984a).

Nursing is physically hard work; the financial rewards, though improved, provide little incentive for those anticipating a life long career; the emotional burden can be significant; and there can be considerable conflicts arising from nursing's position in the system. However, few, if any, nurses are motivated by entirely selfless reasons. According to Campbell, there are potentially great rewards to be obtained from the act of caring, in particular the human need to be needed is satisfied. If the right balance of mutuality, or interdependence, is struck, the real reward is the personal character of the relationship which is created, where each participant is indebted to the other. Often nurses claim this indebtedness as 'job satisfaction' - a patient expressing relief from discomfort, a smile of gratitude, a discharged patient. (Tschudin 1992). Patients often express considerable gratitude to nurses (Zaner 1985), and the fact that nurses derive great reward from this is illustrated in Marck's study. (Marck 1990). This demonstrated that patients requiring relatively greater effort than others were seen as

[13] This is in line with the idea of a covenantal relationship, outlined earlier.

more rewarding to care for when their condition is improving, or when relatives and staff acknowledge nursing efforts. In hospital wards in the relatively dour emotional climate of west Scotland, evidence of this interdependence can be seen frequently; patients being discharged and their relatives offering hugs, kisses, handshakes and small gifts to nursing staff, who clearly take considerable pleasure from these rituals. With patients who have been nursed over a long period of time, these mutual bonds can be strong. When the bond is disrupted by death, the distress often suffered by nurses is evidence that the care has not just been detached provision of a service.

May, in his delineation of covenantal relationships (discussed earlier), emphasises the benefits to the carer, who both gives of her skills, and receives the trust of the patient. He believes this mutuality nourishes the relationship. (May 1983). Gadow (1980) sees the reciprocity of the relationship as the foundation of nursing's commitment to patient dignity. Veatch (1981) believes that moral decision making is enhanced by mutuality.

Nurses have been interested in the idea of mutuality, or reciprocity, for some time. (Watson 1979, Gadow 1983, Yuen 1986, Fry 1990). A common theme of mutual exchange emerges from these writers. (Marck 1990). This 'mutual' relationship Campbell describes as 'being there together'. This idea is currently of considerable interest in American nursing; the influential theorist Benner in her description of nursing classifies a variety of nursing skills under the umbrella term 'presencing' - or 'being there'. (Benner and Wruberl 1989). Martin Buber's 'I-Thou' relationship has also been of interest to nurses, both Tschudin (1992 and 1994) and Gadow (1990) deriving their ideas from his work. Gadow goes so far as to claim that the mutuality of the nurse-patient relationship becomes the moral foundation of nursing; the nurse becoming sensitive to who the patient is as a person, and vice versa. From my own experience it is certainly true to say that patients, not invariably but often, consider the nurse as a person who happens to be a nurse, rather than the other way around. When a true reciprocal relationship exists, patient and nurse share the meanings of their experiences, and share control. The patient becomes more effective in coping, the nurse in caring. (Marck 1990).

There are several problems, however, with considering mutuality as a feature of professional care. Firstly, the need for reward outlined above can become a demand, the nurse seeking to increase a patient's dependency in order to meet his/her own needs, which does not lead to the good for the patient. I am not blind to the fact that I chose to spend my own nursing career in 'life saving' areas, where the reward experienced from the efforts can be immense, for my own personal satisfaction. Secondly, if the ideal of care is impossible to meet, for whatever reason, this can lead to guilt, and possibly disengagement from the patient, when this ideal is not met. (Campbell 1984B). There is considerable empirical evidence to support this latter suggestion in nursing: research evidence suggests 'burn out' and loss of caring occur as a direct result of, among other things, being unable to give 'ideal' care.(Duquette et al 1994). These will obviously detract from the quality of the reciprocal relationship. Thirdly, and most importantly, mutuality, especially as described by Buber, implies that both parties are equal. In fact, nurse and patient do not, and cannot, stand in the same position for two reasons: one to do with the nature of illness, and the second to do with the context of current health care delivery systems, a point which Campbell makes. In either case, the vulnerable person is in an unequal relationship in which another has control.

Zaner (1985), drawing on Rawlinson and Pellegrino, points out that illness is not sought out - it happens. It distorts our ordinary relations with others insofar as it debilitates, humiliates, isolates and leaves one at the mercy of others. When one is sick, the inequality in the relationship is qualitatively, not just quantitatively, different. Mutuality or reciprocity is difficult to visualise in the unequal relationship thus described. Does attempting to achieve reciprocity/mutuality therefore provide a way of redressing this inequality?

Another aspect of the inequality of the relationship is that often nurses care for people who are unconscious, unco-operative, aggressive and so on, and it is well known that nurses can find 'difficult' patients profoundly unrewarding to nurse. Nurses in this position must then make deliberate and conscientious efforts to ensure that these

patients receive care on a par with other patients. There is evidence that this is often not achieved. (Stockwell 1972 and 1984, Kus 1990). Marck (1990) suggests that mutuality here might occur through the nurse using imagination and sensitity in the light of knowledge and beliefs about the patient. The cultivation of tolerance, and appreciation of diversity, might also assist.

It is difficult to talk about nursing as a form of 'moderated love' without descending into sentiment. Campbell's work has been of interest to nurses, but has not received widespread endorsement. I believe this is for two reasons; firstly, the use of the word 'love' is distrusted because of its associations; and secondly, the theological basis of his work has not appealed to a young profession trying to distance itself from its religious and military roots. The language he uses is not attractive to nurses trying to establish a scientific and professional base for practice. The word 'love' carries such strong connotations in our society that it is difficult to remember that the Judaeo-Christian tradition of 'love thy neighbour' is a command which is not mere sentiment, but a disposition to act in ways which express respect for persons. In examining Campbell's ideas, I have not pursued a theological theme, believing with Benner that it is possible to accept the obligation to others without having to accept an obligation to God. An ethic which is detached from a religious context is more acceptable in a multicultural activity like nursing than one which is relatively neutral.

Nevertheless, I believe that Campbell's ideas of what nursing is are consonant with the experience of nurses, and that scientific practice requires to rest on a solid moral foundation. As he maintains, the effort of caring cannot be described in terms of the intellect alone. Campbell, as a theologian, would say that help is given in mysterious ways; I, as a nurse, would say that help comes from having a clear sense, both intellectual and emotional, of the aims of care and of the person being cared for.

Dialogical Relationship

Bishop and Scudder (1991) point out that a covenant is an agreement between some

parties which excludes others. They propose a dialogical relationship which is 'purely relational and personal' (p19). (A dialogue can be between two or more people). They claim that the nurse-patient relationship can be better articulated as a dialogue than as a covenant in terms of describing actual nursing experience. In common with a covenant, there is mutual trust and understanding (they claim more so than in a covenant, which has a greater emphasis on the patient trusting than the carer). They outline some problems with the covenantal approach, in that it does not account for everyday experience. Often the patient does not display trust or co-operation, and the nurse continues to offer appropriate care, despite the lack of this. Often, too, what the nurse offers is founded on what the profession, or society, sees as appropriate, and is not what the patient actually wants. The nature of the relationship also poses problems. It is fluid and changes constantly: patients move from being highly dependent to independent - Thompson Melia and Boyd (1994) recognise this and suggest that it is appropriate for the nature of the relationship to change from covenantal to contractual in different situations. Care is shared - nurses change shifts and move from patient to patient - does this mean that the patient forms a covenant with each, or is there a sort of blanket covenant? Trust grows as relationships develop, it is not always given at the start. This is perhaps a much more likely scenario in current health care: MacIntyre (1977) claims that 'where a community of moral and metaphysical beliefs is lacking, trust becomes much more questionable. Once cannot rely on others judgements unless one knows what they believe. So one cannot accept the moral authority of someone just because of their professional position'. (p 210). Bishop and Scudder appear to believe that the dialogue between nurse and patient allows this trust to grow: nurse and patient must come to know each other personally. They claim that for these reasons a notion of a covenantal relationship cannot encompass all nurse-patient transactions; in this I am inclined to agree with them.

They offer the idea of a dialogic relationship, under which (I take them to mean) special situations in which contracts, codes or covenants are appropriate would be subsumed. Whereas a covenant relationship assumes a common purpose, a dialogic relationship does not. Each party responds to the other as they are, for example,

dealing with unco-operative patients. Here the relationship is cultivated and developed, not through the establishment of a covenant, but through dialogue between the two parties. [14] This dialogue is not confined to the purpose of regaining health, or ameliorating distress. Personal conversations also take place. The dialogue may, or may not, become a covenant in the course of time. In this discussion, they are drawing on Buber's idea of the 'I-thou' relationship, but point out that while for Buber dialogue is an end in itself, a caring dialogue entails at least one of the parties focusing on the other's well being.

[14] There is some empirical evidence that this 'dialogue' between nurse and patient does alter the nurse's response to moral dilemmas over time (Chally 1990).

CHAPTER 5: THE POSITION OF THE NURSE

Most of the discussion to this point has focused on the one to one nurse-patient relationship. This narrowed focus, although essential to clarify understanding of this relationship, is unrealistic. The nurse operates in a hierarchic, institutional setting, with an extra duty to the physician.

