

**VIRTUOUS NURSING: MORE CARING THAN SCIENCE AND MORE SCIENTIFIC  
THAN CARE**

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## Summary of Sources

This thesis contains no material published elsewhere or extracted in whole or in part from a thesis by which I have qualified for or been awarded another degree or diploma

No other person's work had been used without due acknowledgement in the main text of the thesis.

This thesis has not been submitted for the award of degree or diploma in any other tertiary institution.

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## **Abstract**

Western nursing has been deeply influenced by Christianity and more latterly by the Nightingale ideal of the good nurse. Both views have, as their foundation, the belief that there is an objectively knowable good way to live. This belief presents problems to the modern nurse and has, in large part, been rejected. However, the rejection of this objective moral foundation for nursing has resulted in a crisis of confidence about the best way to articulate what it is to be a good nurse. Two new ways have emerged in recent times.

A scientific approach to nursing has elevated the work of nursing to increasingly complex levels and resulted in significantly improved health outcomes for patients. This scientific approach to nursing has manifested itself in two ways. It has resulted in the development of theories of nursing based on psychological concepts. Parallel to this approach has been the tendency for nursing itself to become increasingly scientific and nurses in turn to be technologists. It was thought that nursing that was increasingly shaped in scientific terms would achieve professional status because it presented a scientifically verifiable knowledge base. At the same time, however, it has resulted in an understanding of what counts as being a good nurse being reduced to the nurse's ability to perform tasks to a high level of clinical precision.

Alternatively, nursing as a care-based activity has made a caring attitude the moral centre point of nursing. On this view objective standards of practice are regarded as secondary to the emotional care that the nurse brings to the patient. This belief arose in part because notions of the objectivity of science were challenged as ideological rather than the dispassionate form of knowledge that scientists claimed. It was fostered by the emergence and dominance of phenomenology and the influence of the feminist care ethic. There was also some anxiety about what had been lost in nursing by the embrace of science. In addition, the care ethic seemed to promise the possibility of defining nursing in its own terms in order to make nursing a distinct professional body. However, the demands of an ethic of care have proven elusive and, in the minds of some, unattainable.

Given these criticisms of both these ways of thinking about nursing it is proposed that nursing think of itself as a virtues-based activity. Virtues theory incorporates within it the strengths of the two formerly mentioned ways of describing nursing without being subject to the limitations of each. Virtues such as love friendliness, compassion , courage and conscientiousness and the intellectual virtue of prudence or practical wisdom enable nurses to realise that goal in their practice.

In this thesis virtue theory will be analysed and applied to nursing in the following way. Some Aristotelian concepts will be identified and their application to professional ethics by contemporary virtue theorists will be discussed. This involves an explication of some virtues that enhance shared conceptions of the practice of nursing. The significance of the good nurse in the shaping of good nursing practice will be considered alongside a reflection on the place of moral luck in nursing practice. It is argued that when nurses think of themselves as participating in a tradition of health care they find meaning in their work, Finally an understanding of nursing as a virtue-based activity clarifies good practice in such a way that nurses are able to elicit from it the qualities needed for its good practice.

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## 1 Introduction

Nursing is an activity that spans cultures and has endured over time in some form since humans have lived together in groups. It expresses itself in its most elemental form in the care and nurture that families provide for each other. Modern nursing has emerged in a considerably more sophisticated form than its earlier manifestation and, yet, there remains within nursing a core of common activities that renders it recognisable in its various settings. The gradual clarification and emergence of the role of the modern nurse has occurred as a result of the impact that the beliefs, assumptions and thought processes which constitute the matrix of Western culture have had on nursing.

This thesis will examine the influences from within western culture that have effected nursing practice. Nursing, dealing as it does with the vulnerable sick, is, and has always been, a socially significant and profoundly moral activity. The ethical aspects of nursing cannot, therefore, be separated from, or thought of as optional when the adoption of new or different ways of describing nursing activity are considered. The good practice of nursing depends on serious reflection about both the practice and ethic of nursing.

The activity of nursing has long been significant in western culture both for its civic benefits and as a religious act. It has been from these two fundamentals that nursing draws its traditional image. Although this traditional image is inseparable from the image of Christian service, nursing activity has been synonymous with a spiritual calling that predates Christianity. In modern times, however, nursing has extracted itself from its vocational identity and sought new ways to represent itself to the wider community. The evolution of an ethic for nursing practice has not unfolded in an orderly fashion. Rather its emergence has mirrored the dominant ethical underpinnings of its time reflecting an underlying ambivalence about the way that western culture relates to or cares for its sick.

Nursing practice today is a composite of scientific endeavour underpinned by an ethic which initially drew on religious influences and has relied more latterly on the



work of rationalistic philosophers. This has presented nursing with an identity that continues to rely at some level on its portrayal as a saintly and self-sacrificing mother for its moral authority yet also presents itself as modern and rationalistic in order to gain community recognition of its professional status. The nurse who tries to hold these two ways of operating together is practising within a framework that is internally incompatible. The framework demands such a degree of compartmentalisation on the part of the nurse that the resultant inner conflict can render the nurse unable to sustain the work of nursing.

Alternatively, the practitioner who elects to have a practice prescribed by rationality may become an exemplary technical practitioner but finds that, in the matter of guidance about ethical matters, the rationally derived ethical frameworks of deontology and utilitarianism do not provide all the answers that a nurse needs in the matter of good nursing practice. There is a barrenness about such a practice that is limited to answering questions of action without the accompanying interest in questions about what sort of person does the nurse need to be in order to be a good nurse.

As a response to the limitations and tensions of a rationalistic framework for nursing, nurses are now more likely to describe themselves as carers rather than scientists. An ethic of care has become significant in nursing as it returned the patient to the centre of nursing practice and verified the importance of the emotional work of nursing. The care ethic brings together phenomenological philosophy and feminist thought. It was thought that, by emphasising the nurse-patient relationship and the moral demands of such a relationship, nursing approached a convincingly authentic account of what it meant to be a nurse.

Although the care ethic has been the means of uncovering some aspects of the nurse-patient encounter in a richer way, it has still not provided a complete account of nursing. The nurse who is immersed in the care ethic can experience a a disturbing sense of uncertainty in regards to the demands of highly technical practice that nursing has become. The care ethic also places demands on the nurse beyond those which are ordinarily associated with the role of nurse. The caring nurse is described as exhibiting levels of, at times, god-like wisdom and intuition. Identified as it is with feminist concerns, the nurse can also be drawn to issues to do with the emancipation of the profession against perceived domination by medical and other

professionals and to speak for the needs of the disadvantaged and the marginalised in society. Although these issues come within the purview of nursing, they are not central to its practice. Nurses need not feel compelled to involve themselves with these issues as a means of giving a full expression the role of nurse. Despite the intent of the care ethicist, a care ethic may leave a nurse feeling as fraught and unsupported by the care ethic as may the scientific paradigm. This is an additional pressure that nurses, already dealing with institutional pressures to demonstrate increasing efficiency of practice could do without.

It is suggested that nursing conceived as a virtues-based activity captures the competing influences on nursing today in a way that enhances practice and will sustain nursing into the future. Virtues theory gives a rational, non-religious account of a moral framework which allows the nurse to accommodate technological practice with an ethical system. Paying attention as it does to matters of character, virtues theory goes beyond other rationally derived accounts of morality. The good practice of nursing is not limited to doing the right thing. It is dependent on the nurse doing the right thing in the right way. The nurse that brings good qualities of character to his or her practice is thus known as the good nurse.

## 2 History

Nursing has not always been the distinct and professional activity that it is today. That is not to say that the provision of physical care for the sick and injured is a recent phenomenon. The sick have always been cared for wherever or whenever humans have lived in community.<sup>1</sup> Care for the sick was blended with domestic activity and therefore not a recognisably distinct activity because of its association with the provision of everyday care in the household and because of the status of the caregiver. The status of those who have cared for the sick and injured has varied widely. Nursing has, at different times, been considered the proper work of slaves or servants, soldiers, women<sup>2</sup> and those with a religious calling.

### 2.1

T

#### he Importance of Nursing in Early Western Culture

Western culture has its origins in the Babylonian, Egyptian, Hebrew, Greek and Roman civilisations. Whilst these cultures had differing views as to the cause of illness, the nursing care that was provided was similar across the cultures and there was agreement that attending to the needs of the sick was sacred work. Egyptians, Babylonians and the Hebrews<sup>3</sup> believed that illness was a result of a curse or punishment by the gods or God. Therefore the work of curing or working against the affliction was, at first, sacred work. The priest or cultic worker was the primary source of cure. Once the demon was driven out or atonement made for some wrong done, cultures varied in the way that they cared for the sick. Care for the sick also had civic implications. A healthy population was a strong population which could both extend its borders and defend itself against invaders. Robust civilisations required midwives who could assist women to deliver their children and healers who understood the benefits of certain herbs and other therapeutic practices. Both the religious and civic aspects of nursing activity are evident in the practices of the civilisations from which western culture emerged.

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<sup>1</sup> Vern L. Bullough and Bonnie Bullough, The Care of the Sick: The Emergence of Modern Nursing, (New York: Prodist, 1978) 1.