"Central to understanding the triad of physician-nurse-patient are conflicts and tensions engendered by various restraints on power and authority that stem from the prevailing hierarchies in health care institutions" (Engelhardt 1985 p 63). Engelhardt, a physician, differs from other writers (Oakley 1984; Aroskar 1985) in claiming that doctors and nurses share the same views of health and illness, and says that their diffferences only turn on their capacities to fashion social reality. The functions of diagnosing and prescribing are restricted to physicians - these are the special privileges by which physicians restrain trade. He recognises nurses concern for independence and special professional integrity, but claims that nursing developed as a profession ancillary to medicine. Here he appears to ignore the long standing tradition of women as carers in the community, aside from the rise of technical medicine. He also appears not to notice the functions of reassurance, comfort and emotional support, and the provision of intimate care which many nurses feel to be the core of their practice, and therefore denies the existence of a conceptually unique core to nursing. However, Engelhardt describes the position of nurses as 'the people in-between' physicians, patients and institutions, and this is a useful characterisation of the context in which nurses work.

The 'In-Between' Position

The patient, according to Engelhardt, is the source of authority for health care, and the physician is in authority over the provision of health care. Since the nurse is the agent of both, 'caught in the middle', there is considerable potential for conflict, due to the ambiguity of her position. Other writers agree: Winslow and Winslow (1991) claim

that nurses are often caught in the middle attempting to hold together diverse elements of care for the patient whose condition may cause conflict about what is right and good. It is not only other groups of people that nurses are caught between. The language of care and compassion which is a feature of considerable writing in current nursing ethics is a much older one than that of rights and autonomy and nurses seem to be caught in the middle of two ways of ethical thinking. According to Lawrence and Helm (1987), nurses are caught between hierarchic and paternalistic values and feminist doctrines and values. The advent of the latter appears to have muddied the waters, rather than offering new scope for thought.

There is some empirical evidence to support the proposition that nurses experience considerable conflict resulting from the 'in-between' position. Elander et al (1993) describe the struggle of nurses to reconcile patients and relatives interests. International studies (Norberg et al 1980, Akerlund et al 1985, Norberg et al 1994) describe the conflicts experienced by nurses in dealing with forcible feeding of the demented elderly. Nurses appear to be confused in trying to theoretically decide on principle priority. They appear to be willing to abandon previously expressed principles *either* by giving importance to the particular relationship *or* by relinquishing moral authority to others. There is considerable evidence in practice of the difficulties faced by nurses referred to by Beauchamp and Childress (1989) as a consequence of their position in health care. The barriers to behaving in ways which the nurse believes to be ethical are immense, working as they do in an environment where actions can be controlled by the threatening of employment security, and less obviously, but no less frustratingly, where nurses moral perspectives are not taken seriously. The long running saga of Graham Pink (Beardshaw 1982, Vines 1983 and Vousden 1985) who challenged the health authority over short staffing detrimental to patient care; and the nurses who refused to participate in electro-convulsive therapy, all of whom were disciplined and some of whom lost their jobs (Turner 1990, Wright 1990, Tadd 1991, Jones 1993) are a familiar warning to UK nurses. The cases of Tuma and Bardenilla in the USA also carry a salutary warning. These nurses challenged physician and institution decisions in the belief that they were acting in the patients' best interests, and suffered considerably in the process of doing so.

(Johnstone 1989). Bardenilla tellingly remarked that the nursing perspective was regarded as inappropriately emotional. Johnstone (p12-16) also reports the outrage in the New Zealand press when it came to light that anaesthetised women were used for medical students to practise vaginal and uterine examination, and to insert and remove intra-uterine contraceptive devices, without their consent. Nurses in the hospital had been unhappy about the practice, and had challenged it through their professional association, but had effectively been ignored. One writer has claimed in the light of evidence of this nature that nurses simply are not free to be moral, except by personal sacrifice. (Evans 1986).

Conventionally, the position is seen as problematic for the nurse - a source of considerable conflict. Not all writers are as pessimistic, some see it as an opportunity. It is a position unique to nurses, and nurses can exploit it to benefit patients. Winslow and Winslow (1991) advocate compromise, rather than rigid adherence to principle. They point out that if society claims to be a democratic pluralistic society, negotiation, accommodation and concession are implicit within these terms. They suggest that hospitals are pluralistic societies where the nurses should see their position as allowing them to co-ordinate communal decisions, involving compromise. They define compromise as 'the accommodation of divergent moral positions through a process of mutual concessions'. They maintain that compromise is compatible with moral integrity if the following conditions are met:

factual and moral complexity is acknowledged
moral language is shared
mutual respect exists on the part of those who differ
recognition exists of limits to compromise

But these conditions are by no means easy to achieve. The scientific orientation of health care workers often permits a false sense of certainty: the open expression of uncertainty is discouraged. Gilligan's work referred to previously suggests that there are different moral 'languages' and that there is a need for people to be aware of these. The hierarchical nature of the institution mitigates against people at the top of the

hierarchy having respect for the opinions of others. The evidence suggests that people do draw up limits within which compromise is no longer possible, but unfortunately the evidence also suggests that when people cease to compromise, they do so at personal risk as discussed above.

It is questionable to as to how far one can see a hospital as a democratic, pluralistic society when hierarchies are so embedded in their functioning, and their suggestion that nurses take the lead in negotiating compromises is a brave one, but one which current power structures make unlikely.

Bishop and Scudder (1991) claim that the position of the nurse is not so much a problem as an advantage if the image of the system is cast in the image of a 'web of connection' rather than a hierarchy of relationships. 'When relationships are cast in the image of hierarchy they appear inherently unstable and morally problematic, but when transposed into the image of a web, relationships change from an order of inequality into a structure of interconnection.....nurses function to maintain the connections between patients, physicians and hospitals." (p 18-19). This connection is required for adequate everyday care.

Some nurses resist the notion that the context of the work should be a factor in exploring nursing ethics, claiming that concentrating on the in between stance neglects the primacy of the nurse patient relationship (Cooper 1988, Gadow 1990). But to ignore it is to ignore reality, and ethics is a practical concern.

Invisibility

The medical sociologist Oakley in 15 years of working in hospitals, never noticed nurses until she was ill herself, and realised the important contribution made to her well being (Oakley 1984). Thomas, a physician/philosopher commenting on experiences as a patient in 1983, considered that the institution's function was enabled solely by the nurses - acting as the 'glue' which held the whole enterprise together. (cited in Winslow and Winslow, 1991). In the complicated web of relationships -

patients/physicians/relatives/other health care workers/administrators - the nurse is often the only individual in contact with all of these. Despite this, the part played by the nurses appears to be invisible.

In the USA, the Clinton administration proposed health system reforms have generated considerable publicity, in which there has been no mention of the part to be played by nurses, despite the fact that nurses are the largest single component of the system, and a critical element in reducing in patient days, and therefore costs. (Anderson 1993). In the USA, as in the UK, there has been substitution of qualified nurses by those less qualified, despite the (limited) evidence available suggesting that costs are not necessarily reducedby this strategy. (see Chapter 5).

McWilliam and Wong (1994) carried out an empirical study identifying components of the invisible work of nurses in relation to discharging patients, which are all related to the work context. According to their research, nurses have considerable work to do in relation to bureaucracy, which is hidden from patients. Tasks such as co-ordinating the efforts of other health care workers, liasing with support depts., and sorting out unforeseen problems are all undertaken in order to ensure that patients are cared for. Nurses try to compensate for the inadequacy or failure of the system for the benefit of the patient. (Winslow and Winslow 1991).This work, often considerable, is taken for granted by both nurses and others, and never discussed.

Why should nursing be so invisible? The reasons appear to be partly due to social expectations, and partly due to the nature of nursing itself. According to Colliere (1986), care is viewed as menial work, requiring no particular ability or knowledge, and therefore socially and economically unrecognised. A lack of recognition may lead to a lack of confidence, and so nurses come to believe that their work requires nothing special. Nursing education has traditionally reinforced this; it is only relatively recently that colleges of nursing have stopped using texts for nurses written by physicians which were in essence simplified versions of medical knowledge as their primary texts. Textbooks written by nurses traditionally have been no more than guidelines for various technical procedures. Until recently, nurses in general have not

been required to think in any depth about the nature of their work, and to come to believe that it is important.

The public appear to be disinterested in care, showing more interest in those who provide dramatic, high-tech cure - as witnessed by the public appetite for documentaries on hospital activities. It is difficult to imagine high rating figures for programs showing nurses providing for the comfort and needs of say, the elderly demented. Hospital documentaries never show the intimate side of nursing work, or the activities performed in relation to the function of the nurse holding the system together - it just isn't exciting enough.