<sup>2</sup> J. M. Mellish, A Basic History of Nursing, 2<sup>nd</sup> ed. (Durban: Butterworths, 1990) 10.

<sup>3</sup> Diego Gracia, "What kind of values? A historical perspective on the ends of medicine," The Goals of Medicine: The Forgotten Issues in Health Care Reform, ed. Mark J. Hanson & Daniel Callahan (Washington DC: Georgetown University Press, 1999) 89.

The Egyptians were experts at bandaging, suturing, surgery and splinting.<sup>4</sup> Although medical records for the Babylonians were less systematic than in the Egyptian culture<sup>5</sup>, priestly activities for both cultures consisted of bathing the sick, offering massages, dressing wounds and paying attention to the diet of the unwell person.<sup>6</sup> The Hebrews had the most highly developed hygiene and dietary laws.<sup>7</sup> The physical care and support offered to the recovering person can be described as nursing activity although the tasks were variously performed by servants, slaves, priests, mothers, wives and physicians' assistants.

The presence of women as midwives was constant across all cultures. It was, in fact, an area of care from which males excluded themselves.<sup>8</sup> This accounts for the paucity of documentation about the skills and techniques that midwives employed. It should not, however, be assumed that midwives were considered insignificant in their society. The bearing of children was a religious and civic matter.<sup>9</sup> Deities had oversight of the midwives and nurses.<sup>10</sup> The Egyptian temples were places where infertile women were prayed for.<sup>11</sup> In the Hebrew Scriptures Hannah visited the temple and prayed for the gift of a son (1 Sam 1:3-17). God blessed the Hebrew midwives, who refused to obey the order of the Egyptian Pharaoh to practice infanticide (Exodus 1: 15-22). The image of the nurse who gently cares for the child and the sick is one that is used to illustrate the tender care that God has for humankind (Is. 66: 13).

The Greeks interpreted health and illness in terms of order and disorder. Ill health represented an imbalance in the harmony of the body's various elements. The healing work was grounded in observation of the natural state of wellness and the alterations in the body when a person was unwell. That said, healing work remained

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<sup>4</sup> Bullough & Bullough, 6-7.

<sup>5</sup> Bullough & Bullough, 8.

<sup>6</sup> Bullough & Bullough, 9.

<sup>7</sup> Josephine A. Dolan, Nursing in Society: A Historical Perspective (Philadelphia: W. B. Saunders Company, 1978) 13-15.

<sup>8</sup> Bullough & Bullough, 24.

<sup>9</sup> Bullough & Bullough, 10.

<sup>10</sup> Bullough & Bullough, 6.

<sup>11</sup> Bullough & Bullough, 6.

sacred work. It was thought that God represented perfection and work that restored the body to harmony or perfection, returned a person to a god-like state.<sup>12</sup>

The Romans had a more pragmatic need for the skilled nurse or carer. The Roman Empire relied on its military might and they organised a system of care for their soldiers based on field hospitals. These were originally tents located on the battlefield but were later hospitals built on the Roman frontier.<sup>13</sup> Soldiers knew rudimentary first aid and the army had trained attendants who nursed their sick in hospitals located near the battle scene. The tradition of soldier as nurse arose by necessity. This kind of nursing could not be performed in the domestic setting as soldiering occurred away from home and the nature of the injuries demanded a particular level of expertise that may not have been readily found at home. Roman culture, therefore, adds soldiers to the list of people who found themselves to be, at times, nurses.

## 2.2

## N

### **nursing as a Christian Vocation**

Nursing became inseparably linked with Christianity as Christianity became the dominant religion of western culture. This occurred because care for the sick was a central feature of early Christian communal life (Acts 4:34-35) and patterns of practice contributed to the formation of Christian traditions which further shaped cultural identity. A Christian view of care for the sick emerged from a simple pattern of nursing activity that was originally based on habits of domestic charity in response to the words and life of Christ. The Christian belief that all people were created in the image of God was continuous with Hebrew teaching. Christians were motivated by Christ's words that service to the poor, the sick and those in prison was service to Christ himself (Matt 25:34-40).

The generation of a Christian theology accompanied the establishment of a tradition of care for the sick. It was a development, however, that was to complicate the practice of care for the sick in western culture. The apostle Paul warned the

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<sup>12</sup> Gracia, 90-92.

<sup>13</sup> Bullough & Bullogh, 22.

Corinthians that some of their sickness was a result of their misbehaviour at the celebration of the Lord's Supper (1 Cor 11: 27-30). Ananias and Sapphira were punished by death for their deceit of the Christian community (Acts 5: 1-11). Christians were, therefore, witness to two conflicting stories about the work of God. On the one hand caring for the sick was to do God's work on earth, and on the other, bodily punishment was also the work of God.

In addition to these tensions, Christianity was influenced by Greek philosophy. These were principally Platonic ideas about the existence of the *forms* or *ideals* as opposed to visible reality. Plato reasoned that the visible things of this world, which are in a state of change and decay, are copies of an *ideal form* that "has a permanent and indestructible existence outside space and time".<sup>14</sup> Contemplation of the *ideal*, due to its eternal nature, was preferable to engagement with more bodily and everyday concerns. When Platonism dominated Christian thought, this led to the heresy of Gnosticism.<sup>15</sup>

There is a tradition of Christian teaching that seeks to control the flesh<sup>16</sup> in order that individuals will become more Christlike (1 Cor 9: 27, Col 2:11, 2 Cor 4: 16-18). This however needs to be interpreted in the light of the evident reverence for the human body that may be found in Christian writing beginning with the Christian conviction that humans are created by God (Gen 1:27). Scripture provides an account of the Almighty sustaining and intervening in creation (Psalm 104). The bodily resurrection of Jesus and the promise of a bodily resurrection for believers are foundational beliefs of the Christian faith (1 Cor 15). This suggests a most profound connection

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<sup>14</sup> Bryan Magee, The Story of Philosophy (London: Dorling Kindersly Limited, 2001) 27.

<sup>15</sup> Gnosticism, as it relates to the body, is dualistic. Gnostics believed that the spirit was superior to the body. This gave rise to divergent practices within the church, both heretical. One group believed that physical acts were inconsequential, thus the freedom in Christ that Paul advocated (Eph 2:8-9) gave licence to immorality. The other group adopted ascetic practices, which denied any pleasure or worth in bodily acts. Henry Chadwick, The Early Church, (London: Penguin Books, 1978) 33-41.

<sup>16</sup> The flesh in Christian terms is that part of our human nature that gives rise to desires and appetites. Mastery, not rejection, of the appetites as they are expressed in bodily activities is the aim. The Christian seeks to live "in the flesh no longer by human passions but by the will of God" (1 Pet. 4: 3). Mastery is therefore the legitimate meeting of need that does not lead to excess. For example, eating is the appropriate response to hunger but gluttony indicates that one is being ruled by the flesh. Merril F. Unger (ed.) "Flesh," Unger's Bible Dictionary, (Chicago; Moody Press, 1979) 370. E. Schweizer, "Sarx," Theological Dictionary of the New Testament: Abridged In One Version, ed. Gerhard Kittel & Gerhard Friedeich, trans. Geoffrey W. Bromley (Grand Rapids, Michigan; William B. Eerdmans Publishing Company, 1988) 1006-1007.

with the world, not only for its own sake, but also as a way of connecting with the creator.

These apparent tensions within Christianity gave rise to some demonstrably Christian traditions, such as asceticism and care for the sick. They reflected the impact that a personal relationship with God had on a believer's life. Some were called to a life of personal denial, while others to a life of practical care. Even in these circumstances there were not stark distinctions between the two traditions. Each calling held within it some element of the other. There is an element of self-denial involved in the service of others. The mystics and ascetics were known for their acts of charity to the needy.<sup>17</sup> The two views can be held together to form a coherent ethos for the proper care and regard of the body. Achieving a balance between the two views has, however, been a source of debate that the church has revisited through the centuries. Despite the tensions implicit in this discussion, Christians established a tradition of care for the sick. Initially this was undertaken by visiting the homes of the sick poor. When Constantine converted to Christianity, Christian activity could be more public<sup>18</sup> and more organised in its care for the sick.<sup>19</sup>

Christian care for the sick extended to communities through the religious houses of the west. Hospitals were incorporated into the design of monasteries so that Christ's instructions to care for the sick and the poor could be observed as part of the religious life.<sup>20</sup> The monks at St Antonines cared for sufferers of erysipelas (St Anthony's fire). The Knights of Lazarus was an order founded to care for lepers.<sup>21</sup> The military crusades of the *Middle Ages* continued the male tradition of nursing.<sup>22</sup>

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<sup>17</sup> Chadwick, 176.

<sup>18</sup> John Foster, Church History 1: The First Advance AD 29-500, (London: SPCK 1972) 81.

<sup>19</sup> Women figured prominently in the increasingly organised approach to care for the sick. Marcella, a Roman matron, was convinced by St Jerome to convert her palace into a convent where women could be taught to care for the sick. Fabiola is credited with building the first hospital in the Western World in 390 AD. Mellish, 36-37.

<sup>20</sup> Dolan, 51.

<sup>21</sup> Carolyn Mackintosh, "A historical study of men in nursing," Journal of Advanced Nursing 26.2 (1997): 232.

<sup>22</sup> Mellish, 44.

The Byzantium Empire had an early hospital system.<sup>23</sup> A study of Byzantium nursing reveals a pattern of nursing similar to contemporary nursing. The nurse attended to the bodily comfort and cleanliness of patients, provided them with proper food and rest and administered therapies of the day such as blood letting, cupping and enemas.<sup>24</sup> It was a part of the nurse's role to offer comfort and support to the patient.

Towards the end of the medieval period nursing began to acquire its distinctly female identity. Brown et al suggest that male involvement in nursing receded, in part due to the declining influence of the monasteries.<sup>25</sup> They provide a twofold explanation for this. The first is the perception that the moral standards of the monasteries were becoming increasingly lax. The second is that as the medieval period came to a close, the focus of learning shifted from the monasteries to the academies and universities. Men no longer had to be professed or wealthy to pursue a life of learning. The convents, however, remained the only places, with some rare exceptions, that women could legitimately pursue a holy or intellectual life. More compellingly, women who were identified as healers in any other context than within the convent were increasingly vulnerable to the charge of witchcraft.

This healing role as practiced by the "consecrated virgins" became increasingly limited. Christian doctrine had hardened over time to a position that arguably "despised the body and saw it as a source of corruption".<sup>26</sup> Women were regarded as innately corrupt. This was, at least in part, because their lives were more closely dominated by bodily functions than men. Further to that, women's knowledge was acquired on the basis of their experience of bodily processes from which men were excluded.<sup>27</sup> Their knowledge was therefore regarded as corrupt. It was only as women denied the rule of their bodies by embracing permanent virginity that they were able to fulfil their spiritual calling. In the process, however, they were also denying to themselves their traditional means of learning about bodily functions in order to care for the sick. The role of the carer became the offering of spiritual care

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<sup>23</sup> Lambrini Kourkoura, "Past and present. Some details of the administration and functioning of the Byzantine hospitals," International History of Nursing Journal 3.1 (1997): 79.

<sup>24</sup> Lambrini Kourkoura, "Working conditions and duties of nurses in Byzantium," International History of Nursing Journal 4.1 (1998): 32.

<sup>25</sup> Brian Brown, Peter Nolan and Paul Crawford, "Men in nursing: ambivalence in care, gender and masculinity," International History of Nursing Journal 5.3 (2000): 6.

<sup>26</sup> Marie Françoise Colliere, "Invisible care and invisible women as health-care providers," International Journal of Nursing Studies, 23.2 (1986): 99.

<sup>27</sup> Colliere, 100.



for the purpose of salvation. The other task of the professed woman was to preserve her own purity. Physical care of the body was delegated to staff, over whom the nuns had a supervisory role.<sup>28</sup>

This of course is not a complete account of the caring activity of consecrated medieval women. They did not keep entirely separate from the physical demands of the sick. As they cared for the sick they expressed themselves in different ways. Some regarded care for the body as an act of humiliation. St Catherine of Siena performed an act of extreme connection with the body of another by drinking the pus from a sick woman's breast abscesses. This was a gesture aimed to assist her to achieve a complete sense of her poverty of spirit and her total dependence on the work of God for her salvation. Others engaged with the body as an act of devotion to Christ. They cared for the sick as though they were tending the wounds of Christ. The carer could handle the body of another and regard it as she would her heavenly bridegroom. This attitude sustained extraordinary acts of service and remains a powerful motivation for Christian nurses today as it captures a spirit of obedience to the call of Christ. Yet another motivation to care for the sick was to look beyond the physical needs of the sick and to prepare them for their eternal destiny. These attitudes reveal significant uneasiness with engaging and caring for the body for its own sake. They were dualistic in the sense that they valued the unseen or the spiritual over the visible body. Further to that, they demonstrated the belief that dealing with the body led to one's defilement so that the only way to engage in physical care was to spiritualise it.

By the end of the medieval period a tradition of institutionalised Christian care for the sick by religious women had been established. It was, however, a tradition that was intellectually impoverished and underpinned by a theology that fuelled an ambivalent attitude to the body. This intersection of lack of knowledge about the body and the uncertainty about the proper attitude to the body paralysed nursing activity significantly. Despite such paralysis, however, and despite the certainty that a generic or domestic form of nursing continued outside of religious institutions, nursing became inseparably identified with the religious life.

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<sup>28</sup> Colliere, 100.

## 2.3

## N

### nursing as a Modern Vocation

With the dissolution of the monasteries in the 16<sup>th</sup> Century, English nursing once more became the concern of the householder and the servant.<sup>29</sup> It took some time to rebuild nursing as a distinctive identifiable activity. When nursing re-emerged, it took two different forms.

#### The Untrained Nurse

The untrained nurse was employed in workhouse infirmaries and asylums. These places attracted workers of the servant class or those who were otherwise unemployable due to age or bad fortune. If these people (male or female) were sufficiently strong and had a reputation for sobriety, they were considered suitable for employment.<sup>30</sup> Males and females were employed to care for the male and female patients respectively. Their duties were the administration of medication, provision and application of dressings and to serve under the direction of the surgeon.<sup>31</sup>

There are scattered references to the kindness and care that such untrained attendants brought to their duties.<sup>32</sup> However, the role commonly devolved to a custodial nature.<sup>33</sup> The untrained female nurse was famously caricatured by Dickens as Sairey Gamp. Sairey Gamp was ignorant, lazy and slovenly. She did nothing to help or improve the state of the sick person and, even worse, exploited the miserable circumstances of the poor and the sick. This characterisation of nurses gained a stronghold in the public perception.<sup>34</sup> That perception was not, however, uniform. In the soon-to-come debates about the need for a standardised approach to nurse training there were those who spoke up for the untrained nurse as one who only required a kindly disposition (and a strong constitution) to perform adequately in the nurse's role.<sup>35</sup>

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<sup>29</sup> Mackintosh, 232.

<sup>30</sup> Mackintosh, 233.

<sup>31</sup> Mackintosh, 233.

<sup>32</sup> Judith Baber, "All the young men gone: losing men in the gentrification of Australian nursing circa 1860-1899," *Nursing Inquiry* 3 (1996): 220.

<sup>33</sup> Mackintosh, 233.

<sup>34</sup> Sioban Nelson, "Pastoral care and moral government: early nineteenth century nursing and solutions to the Irish question," *Journal of Advanced Nursing* 26.1 (1997): 7.

<sup>35</sup> Richard Trembarth & Donna Hellier, *All Care and Responsibility: A History of Nursing in Victoria 1850-1934* (Melbourne: Florence Nightingale Committee, Australia (Victorian Branch), 1987) 13.

### **The Religious Nurse**

The religious nursing orders were re-established at the beginning of the 19<sup>th</sup> century in both protestant and Catholic traditions. The Catholic nursing orders represented a recommencement of a model of nursing in England that had been uninterrupted in Europe and Ireland. The protestant nursing orders were modelled on the French Daughters of Charity<sup>36</sup> and also on the order of deaconesses established in Germany. Elisabeth Fry founded the Protestant Sisters of Charity (later changed to the Institute for Nursing Sisters) in London in 1840. Another Anglican order of nursing, The Sisters of Mercy, was associated with St John's House and the St. George, Westminster and King's College Hospitals.<sup>37</sup> The Sisterhood of the Holy Cross was a Roman Catholic order founded in 1845. Ellen Ranyard established the Biblewomen nurses in London in 1868. These women were district nurses who taught domestic skills, cooked and cleaned, dressed wounds, monitored illness, cared for children and prayed and read scripture with their patients.<sup>38</sup> Although this group was not a professed order, they lived in community, were paid very little and their spiritual work was considered as significant as their healing work.<sup>39</sup>

These Christian nurses gave practical expression to the reforming spirit of the time, which combined the influences of the Enlightenment ethos of the nobility of humankind, the impact of Wesleyanism on social reform and the Oxford movement on the Church of England.<sup>40</sup> However, as an ideological underpinning for nursing, the distinct traditions were so at odds with each other that it is unsurprising that such a coalition failed to generate an identity of sufficient coherency to attract widespread support. Although nursing was emerging from its earlier period of paralysis and was finding other ways to express itself as an integrated act of faith and practice, had it remained captive to its various denominational incarnations, its capacity to make a significant contribution to improvement in health standards of the community would have remained seriously diminished.

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<sup>36</sup> These were established in the 17<sup>th</sup> Century by St. Vincent de Paul. Bullough & Bullough, 60.

<sup>37</sup> Nelson, 11.

<sup>38</sup> Lori Williamson, "Entering into the spirit of nursing: Holistic healers, past and present," International History of Nursing Journal 6.1 (2001): 20-22.

<sup>39</sup> Williamson, 21.

<sup>40</sup> Katherine Williams, "From Sarah Gamp to Florence Nightingale: a critical study of hospital nursing systems from 1840-1897," Rewriting Nursing History, ed. Celia Davies (London: Croom Helm, 1980) 45.