Lawler, an Australian sociologist, has conducted research into the hidden work of nursing. (Lawler 1991). Her thesis is that nursing is invisible for two reasons: firstly, it is thought of as an extension of women's work, and therefore not worth discussing; and secondly, nurses deal with the privatised aspects of the body and social life. Often, their work involves body functions, which are taboo, and socially unacceptable, and are therefore not discussed or praised. Patients often proudly carry home glass jars containing their gallstones for display, and insist on discussing their surgery in detail, down to showing off their scars, congratulating the surgeon on his handiwork. Very seldom do the same people talk about how their difficulty in regaining bowel function was managed by the nurses, or how nurses comforted them during periods of emotional disturbance. When they do talk about nurses, it seems to be in general terms of their qualities as persons. Wolf (1989) also categorises nursing work, and all these categories fit with the 'invisible' tag: caring, maintaining the system, body work, dirty work and death work. These are all taboo, or taken for granted.

The emotional labour, too, of nursing can be invisible. (Smith 1992). For example, when a nurse cares for a dying patient, or handles an aggressive one, it is possible to measure the physical care, but it is very difficult to establish the amount of emotional effort involved.

Another factor which leads to the invisibility of nursing is the fact that the communications which are involved in caring, dealing with the body, and emotional support are all verbal, and have not commonly been documented. In general, only physical actions are recorded in nursing notes. Nowhere is sitting with the dying, or time spent providing emotional support for relatives documented. Even those physical actions recorded do not convey any sense of the skills and knowledge required. The terse entry 'colostomy bag changed: technique demonstrated' hides what may have been a protracted and time consuming procedure, where the nurse has had to use practical knowledge and skill in changing the bag and teaching the patient, and also has provided emotional support and human warmth in an attempt to show respect and preserve dignity and self esteem.

Is invisibility a problem? There are good pragmatic and philosophical reasons for attempting to make nursing more visible. The functions that nurture, support and maintain another's abilities are hidden, and therefore may not be valued. (Shannon 1991). In today's econonomic climate, with its emphasis on value for money, nurses are for the first time being asked to demonstrate the value of what they do. They have found this difficult to articulate. The Royal College of Nursing have published anecdotal accounts showing how nursing interventions have improved lives and speeded recovery: trying to make the invisible visible. (Royal College of Nursing 1992). There is also research going on into the effectiveness of nursing interventions on patients outcome (Bond and Thomas 1992).

Nursing cannot be justified as an important endeavour in practical terms without articulating practice; neither can one explore the nature of nursing without articulating practice. Those nurses who are engaged in measuring workload and outcomes are generally agreed that much of the practice of nursing remains hidden. Many dimensions of the work are difficult to address by measurement systems. (McWilliams and Wong 1994). In this they are in agreement with those who attempt to study the nature of nursing. (Benner 1984; Fry 1989).

If nurses fail to recognise the importance of their work, they must accept others

meanings. Nurses often forfeit recognition for the professional judgement and autonomy which they exercise (McWilliams and Wong 1994). The disadvantage of this is that they then cannot take steps to examine and improve judgement, and learn from failure, if they are not aware of what is happening. Learning and the acceptance of open responsibility will then not occur. If actions are based on inexplicated values, then nurses are not able to examine and judge these or their derivation. Nor can they learn from events, or pass this learning on. In addition, the invisibility of nursing, while preventing good care from being recognised, valued and given credit, will also camouflage where nursing intervention has been poor and delayed recovery.

Goodwin et al's study (1979) demonstrates this point admirably: if nurses are not aware of the role of the emotions of anger and discrimination in placebo administration, they are unable to recognise and deal with their own feelings of inadequacy in these situations, and to see how these govern their actions. They are not placed then to act in the patients best interest. The 'hidden euthanasia' described by Brown and Thompson (1979), because of its invisibility is not amenable to open discussion and rational examination. Again, this is not in the patients' best interests.

Informal Power

Hutchinson (1990) describes how nurses bend rules and what these behaviours mean to nurses. The basic social and psychological problem is conflict. The basic process chosen to cope with this is subversion. There is often collusion; with the patient or with other professionals. The context is revealed as an important factor. Nurses' thinking appears confused; they *say* they are working to abstract principles, but their *actions* demonstrate that they are responding to particular situations. They claim their actions are directed to patient good, and the incidences cited do demonstrate where good has been achieved. However, it is difficult to believe that there are no instances where subversion has *not* turned out to be in the patient's best interest, and Hutchinson does not explore this aspect. The hidden nature of the transactions may conceal good, but it equally may conceal harm. Lawrence and Helm (1987) also cite

empirical evidence that manipulating circumstances and using covert strategies is an attractive alternative to conflict for nurses.

I have already suggested that a situation where nurses manipulate events, and conceal the truth, is an unhealthy one, and have referred to traditional ethics which emphasise the importance of truth telling as a moral good. The evidence referred to previously suggests that nurses tend to conceal truth from physicians and institutions, and much less so from patients. Sometimes there exists a 'conspiracy' between nurse and patient. Is this a justifiable way in which to behave, given that nurses may feel they cannot 'take on the system'? Sissela Bok makes a case for the ethical justification of concealment and secrecy (though not, as far as I can make out, outright lying). (Bok 1986). Bok is talking about life in general, and not about any one particular group of people; but I think much of her thinking is reflected in the way in which nurses act.

Conflicts over secrecy are conflicts over power - the power which comes through controlling the flow of information. Nurses are in the ideal position - the 'in between' position - to enable them to do this. As the people who are in contact with everyone in the web of relationships they are have surveillance over all the information which flows between them. It is easy to manipulate this flow, as the empirical evidence discussed earlier shows. Why do nurses do this? To have no capacity for secrecy is to be out of control over how others see you, therefore nurses by pursuing strategies of secrecy and deception can control their own identity, and maintain a sense of control of the situation. To have no insight into what others conceal is to lack power, so if nurses conceal information from physicians, they are in fact curbing their power.

"In seeking some control over secrecy and openness and the power that makes it possible, human beings attempt to guard and to promote not only their autonomy but ultimately their sanity and survival itself". (Bok 1986 p 20).

The claims in defense of control over secrecy and openness as justifiable strategies are, Bok suggests:

secrecy protects identity, allows the perception of oneself as unique and worthy of respect

secrecy protects plans/actions, it guards projects requiring prolonged work and creativity, it allows negotiation, bargaining, tentative probing - since plans may fail if exposed too soon

secrecy allows people to protect what they own.

In the case of nurses, one can easily see how the first claim is demonstrated: allowing a feeling of power in what is an overtly powerless position. One can also clearly see the second demonstrated in Brown and Thompson's study (1979) of nurses delaying calling physicians to achieve their intentions of peaceful and dignified death. And it is not too far fetched, I believe, to think of the third claim in terms of protection of the special relationship between nurse and patient - which offers such clear rewards to nurses. As Bok says, the claims may be abused, or overstretched, but they do meet fundamental human needs.

There are, as she correctly points out, considerable dangers, as well as benefits to secrecy, some of which I have already touched on. Because the nurses in Brown and Thompson's study are keeping their actions quiet, they are not up for discussion and they cannot learn from them: feedback and criticism are stifled. Therefore secrecy 'debilitates judgement', in Bok's words. (p 24). Associated with this, it can conceal nurses' character traits such as callousness; and it can spread and become endemic within a community. Reading an account of the recent events leading to the conviction of Beverley Allitt (Davies 1993), one is struck by just such an atmosphere of secrecy and non-communication in the institution.

If these tactics come to light, the effect on others may be much worse than if nurses are openly assertive. The freedom of choice that secrecy gives one person reduces that of others. It also demonstrates lack of respect for others: physicians and institutions. When they realise this, they often act to control the actions of those who have been instrumental in concealing facts, or evading issues.

So Bok concludes that there can be no presumption in general for or against secrecy and concealment (unlike lying). Morreim too argues that real life demands mean that we have no option but to be 'moral artful dodgers' - that we are morally obliged to be ingenious in avoiding conflicts of principles and values. (Morreim 1986 p49). Jackson (1991) also sees secrecy as different from lying, and we are under no duty not to deceive intentionally without lying. Gillon (1993) suggests that the moral obligation against even lying is not absolute; it is defensible if pursing the best interests of the patients. This then, suggests that nurses may be morally justified in their use of secrecy and concealment. However, one cannot escape from the problems associated with these strategies outlined above. Nurses may have a moral aim in mind - but they must be clear exactly what they are doing and what the dangers are. The evidence limited though it is suggests they often do not.

CHAPTER 6 : CONCLUSION

The Role of the Nurse and the Nurse-Patient Relationship

I have examined the roles of handmaiden, advocate, and skilled companion which could be fulfilled by the nurse. The evidence seems clear that nurses, by virtue of the nature of the system in which they work, often do act as physician assistants, and patient advocates. However, this is a feature of the systems in which they work. Integral to the nurse-patient relationship itself, however, is the idea of the companion. This stands independently of the context: it is possible to see the nurse acting as companion in sickness and distress, regardless of the type of system, or whether any system exists at all. I have agreed with Campbell that this concept does in fact provide great opportunities for the nurse to achieve the good for the patient. Campbell's account of the nature of nursing is unusual but appropriate in that it captures those things which set nurses apart from other caring professions: i.e. the physical and emotional dimensions of giving nursing care. I have extended Campbell's metaphor to include the notion of guide and interpreter, endorsing Zaner's idea of sickness and suffering as 'alien territory'. Ideally, the nurse has knowledge of the territory, intellectually by virtue of theoretical knowledge of life and social sciences, and emotionally by virtue of the exercise of imagination and sensitivity, and from having been there before with others. She is equipped with the practical skills which enable her to guide and support the patient through the experience, and she understands the importance of the physical body and the emotional reactions to the experience. It is the patient, however, who has decided where she wishes to go, and decides on whether or not to follow the nurse's guidance, or accept her interpretation of events.