### **Nightingale's Reform of Nursing**

Although it is possible to exaggerate the achievements of Florence Nightingale and there remains disagreement amongst scholars about her motivation and her real interests<sup>41</sup> it remains unarguable that she made a significant contribution to nursing and she retains an iconic status amongst nurses to this day. A detailed discussion of her contribution to nursing is not a task of this thesis, however, it is relevant to identify some of her legacies.

Florence Nightingale was successful in convincing Victorian England that trained nurses were an essential part of a public health strategy. She was equally successful in persuading the wider community that nursing was a formal expression of true womanhood. Therefore nursing was not a departure from respectability, it was instead, a fulfilment of a woman's calling. Women from all social backgrounds offered to be trained as nurses. Their motivation stemmed from a mixture of altruism, devotion to God, and humankind and the possibility of being involved in work that was morally and socially significant. Her success in recasting nursing as an acceptable occupation for women can be attributed to her description of nursing in ways that were already accepted by the public at the same time eliminating aspects from that image that would arouse suspicion amongst the public.<sup>42</sup> She relied on religious images of the self-sacrificing nurse but avoided an appearance of sectarianism by keeping her religious references broadly spiritual and practical in nature rather than reflecting a particular denominational identity.<sup>43</sup> As a result nursing has inherited a powerful identity that is: vocational but not religious; female; committed to the benefit of others and inclined to regard action that takes account of personal gain as a betrayal of the essence of nursing.<sup>44</sup>

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<sup>41</sup> Nightingale's sustained interest was in the "reform of the army medical services and, if necessary the army itself." Monica E. Baly, "The Nightingale nurses: the myth and the reality," Nursing History: the State of the Art, ed. Christopher Maggs (London: Croom Helm, 1987) 35.

<sup>42</sup> The "fear of popery" contributed to the marginalisation of Anglican nursing orders that, despite their denominational affiliation, appeared to be representing a return to the Catholic Church. Nelson, 11.

<sup>43</sup> Nightingale experienced and was repelled by the sectarian strife that arose amongst the religious nurses of various traditions who were recruited for Scutari. Monica E. Baly, "Florence Nightingale and the establishment of the first school at St. Thomas's – myth v reality," Florence Nightingale and Her Era: A Collection of New Scholarship, eds. Vern L. Bullough, Bonnie Bullough & Marietta P. Stanton (New York: Garland Publishing, 1990) 5.

<sup>44</sup> Josephine Castle, "The development of professional nursing in New South Wales, Australia," Nursing History: The State of the Art, ed. Christopher Maggs (Wolfeboro, New Hampshire: Croom Helm, 1987) 29.

## 2.4

## B

### **beyond a Vocational Identity for Nursing**

Australian nursing developed in parallel manner to that of Great Britain. Standards of nursing varied greatly in regional Australia. Nurses were largely untrained and were commonly recruited from domestic staff<sup>45</sup> or from amongst more robust patients.<sup>46</sup> A tradition of trained nurses began in Australia with the arrival of five Irish Sisters of Charity, sent to Sydney in 1838.<sup>47</sup> In a further effort to lift nursing standards, six Nightingale trained nurses were invited to Sydney in 1868 to staff the Prince Alfred Hospital in Sydney. These two groups were the genesis of a modern tradition of nursing in Australia. Nursing life was divided between secular and religious organisations, although they appeared so similar in some respects that even if nursing was not to be practiced in the religious life it required a sense of vocation.<sup>48</sup>

In the mid-twentieth century the post-war boom period contributed to improved standards of living and education for Australians. Healthcare practices became increasingly sophisticated and a vocational model of nursing became less attractive for Australian nurses. Subsequently Australian nurses became politically active<sup>49</sup> and nursing became more identifiably professional. It was a beneficent occupation and had developed various bodies of association and governing boards.<sup>50</sup> Educational standards for nurses had steadily expanded to the extent that, by 1993, all nursing education had shifted from hospitals to tertiary-based programmes.<sup>51</sup>

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<sup>45</sup> Castle, 13.

<sup>46</sup> Castle., 22-23.

<sup>47</sup> M. M. K. O'Sullivan, 'A Cause of Trouble?' Irish Nuns and English Clerics (Sydney: Crossing Press, 1995) 1.

<sup>48</sup> Nurses in the public hospitals worked long hours for little pay and at some institutions they paid for their own training. Judith Bessant & Bob Bessant, The Growth of a Profession: Nursing in Victoria 1930s-1980s (Bundoora: La Trobe University Press, 1991) 34. They wore uniforms on and off duty. Judith Ann Barber, "Uniform and nursing reform," International History of Nursing Journal 3.1 (1997): 20. They lived on the hospital grounds. The original Nightingale wards at the Royal Prince Alfred Hospital located the ward sisters' accommodation adjacent to the ward so that they could be on call day and night. Dorothy Mary Armstrong, The First Fifty Years (Sydney: Royal Prince Alfred Hospital, 1965) 20. In addition "before the war marriage was barred, if not officially then effectively, by the living in requirements." Castle, 21.

<sup>49</sup> Bessant & Bessant, 109.

<sup>50</sup> Castle, 11.

<sup>51</sup> George R. Palmer & Stephanie D. Short, Healthcare and Public Policy: An Australian Analysis, 2<sup>nd</sup> ed. (Melbourne: Macmillan Publisher Australia Pty. Ltd., 2000) 166.

There is an alternative interpretation of these events which undermines the extent to which professional standing can be derived from indicators such as standards of education. Hospital-based training had become an increasingly expensive way to educate nurses. Initially trainee nurses were an inexpensive cost to the health system.<sup>52</sup> However, as education requirements increased and nurses were required to spend more paid time away from ward work, this form of training came to be regarded as a luxury the health system could no longer afford. At a time of over-full employment in the Australian economy, nursing was failing to attract a suitable calibre of applicant.<sup>53</sup> The change to tertiary education for nurses also became a political matter. The Hawke Opposition promised to shift nursing education to tertiary bodies during the 1983 election campaign and when it was elected to power the promise was acted on.<sup>54</sup> Even though nurses were advocating a change to tertiary education, and some advances had been made in this regard, there was genuine ambivalence amongst nurses about the direction that political action was taking them,<sup>55</sup> and external factors such as economic pressures and the political climate expedited this change in nursing. This qualifies, to some extent, the claim that nursing exercised governance over its own affairs. These considerations aside in the latter part of the twentieth century Australian nursing became largely separated from its vocational identity.

## 2.5

C

### Conclusion

A sense of vocation or calling to the work of nursing has been a powerful force for many nurses. This sense of vocation sustained many early nursing leaders and, without it or the accompanying conviction that service for the sick was service offered to God, the development of a universally held notion of good nursing practice may have been a far more difficult one to generate. Many nurses, whether they express their belief in a deity by religious affiliation or not, affirm these ideals and consider that their work continues in the vocational tradition and remain sustained by that ideal.

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<sup>52</sup> Bessant & Bessant, 35.

<sup>53</sup> Castle, 14.

<sup>54</sup> Palmer & Short, 166.

<sup>55</sup> Castle, 27.

The vocational ideal failed nursing when nurses were required to demonstrate a greater identity with their denominational creed than with the pursuit of the calling of the practice of nursing itself. Nursing can be considered a vocation because it does require a commitment to the good of others and there is an undeniable cost involved to its practitioners. Nightingale significantly advanced nursing by articulating a “non-religious” vocation for nurses. However her insistence that the notions of vocation and profession were incompatible with each other limited further advancement of nursing.<sup>56</sup> This had the effect of polarizing nurses’ allegiances. Adoption of a professional model for nursing ethos implied rejection of nursing as a vocation. As science increasingly dominated modern life, nursing turned to science to provide an objective means to both justify and to advance its practice. There was also the hope that science could be relied upon to give a quantifiable standard of what constituted good nursing practice.

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<sup>56</sup> Nightingale’s stated objection to the establishment of a nursing register was that such a register would inhibit innovation in nursing practice. Van der Peet claims that her actual reason for her objection was “that the moral dimension of nursing was incompatible with such a public register”. Rob van der Peet The Nightingale Model of Nursing (Edinburgh: Champion Press, 1995) 59.

### 3 Nursing as a Science-Based Activity

#### 3.1

O

#### Origins of a Philosophy of Science

Science is the endeavour to describe, explain and understand the workings of the physical world<sup>1</sup> in a systematic way. It is underpinned by the assumption that knowledge can be generated by objective means in both the gathering of data and by the subsequent analysis and presentation of such data. Early scientific activity was focussed on gaining an understanding of the physical world but it rapidly progressed to an expectation that natural events could be predicted and controlled or harnessed in such a way so as to, at least, reduce humankind's vulnerability to the forces of nature and to, at best, bring benefit to humankind. The following outline sketches the progression of scientific activity alongside the emergence of new ways of thinking that contributed to the dominance of science in western culture.

The scientific revolution gained momentum in the seventeenth century. It reflected a "mathematization of nature".<sup>2</sup> Until that time, mathematics was used to buttress theories about the world and the way in which it was ordered. Subsequent to the work of Copernicus and Galileo, theories about the natural world became accountable to a mathematical explanation. Previously held *instrumentalist* views of the world were discarded in favour of a *realist* view. The efforts of Galileo and Copernicus were significant, not so much for their advancement of reason (this was no departure from human tradition) but for their view that rationalistic inquiry could and indeed ought to be verified in quantifiable, which is to say mathematical, terms.

Descartes integrated this new way of thinking about the world to formulate a philosophy that described nature in mechanical terms and extended the promise to humans that there was now no longer any limit to understanding. Nature's mysteries could be uncovered by means of rational inquiry which was accompanied by a rejection of a mystical or spiritual way of viewing the world. By the latter half of the

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<sup>1</sup> John Henry, The Scientific Revolution and the Origins of Modern Science (New York :St Martin's Press, Inc., 1997) 5.

<sup>2</sup> Henry, 8.



seventeenth century, dualistic thinking which made a sharp distinction between both the material and the spiritual dominated scientific endeavour.<sup>3</sup>

A development which accompanied the investigation of natural causes in a realist tradition was the emergence of an experimental approach to the generation of knowledge. Francis Bacon (1561-1626), Blaise Pascal (1623-1662) and Robert Boyle (1627-1691) played major roles in advocating an experimental approach to the generation of knowledge. Bacon's role as the originator of the experimental method is disputed, but he nonetheless played a central role in establishing its importance.<sup>4</sup> He articulated a utilitarian view of nature, arguing that nature could be fully known, controlled and drawn into the service and betterment of mankind.<sup>5</sup> Pascal, like Galileo, made a more concrete contribution to the acceptance of the experimental method by devising a series of public experiments which challenged Aristotelian ideas about the nature of vapours and liquids.<sup>6</sup>

These scientists prompted a cascade of experimental investigations into all manner of aspects of the natural world. William Harvey (1578-1657) provided a demonstrable account of blood flow in the human body.<sup>7</sup> The invention of the microscope contributed to the discovery of further information about the human body. Marcello Malpighi (1628-1694) discovered the capillary connections between arteries and veins.<sup>8</sup> Significant advances were made in the area of embryology.<sup>9</sup>

Any pause in the impetus of the scientific revolution was dispelled by the subsequent emergence and dominance of the thinking of Sir Isaac Newton (1642-1727). Newton was a "convert" to the mechanistic view of nature but his investigation of the natural world extended beyond the mechanical. He sought mathematical descriptions of motion and forces the essence of which might never be truly known but the effects of which could be. By this means "the concept of force could be admitted into scientific demonstrations" which reconciled "the tradition of mathematical philosophy

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<sup>3</sup> Richard S. Westfall, The Construction of Modern Science: Mechanisms and Mechanics (Cambridge: Cambridge University Press, 1977) 30-31.

<sup>4</sup> Westfall, 114.

<sup>5</sup> Westfall, 118.

<sup>6</sup> Westfall, 45.

<sup>7</sup> Henry, 27.

<sup>8</sup> Henry, 31.

<sup>9</sup> Westfall, 100-101.

represented by Galileo, with the tradition of mechanical philosophy represented by Descartes” thus providing the substantive foundation for the progress of scientific inquiry today.<sup>10</sup>

## 3.2

T

### **Theories of Nursing as a Science-Based Activity**

Scientific inquiry was not limited to the study of the physical world. From the early twentieth century onwards the scientific method of objective observation and controlled experimentation has been used to examine human behaviour. Similar mathematical approaches of quantifying responses and presenting results in a systematic way led to the establishment of schools of human sciences. Nursing also turned to the sciences to provide an objective, and to some extent, mathematized account of itself. This has resulted in the generation of a series of “scientific” theories of nursing largely emerging from the schools of psychology and education. As nursing has become a more distinctive occupation, nurses have turned their attention to defining their activity in scientific terms. This intellectual endeavour has been fostered by the increasing levels of education that nurses have acquired. Scientific theories of nursing (flowing steadily from the United States due to the early connection that nurse training connected with university education) have been advanced to highlight such aspects of nursing as its rehabilitative dimension, its responsiveness to human needs, its claim to make up for a deficit of self-care and its claim to enable “human becoming”.

### 3.2.1

N

#### **Nursing as Rehabilitation**

Lydia Hall (1906-1969) developed a scientific model of nursing “Care, Core and Cure”.<sup>11</sup> She was concerned to describe nursing in scientifically verifiable terms yet also in a way that addressed the fragmented approach to care that was characteristic of nursing in the 1950s and 1960s.<sup>12</sup> Hall utilised the theoretical insights not only of

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<sup>10</sup> Westfall, 159.

<sup>11</sup> Lydia Hall, “Nursing: What is it?” *The Canadian Nurse* 60.2 (1964): 151.

<sup>12</sup> T. A. Touhy & N. Birnbach, “Lydia Hall, the core, care and cure model,” *Nursing Theories and Nursing Practice*, ed. M. Parker (Philadelphia: F. A. Davis, 2001) 131-142.

Carl Rogers but also educational theorists such as Sullivan and Dewey.<sup>13</sup> She advanced the notion that a therapeutic relationship ought to be client-centred and that nursing is an educative process which elicits change.<sup>14</sup> This educative process could be achieved by creating a supportive environment that nurtures a motivation for rehabilitation which “springs from the self-actualising tendency of life itself”.<sup>15</sup>

Hall argues that to be rehabilitative, nursing must respond to three dimensions of human illness: care, core and cure. The care domain is nursing's unique function and focuses on bodily care activities such as feeding, washing and toileting; the core of a person is cared for by the therapeutic use of the agent of care whether they be nurses psychotherapists, social workers, chaplains and in the cure dimension nursing is ancillary to medical services.<sup>16</sup>

Hall identified rehabilitation and long-term care units as the areas of healthcare where nursing activity is most characteristic of the care aspect of nursing. In units where her philosophy informed the work practices, empirical evaluation demonstrated a reduction in length of stay for patients and longer-term life satisfaction levels than those experienced by patients who had been cared for in traditional institutions.<sup>17</sup>

The heart of Hall's scientific philosophy of nursing is that the environment of care that nurses provide for patients is therapeutic in itself. This environment is best achieved in a non-directive setting where goals for recuperation and rehabilitation are a negotiated process between patient and nurses. Hall supported the education of nurses to a professional level for nursing. Given her belief that the unique domain of nursing care is that which is practiced in the rehabilitative stage of recovery, she presents an interesting challenge for current nursing philosophers. Advanced levels of education for nurses are generally recommended on the basis of the increasingly complex nature of the acute phases of care that nurses are required to deliver. However in the rehabilitative centre where her philosophy of care is best applied, she

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<sup>13</sup> Carolyn H. Fakouri, Marcy Grandstaff, S. Brook Gumm, Ann Marriner Tomey & Kim TippeyPescoe, “Core, Care, and Cure model,” *Nursing Theorists and Their Work*, eds. Ann Marriner Tomey & Martha Raile Alligood, 4<sup>th</sup> ed. (St. Louis: Mosby, 1998) 133.

<sup>14</sup> Fakouri et al., 134.

<sup>15</sup> Fakouri et al., 134

<sup>16</sup> Fakouri et al., 135.

<sup>17</sup> Fakouri et al., 135.

required high level of training for nurses to practice the more bodily aspects of nursing activity. Hall stressed that it was through the creative and reflective practices of care, negotiation, teaching and support that nurses were at their most therapeutic. These attributes do not come naturally to the untrained. They are, however, practiced in what is sometimes considered to be the mundane setting of offering simple bodily care to patients.

The strength of Hall's philosophy is that it has a sound theoretical base and thus that it can be verifiable. It is also attractive as it presents an idealistic version of nursing which ennobles as central the bodily aspect of nursing which is commonly considered the most humble. Her philosophy of nursing holds within it an implicitly moral view of nursing. The strength of Hall's view of nursing is, however, also its point of vulnerability. Hall's model is practitioner-intensive. It is therefore expensive and, whilst improved outcomes can be demonstrated by using highly trained practitioners for bodily care, economic pressures mitigate against its widespread adoption.

### 3.2.2

N

#### **nursing as Response to Human Needs**

Other science-based theories of nursing rely on the idea of nursing as a response to human need. Virginia Henderson (1897-1996) is best known for providing a widely adopted definition of nursing,<sup>18</sup> as follows:

“The unique function of the nurse is to assist the individual, sick or well, in the performance of those activities contributing to health or its recovery (or to peaceful death) that he would perform unaided if he had the necessary strength, will or knowledge. And to do this in such a way as to help him gain independence as rapidly as possible.”<sup>19</sup>

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<sup>18</sup> Sr Judith E. Alexander, Deborah Wertman De Meester, Tamara Lauer, Ann Marriner Tomey, Susan E. Neal & Sandy Williams, “Definition of nursing,” Nursing Theorists and Their Work, ed. Ann Marriner Tomey & Martha Raile Alligood, 4<sup>th</sup> ed. (St. Louis: Mosby, 1998) 100.

<sup>19</sup> Virginia Henderson, The Nature of Nursing: A Definition and its Implications for Practice, Research and Education (New York: Macmillan, 1966) 15.