In describing this conception of the nurse, I am irresistibly reminded of the frontier scouts in the American West in the 19th century. These men took on the task of guiding people through unknown and potentially dangerous territory. Their qualifications for doing so were intimate knowledge of the terrain, and of the potential enemies inhabiting it. It is not difficult to see a parallel here consistent with the empirical evidence; nurses know not only the terrain of illness and therapy, but also how to negotiate the bureaucratic system in an effort to further their patient's interests: Thomas's 'glue' in the system. The frontier scout's sole aim was to see

their charges safely through the journey. For this they received payment: it was not a disinterested seeking after good. In the course of long journeys, and in the face of common danger, a temporary but of necessity trusting relationship was formed between scout and traveller. I would not care to carry this metaphor too far: there is no parallel to the intimacy between nurse and patient requiring body care, which introduces another dimension. The nurse is concerned not just to maintain physical safety, but may aspire to maintain the patient's sense of self. The scout's role was also played out within a contractual relationship, and as discussed above, this does not fully describe the nurse-patient relationship.

I have said that this role would be valid regardless of the system within which it is carried out. The current UK system however is particularly suited for the nurse to function as a guide and interpreter, by virtue of her 'in between' position, previously discussed. So I have settled upon an extension of Campbell's skilled companion concept as that which most nearly answers the research question, and I have tried in previous chapters to show why that is so. I am less sure however about the relationship within which this role is played out. It seems clear that a contractual relationship does not actually describe what nurses do, nor is it one to which they aspire. Neither do patients appear to see the relationship with the nurse as contractual. The idea of a covenantal relationship may be one to which nurses might aspire, but I am unsure that this accurately describes the nature of the relationship which most patients and nurses experience in that, for reasons discussed earlier. There is some evidence which may support Bishop and Scudder's description as dialogic in nature (Cooper 1990); and their description is compatible with personal clinical experience, but I can find no other writers discussing this model. I believe however it holds the potential for further exploration and analysis, outwith this dissertation.

Campbell endorses the covenantal relationship as an appropriate model for the caring professions, within which the professional offers 'moderated love'. This appears to be an excellent moral ideal for nurses to aspire to in their practice. One of the problems however with advocating that nurses aspire to offer 'moderated love' is that there is a grave danger of running into the trap of being overly sentimental, and attributing to the nurse a greater importance in the patient's life than is really the case. There is also the problem that one has to to differentiate what is significant about the injunction to nurses to respect (love) patients in

relation to the moral injunction laid upon everyone in society to do so. I suggest that in a dialogic relationship, the increased vulnerability of the patient draws forth a correspondingly increased responsibility to ensure respect (love) is given by the nurse. The expectations of society further increase the weight of the moral injunction laid on the profession.

Nursing in Contemporary Society

The fundamental problem for nurses is that their whole reason for being is to care. They are however practising in a society where care is not valued. Hewa and Hetherington (1990) describe a serious crisis among nurses in the USA, which they attribute to a conflict between the underlying values of the nursing profession, and the growing emphasis on a mechanistic and value stripped approach to providing health care. Nursing work has lost meaning and been devalued. The recent sweeping changes in the UK health care system with its emphasis on the market economy have brought us closer to the US model of health care. It is not far fetched to see a similar crisis looming among UK nurses. Some writers propose a re-organisation of the health services on a broader paradigm, based on the health care needs of people, rather than upon the interests of professional groups (Hewa and Hetherington 1990); a pradigm which harks back to the older care and environment model from which nursing emerged (Oakley 1984); a paradigm which is focused more broadly on the social, economic and cultural aspects of existence, as well as the purely physical. (Winslow and Winslow 1991). In addition, these latter suggest that nurses should concentrate less on the relationship between nurse and patient, and that the search for professional identity should concentrate on the elements of the work than are linked inextricably to the context, and to the contribution of the disciplines within it. This is in accord with the line taken by Yarling and McElmurry (1986), Bishop and Scudder (1987) and Foulk and Keffer (1991), but rejected by Cooper (1988), Packard and Ferrara (1988) and Gadow (1983) who place the first emphasis on the nature of the nurse-patient relationship. The recent changes in health care, blurring the boundaries between social work and health care, is perhaps an indication of the beginning of such a change in paradigm. My own view is that the two are inseparable: any account of the moral nature of nursing has to take into consideration the relationship between the nurse and the patient, *and* the context within which that relationship proceeds. Sickness and distress will always be with us, and therefore there will always be the opportunity for nurses to act as skilled companions: the element of the

role in holding the system together described above is only relevant in this particular health care system. In this context, the two need to be considered as to how these are related to each other. This is difficult to do particularly in view of the low visibility of both these elements.

In common with other health care professions, the aim of nurses is to achieve the health and welfare of individuals. The particular contributory aims of the nurse are to maintain the individual's sense of self, of dignity and self worth while providing the physical and emotional care required to reach this state. I believe that the nurse uses her in-between position to organise an environment within which to practise being a skilled companion. The adoption of this role I believe serves to best achieve the moral aims of nursing. It allows nurses to channel practical skills, intellectual knowledge and reasoning and emotional responses to these ends. Clearly, as in any sphere of activity, many will fall short of these ideals. The empirical evidence suggests this, but also suggests that many nurses do achieve these aims, in this fashion. This of course does not address any problems which arise for the status of the profession, the psychological well being of nurses, or the relationship between nursing and other health disciplines. Some of these I have discussed in the course of this dissertation. But there is an idea pervasive in nursing at the moment that seeking an overtly powerful role and equal status with other disciplines inevitably is the only way in which to achieve the moral aims of nursing. My contention is that there are ways in which this is and can be done already. There are very good reasons for the voice of nursing to be heard in public debate, and in clinical decision making, but nurses should make these clear and not hide behind the claim that only thus can patients' interests be best served.

I have found no evidence that the nature of nursing in essence requires the playing of a subordinate role. To be a skilled companion, or advocate, within a contractual, covenantal or dialogic relationship does not require a subordinate position. The subordinate role of nurses appears to have developed, not from the nature of nursing, but as a consequence of the role of women in society, and the historical origins of the current day profession.

Implications for Nurses and Nursing Ethics

In order to fulfil a role as interpreter/guide/companion, the nurse requires a considerable

armoury of skills and knowledge. Scientific and technical skills are taken for granted. What has been less emphasised is the need for sensitivity to questions of communication, to the use of language in all its forms, to the relationship of body and mind, and to the meaning of human experiences. These have all been the concern, not of the sciences, but of the humanities. Studying the humanities expands the practical and conceptual imagination, and this may be something which leads to social and political change. (MacIntyre 1983). There is a small but significant move in nursing away from the heavy emphasis on the sciences toward the necessity for nurses to consider the humanities. If this trend continues, with nurses developing these skills, Campbell and MacIntyre's concepts of the role of the nurse may become much more visible and valued in practice. If nurses continue the very recent trend toward exploring the hidden aspects of practice, this may accelerate this development. The danger here of course is that nurses may move too far away from the sciences, and therefore lose touch with their knowledge of the 'territory' of disease and therapy. A balanced approach is required in order to achieve the synthesis discussed above.

The current accounting orientated climate within the health service, plus the increasing costs of providing nurses with higher education, and the proportionately high number of nurses within the service, has generated a climate within which the cost of qualified nursing care has become a significant factor in health care provision planning. 'Skill mix' has become a familiar phrase to nurses, and nurses fear the development of a service where the intimate and personal care, which has been identified above as a kind of care which is peculiar to nurses, is performed by people who are not nurses. [15] The essence of being a companion is to be there; the idea of 'presence' is an important pre-occupation of nurse philosophers currently. If nurses are removed from the bedside to become quasi-managers and accountants, those who take their place will in fact be the people seeking to achieve the moral aims of the nurse-patient relationship. If the argument that those people require the knowledge and skills outlined above is valid, then the direct result of this trend will be that these moral aims will not be met, or at least not fully met.

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15 This occurs because this care is not seen as valuable, and therefore does not attract significant financial reward.

Health care management is notoriously unimpressed by philosophical speculation and argument: but there is some evidence that shows that staffing wards with qualified nurses is cost effective (Carr-Hill et al 1992). Nurses are also investigating nursing outcomes with a view to providing more evidence of this nature. (Bond and Thomas 1992). It seems clear at the moment that this is an appropriate strategy for nurses to adopt in dealing with management. The thinking underlying changing working practices, i.e. the development of bank and agency staff being employed on a shift to shift basis, clearly is driven by the conception of the nurse as a technician within a contractual relationship. It would be ideal if the profession could combine empirical investigations of nursing with philosophical thinking about the nature of nursing, and demonstrate the relationship between the two. If nurses can clearly articulate the essence of nursing, and provide evidence of its effectiveness, then nursing is in a better position to argue the case for the presence of the educated nurse at the bedside.