Henderson was committed to the description of nursing in scientific terms as a means of professionalisation and to the application of the biological and human sciences in nursing practice. Although she maintained that care was central to nursing practice,<sup>20</sup> she described emotion scientifically as “our interpretation of cellular response to fluctuations in the chemical compositions of the intercellular fluids”.<sup>21</sup>

Henderson adopted a needs-based approach in her account of nursing. She identified fourteen basic human needs that correlate to Maslow’s hierarchy of human needs<sup>22</sup>. These are breathing, eating, elimination, movement, sleep, clothing, maintaining body temperature, cleanliness, safety, communication, worship, work, play and learning or discovery. Unlike Maslow, Henderson does not make this list explicitly hierarchical (although common sense dictates that minimal attention must be paid to biological needs in order to achieve satisfaction for other needs). Henderson provided nursing with means of identifying nursing activity: if the nurse has assisted the person to meet some of the activities of daily living some clarity both of role and outcome has been achieved.

Henderson’s role as a nursing philosopher has been significant and her model of nursing has been helpful in enhancing nursing’s understanding of itself. It is appropriately body-centred and articulates a good aim for nursing. If it is to be criticised as all it could be said that her definition of nursing can be similarly applied to a range of helping activities such as teaching, physiotherapy, psychiatry. If a professional identity is dependent on a distinctive definition of the core activity, her account does not offer a solid underpinning for professional security. In addition her view of the emotional aspect of nursing is reductionist. Although emotions have a biological component, they are not limited to the biophysical domain.

A later needs-based model of nursing has been developed by Roper, Logan and Tierney. They argue that nursing has a distinct identity from medicine<sup>23</sup> which can be described in systematic terms. Their theory is best summarised by the phrase “A

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<sup>20</sup> Alexander et al., 107.

<sup>21</sup> Alexander et al., 101.

<sup>22</sup> Henderson claims not to have read Maslow before she formulated her list. Alexander et al., 104.

<sup>23</sup> Alexander et al., 324.

model of nursing based on a model of living<sup>24</sup>, comprises five major concepts which are drawn together by the use of the nursing process to formulate nursing care as follows: Activities of Living (ALs) which are derived from Henderson are amendable to changes in priority, interrelated and may vary in terms of relevance to the demands of the day; The Lifespan is a person's time of life which influences the way the ALs can be achieved; The Dependence/Independence continuum applies to each AL and need not necessarily correlate to one's time of life. It is not fixed in a particular direction rather one may move back and forth in terms of dependence and be at different stages of dependence for different ALs; Influencing factors such as biological, psychological, socio-cultural, environmental and politico-economic factors affect individual ALs ; Individuality in living describes the manner in which a person forges these elements of his or her life together.<sup>25</sup>

Nursing therefore is the helping activity that recognises the elements in a person's life that are being managed well and those areas where assistance is required. Once an assessment has been made of the person's needs, individualised nursing care can be developed that will have the necessary therapeutic benefit.

Roper, Logan and Tierney's model for nursing is called a practise-based model and has been adopted in designated Nursing Development Units. These units are structured to foster "a therapeutic atmosphere conducive and responsive to change"<sup>26</sup> in contrast to nursing units where ward routine determines the pattern of nursing attention. There has been limited application of this approach to nursing in Australia. There are Nursing Development Units in South Australia and Victoria and one recently established in Sydney.

Practise-based nursing achieves a high level of integration between theory and practise. Both Hall and Henderson agree that the central focus of nursing activity is care. Henderson identified the ALs that are the focus of nursing activity. As Hall applied insights from psychology she was able to describe the distinctive nursing

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<sup>24</sup> Alexander et al., 328.

<sup>25</sup> N. Roper, W. W. Logan & A. Tierney, The Elements of Nursing: A Model for Nursing Based on a Model of Living, 4<sup>th</sup> ed. (Edinburgh: Churchill Livingstone, 1996) 33-34.

<sup>26</sup> Bart O'Brien, "Developing a practice-based model of nursing," Nursing Theory in Australia: Development and Application, ed. Jennifer Greenwood (Sydney: Harper Educational Publishers, 1996) 237.

activity that is found in the therapeutic interactions that are undertaken by the nurse as he or she cares for the body. This view is affirmed by Lawler<sup>27</sup> who formulated the term *somology* to describe the special knowledge that nurses utilise as they attend to patients' needs.

Despite the assertion that practise-based nursing can be applied in any specialty area<sup>28</sup>, the risk of a theory-practice gap occurring is more pressing when nurses try to practice in this manner in environments that are neither philosophically nor structurally committed to this form of care. Practice-based nursing places the person at the centre of the institution. Practically speaking, this means that there is no routine save that which is negotiated as most therapeutic between nurse and patient. Hall acknowledged that, in the acute phase of illness, the kind of bodily nursing care that she describes is secondary to the technological care that is dictated by medical care as there are fewer options available for negotiation that contribute to a person's recovery. This admission implies that there is an appropriate time in one's illness that aligning oneself with ward routine and the demands of an institution is most beneficial in terms of recovery. It is in the recovery phase of illness that there is most scope for the individualising of care that Roper, Logan and Tierney suggest in their model for nursing. This therefore limits the application of practise-based nursing to the rehabilitation setting. It does, however, potentially transform long-term care settings to slow-stream rehabilitation. If nursing is at its most therapeutic in the recovery phase of illness, then the nurse in this setting is observing, planning and intervening in ways that should bring about change in the person, rather than simply practising care that maintains things as they are.

Practise-based theory is criticised as not likely to contribute to the process of change emerging as it does from practice.<sup>29</sup> However, practise-based nursing depends upon practitioners who are reflective by nature and who implement the action research process that has a built-in expectation of change and refinement of practice in order to achieve therapeutic benefits.<sup>30</sup> Application of this model of nursing has been

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<sup>27</sup> J. Lawler, Behind the Screens: Nursing, Somology and the Problem of the Body, (Melbourne:Churchill Livingstone, 1991).

<sup>28</sup> Toney, 329.

<sup>29</sup> Sarah Fry, "Toward a theory of nursing ethics," Advances in Nursing Science July, (1989): 10.

<sup>30</sup> O' Brien, 239.

demonstrated effective when nurses proactively identify areas of practice that need improving and set about implementing those improvements.<sup>31</sup>

### 3.2.3

N

#### **nursing as Response to Self-Care Deficit**

Another kind of science-based conception of nursing is found in the work of Dorothea Orem (b. 1914). She first published a curriculum guide for practical nurses in 1959<sup>32</sup> and continued to refine and develop her theory of self-care deficit subsequently to that. *Nursing: Concepts in Practice* was published in 1971.<sup>33</sup> Her theory takes as its central tenet the idea that nursing is a “human health science”<sup>34</sup> and that nursing has a practical goal. Two influences in her work are Maslow’s hierarchy of human needs and the consumer movement “which focussed on the rights of individuals to be involved in decisions about their health care”.<sup>35</sup>

Orem’s nursing theory has three components. The first is the Self-Care Deficit Theory which describes the person who is unwell as being limited in his or her capacity to self-care and who needs the assistance of a nurse to fill that role. The second is the Self-Care Theory which recognises that everyday behaviours are mechanisms that people engage in to care for themselves and their dependents in daily living. The third is the Nursing System Theory which occurs when nurses prescribe and provide care that performs the task that the person would perform if well. This care can take the form of either: a wholly compensatory nursing system where the patient is unable to meet self-care requisites; a partial compensatory system where both the patient and the nurse perform self-care tasks; or a supportive educative system where the patient needs direction from the nurse in order to perform certain self-care tasks.

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<sup>31</sup> Loretta M. Bellman, “Changing nursing practice through reflection on the Roper, Logan Tierney model: the enhancement approach to action research,” *Journal of Advanced Nursing* 24.1 (1996): 129-138.

<sup>32</sup> Afaf I. Meleis, *Theoretical Nursing: Development and Progress*, 2<sup>nd</sup> ed. (Philadelphia: J. B. Lippencott Company, 1991) 392.

<sup>33</sup> Susan G. Taylor, Angela Compton, Jeanne Donohue Eben, Sarah Emerson, Nergess N. Gashti, AnnMarriner Tomey, Margaret J. Nation, Shery B, Nordmeyer, “Self-care deficit theory in nursing,” *Nursing Theorists and Their Work*, ed. Ann Marriner Tomey & Martha Raile Alligood, 4<sup>th</sup> ed. (St Louis: Mosby, 1998) 176.

<sup>34</sup> Dorothea E. Orem, “Orem’s general theory of nursing,” *Nursing Science: Major Paradigms, Theories and Critiques*, ed. Rosemarie Rizzo Parse (Philadelphia: W. B. Saunders Company, 1987) 71-72.

<sup>35</sup> Merilyn King & Lyn Green, “Orem’s self-care model in diabetes health care,” *Nursing Theory in Australia: Development and Application*, ed. Jennifer Greenwood (Sydney: Harper Educational Publishers, 1996) 163.