I have not come to any conclusion as to whether nursing has an ethic separate from medicine, or indeed from everyday living, but nursing does have distinct values, concerns and challenges which deserve consideration. [16] These differences in perspective may not be sufficient, however, to establish a completely different ethic. For those nurses who study the nature of nursing, and how nurses can attend to patient good, the question is how to reveal these, and to consider how these throw light upon the moral foundations of nursing. Benner's work provides a signpost. (Benner 1984). By studying the practice of nursing as Benner has, we can try to develop an account of the moral frameworks around which nursing has developed, and to examine the respective influences of care and principle based ethics. Very little empirical research has examined the transactions within the nurse-patient relationship, or the context within which this occurs. It is within these relationships, and within this context, however, that the moral goals of nursing are, or are not, realised. (Penticuff 1991). Melia (1994) agrees here, seeing the task of nursing ethics as explicating everyday practice with the emphasis on the patient.

16 That this is not a new development is illustrated by Olson (1993) who describes the separateness of the disciplines of medicine and nursing in the early years of this century.

Schrock in 1980 outlined four fundamental philosophical tasks necessary for advancing nursing knowledge by philosophical enquiry: limiting the search for knowledge, thinking methodically and systematically about nursing; identifying the philosophical demands of the research process and constructing and developing nursing theories. In this dissertation I have tried in a very limited way to contribute to the second task. I have seen this work as an essential first step in exploring and beginning to clarify the nature of the activity of nursing.

REFERENCES

ABEL-SMITH B (1960). A History of the Nursing Profession. Heinemann London.

ABRAMS N (1978). A contrary view of the nurse as patient advocate. Nursing Forum 17 (3) 258-267.

ADLER J E (1987). Moral Development and the Personal Point of View. In: Women and Moral Theory. E F Kittay, D T Meyers (eds.) Rowman and Littlefield. New Jersey.

AKERLUND M, NORBERG A (1985). Ethical analysis of double bind conflicts as experienced by care workers feeding severely demented patients. International Journal of Nursing Studies 22 207-16.

ALLMARK P (1992). The ethical enterprise of nursing. Journal of Advanced Nursing 17 16-20.

ALMOND B (1990). Alasdair MacIntyre: the virtue of tradition. Journal of Applied Philosophy 7 (1) 90 99-103.

ANDERSON C A (1993). Making the invisible visible. Nursing Outlook 41 246-7

ANDERSON E R (1973). The Role of the Nurse. Royal College of Nursing of the United Kingdom London.

ANDRE J (1992). Learning to see: moral growth during medical training. Journal of Medical Ethics 18 148-152.

AROSKAR M A (1980). The fractured image: the public stereotype of nursing and the nurse. In: Nursing : Images and Ideals. Opening Dialogue with the Humanities. S F Spicker and S Gadow (eds). Springer Publishing Co. New York .

AROSKAR M A (1985). Ethical relationships between nurses and physicians: goals and realities - a nursing perspective. In: Caring, Curing and Coping: Nurse, Physician and Patient Relationships. A H Bishop andJ R Scudder (eds). University of Alabama Press.

BAIER A (1987). Need for more than justice. In: : Science, Morality and Feminist Theory. M Hanen and K Nielsen (eds). Canadian Journal of Philosophy Supp. Vol. 13 41 - 56.

BAKER R (1980). Care of the sick and cure of disease: comment on the fractured image. In: Nursing : Images and Ideals. Opening Dialogue with the Humanities. S F Spicker and S Gadow (eds). Springer Publishing Co. New York .

BANDMAN E L (1983). Who Will Advocate for the Nurse Advocate? In: Ethical Problems in the Nurse-Patient Relationship. C P Murphy and H Hunter (eds). Allyn and Bacon. Boston Mass.

BEARDSHAW V (1982). A question of conscience - doubt about ECT. Nursing Times 78 349-51.

BEAUCHAMP T L, CHILDRESS J F (1989). Principles of Biomedical Ethics. 3rd edition. Oxford University Press.

BECKER P (1986). Advocacy in nursing: perils and possibilities. Holistic Nursing Practice 1 (1) 54-63.

BELENKY M F, CLINCHY B M, GOLDBERGER N R, TARULE J M (1986).Womens's Ways of Knowing. The Development of Self, Voice and Mind. Basic Books. Harper Collins New York.

BENHABIB S (1987). The Generalised and the Concrete Other. In: Women and

Moral Theory. E F Kittay and D T Meyers (eds). Rowman and Littlefield New Jersey.

BENNER P (1984). From Novice to Expert: Excellence and Power in Clinical Nursing Practice. Addison Wesley Pub. Co. Menlo Park Calif.

BENNER P (1990). Moral Dimensions of Caring. In: Knowledge about care and caring. J S Stevenson, T Tripp-Reimer (eds.) American Academy of Nursing Kansas Missouri.

BENNER P (1991). The role of experience, narrative and community in skilled ethical comportment. Advances in Nursing Science 14 (2) 1-21

BENNER P, WRUBEL J (1989). The Primacy of Caring: Stress and Coping in Health and Illness. Addison Wesley.

BENOLIEL J Q (1967). The Nurse and the Dying Patient. Macmillan New York.

BERNAL E W (1992). The nurse as patient advocate. Hastings Centre Report 22 (4) 18-23.

BISHOP A H, SCUDDER J R (1987). Nursing ethics in an age of controversy. Advances in Nursing Science 9 (3) 34-43.

BISHOP A H, SCUDDER J R (1990). The Practical, Moral and Personal Sense of Nursing: a Phenomenological Philosophy of Practice. New York State University New York.

BISHOP AH, SCUDDER J R (1991). Dialogical care and nursing practice. In: Anthology on Caring. P L Chinn (ed). National League of Nursing. Publication No. 15-2392. New York.

BLUM L A (1980). Friendship, Altruism and Morality. Routledge and Kegan Paul, London.

BLUM L A (1988). Gilligan and Kohlberg; implications for moral theory. Ethics 472-491.

BOK S (1986). Secrets: on the Ethics of Concealment and Revelation. Oxford University Press. Melbourne.

BOND S, THOMAS L (1992). Input on outcomes. Nursing Times 88 (38) 50-52.

BOTTORFF J L (1991). A methodological review and evaluation of research on nurse-patient touch. In : Anthology on Caring. P L Chinn (ed.) National League of Nursing Publication No 15-2392 New York.

BROCK D W (1980). The nurse-patient relation: some rights and duties. In: Nursing: Images and Ideals. Opening Dialogue with the Humanities. S F Spicker , S Gadow (eds). Springer Publications Co. New York.

BRODY B A (1990). Quality of scholarship in bioethics. Journal of Medicine and Philosophy 15 161-179.

BRODY J K (1988). Virtue ethics, caring and nursing. Scholarly Inquiry for Nursing Practice: an International Journal 2 (2) 87-96.

BROWN N K, THOMPSON D J (1979). Nontreatment of fever in extended care facilities. New England Journal of Medicine 300 (22) 1246-1250

BRUNT J H (1985). Nursing research and philosophy : a delicate balance. Nursing Forum XXII (1) 16-18.

BURNARD P, CHAPMAN C M. (1988). Professional and Ethical Issues in

Nursing: The Code of Professional Conduct. John Wiley and Sons Ltd.

CAMPBELL A V (1984 a). Moral Dilemmas in Medicine. 3rd edn. Churchill Livingstone Edinburgh.

CAMPBELL A (1984 b). Moderated Love: a Theology of Professional Care. SPCK.

CAMPBELL A V, HIGGS R (1982). In That Case: Medical Ethics in Everyday Practice. Parker Longman and Todd. London.

CARPER B A (1989). Ethics of caring. Advances in Nursing Science. 1 (3) 11-19.

CARR-HILL R, DIXON P, GIBBS I (1992). Skill Mix and the Effectiveness of Nursing Care. Centre for Health Economics, University of York.

CARSE A L (1991). Voice of care: implications for bioethical education. Journal of Medicine and Philosophy 16 5 -28.

CHADWICK R, TADD V A (1992). Ethics and Nursing Practice: a Case Study Approach. Macmillan Publishing Ltd.

CHALLY P S (1990). Moral decision making by neonatal intensive care nurses. PhD Thesis. Georgia State University (Cinahl Database Accession No. 142500).

CHALLY P S (1990). Theory derivation in moral development. Nursing and Health Care 11 (6) 302-6.

CHARLESWORTH M (1993). Bioethics in a Liberal Society. Cambridge University Press. Cam.

CHINN P L, WHEELER C E (1985). Feminism and nursing. Nursing Outlook 33 (2) 740-77.

CLOUSER K D, GERT B (1990) . Critique of principleism. Journal of Medicine and Philosophy 15 219-236.

COLLIERE M F (1986). Invisible care and invisible women as health care providers. International Journal of Nursing Studies 23 (2) 95-112.

COMPACT OXFORD ENGLISH DICTIONARY (1991). 2nd edition. Clarendon Press. Oxford.