The concepts used within the theory have been well defined and they enable practitioners to be clear in defining both the task before them and why the task is important. For example: "Self-care" is normal adult behaviour which is performed on a continual basis. Self-care is profoundly therapeutic. Orem identifies a hierarchy of eight universal self-care requisites. An appreciation of what it is that humans need to do to self-care enables the nurse to identify both the problem and a means to address the problem when it is apparent that one of the basic self-care needs is not being met. "Human beings" characteristically reflect on their world and use symbols. They take purposeful action to care for themselves both in normal activities and when they are unwell. They also engage in regular care activities for their dependents. "Health" is a state of wholeness that includes mental and social well-being as well. "Environment" is a person's location in a physiochemical, biological and socio-economic environment. Orem recognises that people relate to their environment in two ways. The environment impacts on people and people also have an impact on the environment. "Nursing" is a specialised health service which is offered on a continuous basis to those who have reduced capacity to self-care. Five behaviours that nurses engage in to fill the self-care deficit are identified: acting for another, guiding and directing, providing support, maintaining and environment that supports personal development and teaching.<sup>36</sup>

Orem's theory of self-care is acknowledged as one of the most widely-understood and applied nursing theories.<sup>37</sup> Meleis<sup>38</sup> attributes the widespread adoption of this theory to two features: the use of medical terminology within the theory and the fact that the theory formation has emerged from an institutional context. Both these features lend a recognisable familiarity to the theory which confers a degree of comfort to nurses as they engage with it. However, Meleis identifies some internal inconsistencies in this theory. Whilst Orem claims her theory is a means of empowerment, it is framed in such a way that nurse activity is exclusively described in terms of nurses as active and patients as passive. Meleis also questions the fundamental assumption that patients actually want to self-care. Valuing of individuality and the desire to do for oneself is a peculiarly Western trait. Many other

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<sup>36</sup> King & Green., 162-172.

<sup>37</sup> Violeta A. Berbiglia, "Orem's self-care deficit theory in nursing practice," Nursing Theory: Utilisation and Practice, eds. Martha Raile Alligood & Ann Marriner-Tomey (St Louis; Mosby, 1997) 129.

<sup>38</sup> Meleis, 400.

cultures understand illness to be a time where one abandons oneself to the illness and takes no part in the curative process.

### 3.2.4

N

#### **nursing as a Response to Human Becoming**

A third conception of nursing as a science-based activity is found in the work of Rosemary Rizzo Parse whose theory of nursing is called *The Human Becoming Theory of Nursing*. It incorporates the work of Martha E. Rogers<sup>39</sup> and the philosophical influences of existentialists Heidegger, Sartre and Merleau-Ponty.<sup>40</sup> These philosophical influences focus on individual experience and the right to self-determination.<sup>41</sup> Merleau-Ponty emphasises the significance of embodiment in a way which contrasts with western philosophy and its valuing of the conscious self above the embodied self.<sup>42</sup>

Phenomenology is understood in Parse's terms as "the study of phenomena as they unfold".<sup>43</sup> Heidegger brought about a fusion between existentialism and phenomenology. His insights about the importance of one's lived experience and the essentially subjective way a person experiences and then through language describes the world, provide the philosophical underpinnings of interpretive research. In advancing the notion that nursing is a human science Parse argues that it is best practiced when the nurse is guided by "the human becoming principle" and illness is

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<sup>39</sup> Rogers describes nursing as a humanistic science. Her theory is called a Science of Unitary Human Beings in which she describes human beings in dynamic terms. She resists reductionism but employs scientific means to describe human beings in their totality. It is an ambitious theory and the concepts are correspondingly complex. Scholars regard it as sufficiently coherent and sophisticated to sustain further research and making further contributions to the articulation of a meaningful nursing identity. Suzanne M. Falco & Marie L. Lobo, "Martha E. Rogers," *Nursing Theories: The Base for Professional Nursing Practice*, ed. Julia B. George, 2nd ed. (New Jersey: Prentice-Hall International Inc., 1985) 214-234. Kaye Bultemeier, Mary Gunther, Joann Sebastian Daily Judy Sporleder Maupin, Cathy A. Murray, Martha Carole Satterly, Denise L. Schnell & Therese L. Wallace, "Unitary human beings," *Nursing Theorists and Their Work*, eds. Ann Marriner Tomey & Martha Raile Alligood 4<sup>th</sup> ed. (St. Louis: Mosby, 1998) 207-226.

<sup>40</sup> Kathleen D. Pickrell, Rickard E. Lee, Larry P. Schumacher & Prudence Twigg, "Human Becoming," *Nursing Theorists and Their Work*, eds. Ann Marriner Tomey & Martha Raile Alligood 4<sup>th</sup> ed. (St. Louis: Mosby, 1998) 464-463.

<sup>41</sup> John Daley & Jennifer Watson, "Parse's human becoming theory of nursing," *Nursing Theory in Australia: Development and Application*, ed. Jennifer Greenwood (Sydney: Harper Educational Publishers, 1996) 184.

<sup>42</sup> Magee, 218.

<sup>43</sup> Daley & Watson, 185.

not understood in objective, measurable terms, but rather in the meaning of the illness as the person experiences it.<sup>44</sup>

Parse has made two major contributions to thinking about nursing in theoretical terms. Firstly, she categorised nursing theories into two groups; those which rely on an understanding of the human body as a complete entity which is defined by the sum of its parts (The Totality Paradigm) and those which rely on an understanding of the human body as a dynamic entity which interact with the environment in ways that sometimes elude measurement (The Simultaneity Paradigm).<sup>45</sup>

Secondly she further developed the description of nursing as a dynamic process, specifically, the human as a “becoming entity”. Parse’s theory is comprised of three concepts; *meaning*, *cocreating* and *cotranscendence*. These are highly abstract concepts: “Meaning” is a construct that is shaped as the individual interacts with the world. It need not be limited to experiences of a religious or philosophical nature. Meaningful moments occur as the individual attaches significance to events of everyday life. “Rhythmicity” refers to the patterns that emerge in the person’s life as he or she relates to the universe. A person “cannot be all possibilities at once and in choosing, one is both enabled and limited”.<sup>46</sup> “Cotranscendence” is the experience of moving towards possibility in one’s life creatively harnessing and transcending the conflict that sometimes emerges as the result of change.

Parse’s theory reflects a commitment to nursing as a human science. It describes nursing in terms that emphasise the human element in all that occurs in the activity of nursing. It has the capacity to sustain the nurse in whatever interaction or activity is required to meet a patient’s needs. It offers nurses a stimulating framework to test

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<sup>44</sup> Rosemary Rizzo Parse, “Nursing science: the transformation of the practice,” Journal of Advanced Nursing 30.6 (1999): 1384.

<sup>45</sup> **The Totality Paradigm** is essentially mechanistic, reductionist and normative and is a traditional scientific way of regarding the human body. The nurse has an authoritative role in the nurse patient relationship and it is the nurse who acts to “shift the person to a position of health”. Exponents of nursing theory that fit into the totality paradigm are Sister Callista Roy, Dorothea Orem, Dorothy Gordon and Ida Orlando.

**The Simultaneity Paradigm** contrasts with the *Totality Paradigm* in that it resists normative values of the human and identifies the person as “the expert and ultimate authority on his or her own health”. The role of the nurse is to participate in the life of the patient in a participatory and nurturing role that facilitates the person’s movement towards health. Exponents in this paradigm are Martha E. Rogers and Margaret A. Newman. John Daley, “Parse’s human becoming school of thought,” Nursing Theory in Australia: Development and Application, ed. J. Greenwood 2<sup>nd</sup> ed. (Sydney: Pearson Education Australia, 2000) 216-219.

<sup>46</sup> Pickrell et al., 465.

and formulate further ideas about nursing. Parse's work is helpful in illuminating the way a nurse approaches the human being in his or her care. It contributes to the notion of holistic care and is most useful in developing a philosophy of care in therapeutic situations particularly community based settings.

Parse's theory is acknowledged as sophisticated and is sufficiently complex as to be a framework that supports demanding research topics.<sup>47</sup> It is not, however, one which addresses the nurse's need to be technically competent at practical skills. This is a limitation which restricts a potentially stimulating and creative theory to the domain of academia when nursing is essentially a practice based endeavour.

### **3.3** **E** **Effects on Nursing**

#### **3.3.1** **B** **Biomedicalisation of Nursing**

This growth in scientific knowledge slowly translated into improvements in treatment methods for the sick. In the late eighteenth century the maternal mortality rate was 1200 per 100,000 live births and infection was its chief cause.<sup>48</sup> The chief cause of infection was thought to be poisonous vapours or *miasma* (if any cause was to be identified at all) or, just as likely, spontaneous generation. Efforts to address the problems of infection included achieving adequate ventilation, dispelling the *miasma* (a solution favoured by Nightingale and her followers)<sup>49</sup> or acceptance of the occurrence of infection and its accompanying mortality as "accident or providence" which many physicians and nurses were inclined to do.<sup>50</sup>

From the early to the mid 1800s Alexander Gordon (Scotland) and Ignaz Fulop Semmelweis (Vienna) came independently to the conclusions that the high maternal death rate from puerperal fever had its origin in a contagion which was passed from woman to woman by a carrier and that its spread could be contained if midwives and

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<sup>47</sup> Pickrell et al., 470.

<sup>48</sup> Ronald S. Gibbs, "Impact of infectious diseases on women's health: 1776-2026," Journal of Obstetrics and Gynecology 97.6 (2001): 1019.

<sup>49</sup> Elaine Larson, "A retrospective on infection control. Part 1: nineteenth century – consumed by fire," American Journal of Infection Control 25.3 (1997): 239.