CONDON E H (1992). Nursing and the caring metaphor: gender and political influences on an ethics of care. Nursing Outlook 40 (1) 14-19

COOPER M C (1988). Covenantal relationships: grounding for the nursing ethic. Advances in Nursing Science 10 4 48-59

COOPER M C (1989). Gilligan's different voice : a perspective for nursing (check). Journal of Professional Nursing 5 (1) 10-16.

COOPER M C (1990). An interpretive analysis of the moral experience of critical care nurses. PhD Thesis. University of Virginia. Cinahl Database Accession No. 1992135107.

COOPER M C (1991). Principle oriented ethics and the ethics of care: a creative tension. 14 (2) 22-31.

CURTIN L L (1978). Nursing ethics: theories and pragmatics. Nursing Forum 17 (1) 4-11.

CURTIN L L (1986). The nurse as advocate: a philosophical foundation for nursing. In: Ethical Issues in Nursing. Chinn P (ed) Aspen Systems. Maryland.

CURTIN L. (1990). The nurse as advocate: a cantankerous critique. In: Ethics in Nursing: an Anthology. T Pence and J Cantrell (eds). National League for Nursing.. Publication No. 20-2294. New York.

DARBYSHIRE P (1990). High flown theory. Nursing Times 86 (2) 54-56.

DARBYSHIRE P (1993). Good buddies. Nursing Times 89 (48) 63. 1993.

DAVIES N (1993). Murder on Ward 4. Chatto and Windus.

DAVIS A J (1981). Ethical dilemmas in nursing: a survey. Western Journal of Nursing Research 3 (4) 397-407

DAVIS A J (1987). Ethical issues in nursing research. International Nursing Research. 9 (3) 400-402. Sage Publications Inc.

DAVIS A J, AROSKAR M A (1978). Ethical Dilemmas and Nursing Practice. Appleton Century Crofts. New York.

DAVIS A J, JAMETON A (1987). Nursing and medical student attitudes toward nursing disclosure of information to patients - a pilot study. Journal of Advanced Nursing 12 691-698.

DOCK S E (1917). The relation of the nurse to the doctor and the doctor to the nurse. In: Ethics in Nursing: an Anthology. T Pence, J Cantrell (eds.) National League for Nursing. Publication No. 20-2294. New York.

DOWIE J (1994). Decision Analysis: the Ethical Approach to Medical Decision Making. In: Principles of Health Care Ethics. R Gillon (ed). John Wiley and Sons Ltd. Chichester.

DOWNIE R S (1984). Ethics and surveys. Journal of Medical Ethics 10 (2) 77-78.

DOWNIE R S (1986a). Professional ethics. Journal of Medical Ethics 12 (2) 64-66.

DOWNIE R S (1986b). Professional ethics: further comments. Journal of Medical Ethics 12 (4) 195-6.

DOWNIE R S, TELFER E (1969). Respect for Persons. George Allen and Unwin Ltd.

DUQUETTE A, KEROUAC S, SANDHU B K, BLANDET L (1994). Factors related to nursing burnout: a review of empirical knowledge. Issues in Mental Health Nursing 15 (4) 337-358.

EDGAR A (1993). Nursing as a moral tradition. Journal of Advances in Health and Nursing Care 2 (3) 3-20.

ELANDER G, DRECHSLER K, PERSSON K W (1993). Ethical dilemmas in long term care settings: interviews with nurses in Sweden and England. International Journal of Nursing Studies 30 (1) 91-97.

ELLIS R (1983). Philosophic inquiry. In: Annual Review of Nursing Research Vol 1. Werley, Fitzpatrick (eds). Springer Publishing Co. New York.

ENGELHARDT H T (1985). Physicians, patients, health care institutions and the people in between: nurses. In: Caring, Curing and Coping - Nurse-Physician-Patient Relationships. A H Bishop, J R Scudder (eds). University of Alabama Press.

ERSSER S (1991). A search for the therapeutic dimensions of nurse-patient interaction. In: Nursing as Therapy. R McMahon and A Pearson (eds). Chapman and Hall London.

EVANS M (1986). Not free to be moral. Australian Journal of Advanced Nursing 3 (3) 35-48.

FOULK G J, KEFFER M J (1991). The Moral Foundation of Nursing: Yarling and McElmurry and their Critics. In: Anthology on Caring. P L Chinn (ed). National League of Nursing Publications No 15-2392 New York.

FRANKENA W K (1983). Moral Point of View Theories. In: Ethical Theory in the Last Quarter of the 20th Century. N E Bowie (ed). Hackett Publications. Indiana.

FRY S T (1989). Toward a theory of nursing ethics. Advances in Nursing Science 11 (4) 9-22.

FRY S T (1990). The Philosophical Foundations of Caring. In: Ethical and Moral Dimensions of Care. M M Leininger (ed). Wayne State University Press Detroit.

FRY S T (1987). Autonomy, advocacy and accountability: ethics at the bedside. In: Ethics at the Bedside. M Fowler, J Levine-Ariff (eds) Lippincott. Pa.

GADOW S (1979). The most pressing ethical problem faced by nurses. Advances in Nursing Science 1979 1 (3) 92-95.

GADOW S (1983). Existential Advocacy: Philosophical Foundation of Nursing. In: Ethical Problems in the Nurse-Patient Relationship. C P Murphy, H Hunter (eds). Allyn and Bacon

GADOW S (1987). Nurse and patient: the caring relationship. In: Caring, Curing and Coping: Nurse-Physician-Patient Relationships. A H Bishop; J R Scudder (eds). University of Alabama Press. B'ham Ala.

GADOW S (1990). The Advocacy Covenant: Care as Clinical Subjectivity. In: Knowledge about Care and Caring. J S Stevenson, T Tripp-Reimer (eds). American

Academy of Nursing. Kansas, Miss.

GALLAGHER A (1995). Medical and nursing ethics - never the twain. Nursing Ethics. 2 (2) 95-101.

GAUT D A (1985). Philosophical Analysis as a Research Method. In: Qualitative Research Methods in Nursing. M M Leininger (ed). Grine and Stratton Inc.

GILLAN J (1994). Credit where it's due. Nursing Times 90 (34) 60

GILLIGAN C (1981). Moral Development. In: The Modern American College. Chickering A W et al (eds). Jossey Bass San Francisco.

GILLIGAN C (1982). In a Different Voice. Harvard University Press.

GILLIGAN C (1986). Remapping the Moral Domain: new Images of the self in relationship. In: Reconstructing Individualism: Autonomy, Individuality and the Self in Western Thought. Heller, Sosna, Wellbury (eds).Stanford University Press, Ca.

GILLIGAN C, ATTANUCCI J (1988). Two moral orientations: gender differences and similarities. Merrill Palmer Quarterly 34 (3) 223-237.

GILLIGAN C, POLLAK S (1988). The Vulnerable and Invulnerable Physician. In: Mapping the Moral Domain. C Gilligan, J Ward, J Taylor, M Bardige (eds). Harvard University Press. Cam. Mass.

GILLIGAN C, WIGGINS G (1988). Origins of Morality in Early Childhood Relationships. In: Mapping the Moral Domain: a Contribution of Women's Thinking to Psychological Theory and Education. C Gilligan, J V Ward, J M Taylor, B Bardige (eds). Harvard University Press. Cam. Mass.

GILLON R (1985). Philosophical Medical Ethics. John Wiley and Son. Chichester.

GILLON R (1992). Caring, men and women, nurses and doctors and health care ethics. Journal of Medical Ethics 18 171-172.

GILLON R (1993). Is there an important moral distinction for medical ethics between lying and other forms of deception. Journal of Medical Ethics 19 131-132.

GILLON R (1994). Medical ethics: four principles plus attention to scope. British Medical Journal 309 184-8.

GLOVER J (1977). Causing Death and Saving Lives. Penguin Books London.

GOODWIN J S, GOODWIN J M, VOGEL A (1979). Knowledge and the use of placebos by house officers and nurses. Annals of Internal Medicine. 91 106-110.

GOW K M (1982). How nurses emotions affect patient care: self studies by nurses Springer Publishing Co. New York

GREEN R M (1990). Method in bio-ethics: a troubled assessment. Journal of Medicine and Philosophy 15 179-197.

GRIFFIN A P (1983). A philosophical analysis of caring in nursing. Journal of Advanced Nursing 8 (4) 289-95.

GRUNDSTEIN-AMADO R (1992). Differences in ethical decision making processes among nurses and doctors. Journal of Advanced Nursing 17 129-137.

GUSTAFSON (1990). Moral discourse about medicine: a variety of forms Journal of Medicine and Philosophy. 15 125-142

HARBISON J (1992). Gilligan: a voice for nursing? Journal of Medical Ethics 18 202-205.

HELD V (1987). Feminism and Moral Theory. In: Women and Moral Theory. E F Kittay and D T Meyers (eds.) Rowman and Littlefield. New Jersey.

HEWA S, HETHERINGTON R W (1990). Specialists without spirit; crisis in the nursing profession. Journal of Medical Ethics 16 179-184.

HILL T E (1987). The Importance of Autonomy. In: Women and Moral Theory. E F Kittay, D T Meyers (eds.) Rowman and Littlefield. New Jersey.

HOFLING C K, BROTZMAN E, DALRYMPLE S, GRAVES N, PIERCE C M (1966). An experimental study in nurse-physician relationships. In: Ethics in Nursing: an Anthology. T Pence, J Cantrell (eds). National League for Nursing. Publication No. 20-2294. New York.

HOLMES R L (1990). The limited relevance of analytical ethics to the problems of bio-ethics. Journal of Medicine and Philosophy 15

HUBERT J (1993). Speaking up. Nursing Times 89 (44) 59-61.

HUGGINS E A, SCALZI C C (1988). Limitations and alternatives: ethical practice theory in nursing. Advances in Nursing Science 10 (4) 43-47.

HURSTHOUSE R (1987). Beginning Lives. Open University Press.

HUTCHINSON S A (1990). Responsible subversion: a study of rule bending among nurses. Scholarly Inquiry for Nursing Practice 4 (1) 3-17.

ILLICH I (1977). Disabling professions. In: Disabling Professions. Illich I (ed.) Marion Boyars. London.

JACKSON J (1991). Telling the truth. Journal of Medical Ethics 17 5-9.

JAMETON A (1984). Nursing Practice: the Ethical Issues. Prentice Hall Series in the Philosophy of Medicine. S Gorovitz (ed). Prentice Hall Inc. Englewood Cliffs, New Jersey.

JAMETON A, FOWLER M D M (1989). Ethical inquiry and the concept of research. Advances in Nursing Science 11 (3) 11-24.

JOHNSON M (1990). Natural Sociology and Moral Questions in Nursing: Can there be a Relationship? Journal of Advanced Nursing 15 1358-1362

JOHNSTONE M J (1989). Bioethics - a Nursing Perspective. W B Saunders/Bailliere Tindall. 1989.

JONES J (1993). NHS 'Whistle Blower' Wins £11,000 Damages. Independent, 15th June 1993.

KELLY B (1990). Respect and Caring: Ethics and Essence of Nursing. In: Ethical and Moral Dimensions of Care. M M Leininger (ed). Wayne State University Press. Detroit.

KELLY B (1991a). The professional values of English nursing undergraduates. Journal of Advanced Nursing 16 867-872

KELLY B (1991b). Professional ethics as perceived by American nursing undergraduates Journal of Advanced Nursing 17 10-15

KETEFIAN S (1989). Moral Reasoning and Ethical Practice. In: Annual Review of Nursing Research Vol 7. J J Fitzpatrick, R L Taunton, J Q Benoliel (eds). Springer Publishing Co. New York.

KNOWLDEN V (1990). The virtue of caring in nursing. In: Ethical and Moral

Dimensions of Care. M M Leininger (ed). Wayne State University Press. Detroit.

KOHLBERG L, LEVINE C, HEWER A (1983). Moral stages: a Current Formulation: a Response to Critics. Karger, Basel.

KOHNKE M F (1982). Advocacy: risk and reality. C V Mosby, St Louis.

KOHNKE M F (1990). The Nurse as Advocate. In: Ethics in Nursing: an Anthology. T Pence, J Cantrell (eds). National League for Nursing. Publication No. 20-2294. New York.

KUHSE H (1993). Caring is not enough: reflections on nursing ethics of care. Australian Journal of Advanced Nursing. 11 (1) 32-42.

KURTZ R J, WANG J (1981).The caring ethic - more than kindness, the core of nursing science. Nursing Forum 26 (1) 4 - 8.

KUS R (1990). Nurses and unpopular patient. American Journal of Nursing 6 62-66.

LAWLER J (1990). A social construction of the body: nurses experiences. PhD Thesis. University of New South Wales. Cinahl Abstract Accession No. 1992142463.

LAWLER J (1991). Behind the Screens: Nursing, Somology, and the Problem of the Body. Churchill Livingstone. Melbourne

LAWRENCE J A, HELM A (1987). Consistencies and inconsistencies in nurses' ethical reasoning. Journal of Moral Education 16 (3) 167-176.

LEININGER M (1981). Caring: the Compassionate Healer. Centre for Human Caring. National League for Nursing Press. Denver Colorado.

LEWANDOWSKI W, MCCLISH D K, JUKNIALLS B W, YOUNGNER S J (1985). Treatment and care of 'DNR' patients in a medical intensive care unit. Heart and Lung. 14 (2) 175-181.

LUTZEN K; NORDIN C (1993). Benevolence, a central moral concept derived from a grounded theory study of nursing decision making in psychiatric settings . Journal of Advanced Nursing 18 1106-1111

LYONS N (1983). Two perspectives: on self, relationships and morality. Harvard Eduational Review 53 (2) 125-145.

MACINTYRE A (1977). Patients as Agents. In: Philosophical Medical Ethics: its Nature and Significance. S F Spicker, H T Engelhardt (eds). D Reidel Pub. Co. Boston.

MACINTYRE A (1983). To Whom is the Nurse Responsible? In: Problems in the Nurse-Patient Relationship. C P Murphy, H Hunter (eds). Allyn and Bacon, Boston, Mass.

MACINTYRE A (1985). After Virtue - a Study in Moral Theory. Duckworth, London.

MARCK P (1990). Therapeutic reciprocity: a caring phenomenon. Advances in Nursing Science 13 (1) 49-59.

MARSHALL M (1991). Advocacy within the multidisciplinary team. Nursing Standard 6 (10) 28-31.

MAY W F (1975). Code, covenant, contact or philanthropy . Hastings Center Report 23 (4) 25-32.

MAY W (1983). The Physician's Covenant. Westminster Press Pa.

MCMAHON R , PEARSON A (eds). (1991) Nursing as Therapy. Chapman and Hall, London.

MCSWEENEY P (1990). Accountability in Nursing Practice. Nursing Standard 4 (18) 30-31.

MCWILLIAM C L, WONG C A (1994). Keeping it secret: the costs and benefits of nursing's hidden work in discharging patients. Journal of Advanced Nursing 19 152-163

MELIA K (1989). Everyday Nursing Ethics. Macmillan.

MELIA K (1994). The task of nursing ethics. Journal of Medical Ethics. 20 7-11.

MEYERS D T (1987). The Socialised Individual and Individual Autonomy. In: Women and Moral Theory. E F Kittay, D T Meyers (eds.) Rowman and Littlefield. New Jersey.

MILLETTE B E (1994). Using Gilligan's framework to analyse nurses' stories of moral choices. Western Journal of Nursing Research 16 (6) 660-674.

MONTAGUE P (1992). Virtue ethics: a qualified success story. American Philosophical Quarterly 29 (1) 53-59.

MORREIM E H (1986). Philosophy lessons from the sclinical setting: seven sayings that used to annoy me. Theoretical Medicine 7 47-63.

MUYSKENS J L (1982). Moral Problems in Nursing: a Philosophical Investigation. Rowman and Littlefield. Totowa, New Jersey.

NEIL R M, WATTS R (1991). Caring and Nursing: Explorations in Feminist

Perspectives. National League for Nursing Press New York.

NEUBERGER J (1994). Professions and public alike need to think about their moral values. Journal of Medical Ethics 20 5-6.

NEWTON L H. (1990) In defense of the traditional nurse.In: Ethics in Nursing: an Anthology.T Pence, J Cantrell (eds). National League for Nursing. Publication No. 20-2294. New York.(1990).

NODDINGS N (1984). Caring: A Feminine Approach to Ethics and Moral Education. University of California Press. Berkely Calif.

NORBERG A, NORBERT B, BEXELL G (1980). Ethical problems in feeding patients with advanced dementia. British Medical Journal 281 847-848.

NORBERG A, HIRSCHFIELD M DAVIDSON B DAVIS A LAURI S LIN JY PHILLIPS L PITTMAN E VANDERLAAN R ZIV L (1994). Ethical reasoning concerning the feeding of severely demented patients an international perspective. Nursing Ethics 1(1) 4-13.

OAKLEY A (1984). The importance of being a nurse. Nursing Times 12/12/84.

OLSEN D P (1992). Controversies in nursing ethics: a historical review. Journal of Advanced Nursing 17 1020-1027.

OLSEN D P (1993). Populations vulnerable to the ethics of caring. Journal of Advanced Nursing. 18 1696-1700.

OLSON T C (1993). Laying claim to caring: nursing and the language of training 1915-1937. Nursing Outlook 41 (2) 68-72.

PACKARD J S, FERRARA M (1988). In search of the moral foundation of nursing.

Advances in Nursing Science 8 (2) 63-73.

PAGANA K D (1990). Let's stop calling ourselves 'patients' advocates. In: Ethics in Nursing: an Anthology. T Pence, J Cantrell (eds). National League for Nursing. Publication No. 20-2294. New York.

PARKER R S (1990). Nurses stories: the search for a relational ethic of care. Advances in Nursing Science 13 (1) 31-40.

PELLEGRINO E D (1985).The Caring Ethic: the Relation of Physician to Patient. In: Caring, Curing and Coping - Nurse-Physician-Patient Relationships. A H Bishop, J R Scudder (eds). University of Alabama Press.

PELLEGRINO E D, TOMASMA D (1981). A Philosophical Basis for Medical Practice. Oxford University Press. New York.

PENCE T, CANTRELL J (1990). The Philosophical Foundations of Nursing Practice. In: Ethics in Nursing: an Anthology. T Pence, J Cantrell (eds). National League for Nursing. Publication No 20-2294. New York.

PENTICUFF J H (1991). Conceptual issues in nursing ethics research. Journal of Medicine and Philosophy 16 235-258.

PIKE A W (1991). Moral outrage and moral discourse in the nurse-physician collaboration. Journal of Professional Nursing 7 351-362.

POLLACK-LATHAM C L (1991). Clarification of the Unique Role of Caring in Nurse-Patient Relationships. In: An Anthology on Caring. P Chinn (ed). National League for Nursing. Publication No 15-2392. New York.

RAWLS J (1971). A Theory of Justice. Harvard Universtiy Press. Cam, Mass.

RAWNSLEY M (1990). Of human bonding: the context of nursing as caring. Advances in Nursing Science 13 (1) 41-48.

REID L (1992). Knickers to that. Nursing Times 88 (9) 53.

ROWSON R H (1990). Introduction to ethics for nurses. Scutari Publications. 1990.

ROYAL COLLEGE OF NURSING (1992). The Value of Nursing. Scutari Press. London.

RUMBOLD G (1986). Ethics in Nursing Practice. Bailliere Tindall. London.

SALSBERRY P J (1992). Caring, virtue theory and a foundation for nursing ethics. Scholarly Inquiry for Nursing Practice 6 (2) 155-167 and 169-171.

SARVIMAKI A (1988). Nursing care as a moral, practical, communicative and creative activity. Journal of Advanced Nursing 13 (4) 462-467.

SCHON D (1991). The Reflective Practitioner: How Professionals Think in Action. 2nd edn. Avebury. Aldershot.

SCHNEEWIND J B (1991). Modern Moral Philosophy. In: A Companion to Ethics. P Singer (ed.) Blackwell Companions to Philosophy Series. Blackwell Publishers Ltd. Oxford.

SCHROCK R A (1980). A question of honesty in nursing practice. Journal of Advanced Nursing 5 135-148.

SCHROCK R A (1981). The meaning and relevance of philosophical inquiry in nursing. PhD Thesis, Edinburgh University.

SCHROCK R A (1990). Conscience and courage - a critical examination of

professional conduct. Nurse Education Today 10 3-9

SELF D J (1987). A study of the foundations of ethical decision making of nurses. Theoretical Medicine 8 85-95.

SHANNON A (1991). The future of nursing. Nursing 4 (41) 26-28.

SHEARD T (1980). Structure of conflict in nurse-physician relations. Supervisor Nurse 14-18.

SHELLEY S I: ZAHORCHAK R M: GAMBRILL C D (1987). Aggressiveness of nursing care for older patients and those with do not resuscitate orders. Nursing Research 36 (3) 157-62.

SHER G (1987). Other Voices, Other Rooms? Women's Psychology and Moral Theory. In: Women and Moral Theory. E F Kittay, D T Meyers (eds.) Rowman and Littlefield. New Jersey.

SIEGHART P (1985). Professions as the Conscience of Society. Journal of Medical Ethics 11 (3) 117-122.

SINGER P (ed). (1986). Applied Ethics. Oxford Readings in Philosophy. Oxford University Press. Oxford.

SILVA M C (1977). Philosophy, science, theory: interrelationships and implications for nursing research Image 9 59-63

SMITH P (1992). Emotional Labour of Nursing: How Nurses Care. Macmillan Education Ltd. London.

SMITH S (1980). Three models of the nurse patient relationship. In: Nursing : Images and Ideals. Opening Dialogue with the Humanities. S F Spicker and S Gadow (eds).

Springer Publishing Co. New York .

STEIN L I (1967). The Doctor-Nurse Game. In: Ethics in Nursing: an Anthology. T Pence, J Cantrell (eds). National League for Nursing. Publication No. 20-2294. New York.

STOCKWELL F (1972). The Unpopular Patient. Royal College of Nursing. London.

STOCKWELL F (1984). The Unpopular Patient. Croom Helm London.

TADD V (1991). Where are the whistle-blowers? Nursing Times 87 (1) 42-44.

TAYLOR S (1985). Rights and responsibilities: nurse-patient relationships. Image: the Journal of Nursing Scholarship 17 (1) 9-13.

THOMPSON I, MELIA K, BOYD D (1994). Nursing Ethics. 3rd edn. Churchill Livingstone.

TOON P D (1993). After bioethics and towards virtue? Journal of Medical Ethics 19 17-18.

TURNER T (1990). Lessons from Stepping Hill. Nursing Times 86 (41) 18-19.

TSCHUDIN V (1992). Ethics in Nursing: the Caring Relationship. 2nd edition. Butterworth Heinemann Ltd. 1992.

TSCHUDIN V (1994). Deciding Ethically: a Practical Approach to Nursing Challenges. Bailliere Tindall. London.

TWOMEY J G (1989). Analysis of the claim to distinct nursing ethics: normative and non normative approaches. Advances in Nursing Science 11 (3) 25-32.

UDEN G, NORBERG A, LINDSETH A, MARHAUG V (1992). Ethical reasoning in nurses' and physicians stories about care episodes. Journal of Advanced Nursing 17 1028-1034.

UK Central Council for Nursing, Midwifery and Health Visiting. (1992). Code of Professional Conduct. 3rd edn.

VAN HOOFT S (1990). Moral education for nursing decisions. Journal of Advanced Nursing. 15 210-215.

VEATCH R M (1981a). Nursing ethics, physician ethics and medical ethics. Law and Medicine in Health Care 917-19.

VEATCH R M (1981b). A Theory of Medical Ethics. Basic Books. New York.

VINES G (1983). Sacked nurse takes ECT case to Europe. New Scientist March 17th 1983 p 708.

VOUSDEN M (1985). Swallow your pride or lose your job - refusal to participate in administration of ECT. Nursing Miror 160 (1) 23.

WATSON J (1979). Nursing - the philosophy and science of caring. Little Brown Co.

WEBB A A, BUNTING S (1991). Ethical decision making by nurses in HIV/AIDS situations. Journal of Association of Nurses. AIDS Care. 3 (2) 15-18.

WHITTET M (1994). Consumers urged to speak up in debate over health services. Nursing Times 90 (25) 9.

WILLIAMS B (1972). Morality: an Introduction to Ethics. Cambridge University Press. Ca. Mass.

WILLIAMS B (1985). Ethics and limits of philosophy. Fontana/Collins London.

WILSON-BARNETT J (1994). The Nurse-Patient Relationship. In: Principles of Health Care Ethics. R Gillon (ed). John Wiley and Son Ltd. Chichester.

WINSLOW G R (1984). From Loyalty to Advocacy: a New Metaphor for Nursing. In: Ethics in Nursing: an Anthology. T Pence, J Cantrell (eds). National League for Nursing. Publication No. 20-2294. New York.

WINSLOW B J, WINSLOW G R (1991). Integrity and compromise in nursing ethics. Journal of Medicine and Philosophy 16 307-323.

WOLF Z R (1989). Uncovering the hidden work of nursing. Nursing and Health Care 10 (8) 462-467.

WORLD HEALTH ORGANISATION (1987). People's Needs for Nursing Care: a European Study. WHO.

WRIGHT S (1990). Standing up for Pink. Nursing Times 86 (40) 18.

YARLING R R, MCELMURRY B J (1986). Moral Foundation of Nursing. Advances in Nursing Science 8 (2) 63-73 1986.

YUEN F K (1986). Nurse-client relationship: a mutual learning experience. Journal of Advanced Nursing 11 (5) 529-33.

ZANER R M (1985) "How the hell did I get here?" Reflections on being a patient. In: Caring, Curing and Coping: Nurse, Physician and Patient Relationships. Bishop A H, Scudder J R (eds). University of Alabama Press.

BIBLIOGRAPHY

ARISTOTLE, translated by W D Ross (1925). The Nicomachean Ethics. Oxford University Press. Oxford.

CAMPBELL K (1984). Body and Mind. 2nd ed. University of Notre Dame Press.

FISHER A (1988). The Logic of Real Arguments. Cambridge University Press. Cambridge.

GILLON R (ed). (1994). Principles of Health Care Ethics. John Wiley and Sons Ltd. Chichester.

GLYMOUR C (1992). Thinking Things Through: an Introduction to Philosophical Issues and Achievements. Massachusetts Institute of Technology.

HOSPERS P (1992). An Introduction to Philosophical Analysis. 3rd ed. Blackwell Publishing.

KANT I, translated and analysed by H J Paton (1948). The Moral Law: Groundwork of the Metaphysic of Morals. Routledge. London.

MACINTYRE A (1967). A Short History of Ethics. Routledge and Kegan Paul. London.

MAGEE B (1987). The Great Philosophers: an Introduction to Western Philosophy. Oxford University Press. Oxford.

MILL J S, Everyman publication. (1910). Utilitarianism, On Liberty, Considerations on Representative Government. J M Dent. London.

MURDOCH I (1970). The Sovereignty of Good. Ark Paperbacks. London and New York.

URMSON J O (1988). Aristotle's Ethics. Basil Blackwell. Oxford.