<sup>50</sup> Gerald Weissman, "Puerperal priority," The Lancet 349.9045 (1997): 123.

doctors washed their hands between attending cases. Gordon could predict which “women would be affected with the disease upon hearing by what midwife they were to be delivered, or by what nurse they were to be attended, during their lying-in” and be right in most instances.<sup>51</sup> Semmelweis achieved a reduction in maternal deaths in his hospital from 18.3% to 1.3% by making the medical students wash their hands with a disinfectant.<sup>52</sup> These improvements were achieved prior to the identification of the microbes that caused the infection. Joseph Lister (1827-1912) “bridged the sanitarian and bacteriological revolutions” by firstly implementing systematic aseptic techniques in his surgical unit and secondly by identifying the lactobacillus as a causative agent of infection.<sup>53</sup> Louis Pasteur (1822-1925) and Robert Koch (1843-1910) made further advances in demonstrating the causative relationship between micro-organisms and infection.<sup>54</sup>

Nursing began to modernise its practices from the early twentieth century. Early nursing practice was limited to “bathing, hot packs, cold packs, ice-cradling, irritants and counter-irritants”.<sup>55</sup> These early practices were transformed by an appreciation of the need for aseptic methods in all practices. The real revolution in treatment methods awaited the development of sulphonamides and penicillin. Until then nursing treatment for tuberculosis patients was limited to a mantra of “rest the patient, rest the part; rest prolonged, continuous and uninterrupted”<sup>56</sup> which entailed long periods of hospitalisation. The wide-scale inoculation against infectious diseases reduced hospital stays dramatically. World War II significantly hastened the development of increasingly sophisticated methods of surgical treatments.

Biomedical research continues to underpin nursing practice today. Nurses themselves report a correlation between instruction in the biosciences and improvements in the interventions they can offer patients. For example, a nurse from a coronary care unit, upon receiving additional teaching on the relationship between low oxygen levels and the likelihood of cardiac arrhythmias, now encourages patients to persist with their oxygen masks rather than allow them to be removed for reasons

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<sup>51</sup> Weissman, 123.

<sup>52</sup> Weissman, 124.

<sup>53</sup> Weissman, 124.

<sup>54</sup> Rogers, 25.

<sup>55</sup> Armstrong, 37.

<sup>56</sup> Jane J. A. Robinson, “Golden jubilee of the British National Health Service: looking back and looking forward for the *Journal of Advanced Nursing*,” (editorial) *Journal of Advanced Nursing* 28.1 (1998): 1.

of discomfort.<sup>57</sup> By contrast, nurses who have an inadequate foundation in the biosciences are anxious about their practice because they are aware that slight errors in these matters have serious, sometimes fatal consequences but lack the depth of knowledge that underpins good practice.<sup>58</sup>

An adequate education in the biosciences is not limited to the advantages it offers to patients. A nurse is better able to be an advocate for a patient when collegial relationships have a shared knowledge base. In addition the nurse enjoys a more confident practice.<sup>59</sup> Dingwall and Allen argue that nursing has “emerged as an occupation at least partly as a result of the technical changes in medicine”<sup>60</sup> and that even when little technology was available to nurses, acts such as sponging a feverish patient more closely represented the “medical technology of the time”<sup>61</sup> than the emotional and caring work that it is sometimes portrayed. Nurses need to accept that they are dependent on a sound scientific basis for practice if their claim for professional status is to be recognised.

### 3.3.2

D

#### **Development of a Process of Nursing**

The nursing process is the means by which nurses deliberate about how to apply nursing theory to practice. It is not a theory of nursing. It is the means by which nurses operationalise nursing theories. It is described as “the tool and methodology of the nursing profession”.<sup>62</sup> The nursing process was developed as part of a move to establish nursing as a scientific discipline. The aim was to make delivery of nursing care “more logical, rational and methodical” thus contributing to nursing practice being more identifiable and accountable, both factors being perceived as contributing to the advancement of the professional status of nursing.<sup>63</sup> It has been taught in

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<sup>57</sup> Sue Jordan, “The biological sciences: What do nurses need to know?” Journal of Advanced Nursing 26.1 (1997): 172.

<sup>58</sup> Jordan, 170.

<sup>59</sup> Sue Jordan, “Should nurses be studying bioscience? A discussion paper,” Nurse Education Today, 14.6 (1994): 424.

<sup>60</sup> Robert Dingwall & Davina Allen, “The implication on healthcare reforms for the profession of nursing,” Nursing Inquiry 8.2 (2001): 68.

<sup>61</sup> Dingwall & Allen, 67.

<sup>62</sup> Marjorie Stanton, Charlotte Paul & Joan Reeves, “An overview of the nursing process,” Nursing Theories: The Base for Professional Nursing Practice, ed. Julia B. George 2<sup>nd</sup> ed. (New Jersey: Prentice-Hall Inc, 1985) 15.

<sup>63</sup> Beverly O’Connell, “Nursing process: a problem-solving approach to patient care,” Nursing Theory in Australia: Development and Application, ed. Jennifer Greenwood (Sydney: Pearson Education Australia Pty. Ltd, 2000) 78-97.

nursing schools since the 1960s in the United States and the mid-seventies in Australia.

The nursing process is an attempt to formalise the distinctive insights and nursing actions that nurses contribute to the healthcare process in a way that interacts with the medical model of healthcare. Its strength is that it retains the particular nursing emphasis of identifying the human response to illness. As part of the implementation of the nursing process there has been an accompanying development of a nursing diagnostic taxonomy that assists nurses to describe that patient's problems in nursing rather than medical terms. For example, a medical diagnosis of obesity would be construed in nursing terms as altered nutritional status relating to dysfunctional eating patterns.<sup>64</sup> Many nurses find these terms unwieldy and time-consuming to use and are unhappy to observe that nursing language can become as littered with jargon and as mystifying as medical language.

The nursing process consists of five elements that provide a nurse with a method of approaching patient care in a holistic and individualised manner. These are that in any patient encounter the nurse assesses the patient situation, makes a nursing diagnosis based on the assessment, develops a plan of nursing care which is then implemented and evaluated.

Although the nursing process appears to proceed in a linear fashion, the stages of the process are "dynamic and continuous".<sup>65</sup> Some regard the mechanistic approach to nursing care modelled by the nursing process as inhibitory to the nurse's ability to adopt a dynamic approach to nursing care.<sup>66</sup> Henderson recognised that nursing decision-making is often a far more fluid process than that described by the nursing process if only because of the speed with which nurses need to make decisions<sup>67</sup>. The work of Benner and Tanner emphasises the intuitive element of the decision making process in nursing.<sup>68</sup> This is not well captured by the nursing process which

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<sup>64</sup> O'Connell, 84.

<sup>65</sup> O'Connell, 78.

<sup>66</sup> Malcolm Masso, "Nursing process: Help or hindrance?" The Australian Journal of Advanced Nursing, 7.3 (1990): 12-16. Ann McMurray, "Time to extend the process?" The Australian Journal of Advanced Nursing 6.4 (1989): 40-43.

<sup>67</sup> Virginia Henderson, "The nursing process – is the title right?" Journal of Advanced Nursing 7.1 (1982): 103-109.

<sup>68</sup> Patricia Benner & C. Tanner, "Skilled clinical knowledge: How expert nurses use intuition," American Journal of Nursing 87.1 (1987): 23-31.

focuses on the identification and documentation of the aspects of deliberation and application of nursing activity.

The nursing process has been found to be not compatible with nursing culture.<sup>69</sup> It has proved to be an unwieldy vehicle for the expression of nursing interests and has exposed nursing activity to an evaluative process that recognises measurable elements at the expense of the less quantifiable aspects of nursing activity. Therefore, in spite of the hope that the idea of there being a “nursing process” would enhance the distinctive professional standing of nursing, this idea has served to fuse nursing identity further with medicine and ultimately contribute to the marginalisation of nursing within healthcare. The most significant benefit it offers is that it provides a structured approach to the teaching of nursing. Given the support that new nurses require it remains an approach to nursing that experienced nurses must know in order to be able to explain their actions in terms that are familiar to new nurses. The nursing process is also a reminder to experienced nurses to be more deliberate in the way they integrate the disciplines of documentation and systematic thought into their daily practice.

### 3.3.3

D

#### Development of a “Bioethics” of Nursing

If nursing is to be considered a science-based activity, it requires an accompanying ethic that addresses itself to the problems that emerge from the world of bioscience as it is applied to matters of health. In the minds of some this places nursing ethics into a “subcategory of biomedical ethics”.<sup>70</sup>

The field of bioethics is a relatively recent “invention”<sup>71</sup> which can be understood as a response to increasingly complicated medical choices made available by technical progress. Prior to the nineteen-sixties heroic measures to save or prolong lives were unavailable. Questions such as “quality of life” for people in “vegetative states” or the benefits versus the problems of treatment for certain types of cancer, the saving of

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<sup>69</sup> O’Connell. 95.

<sup>70</sup> Robert M. Veatch & Sara T. Fry, *Case Studies in Nursing Ethics* (Philadelphia: J. B. Lippencott Company, 1987) 1.

<sup>71</sup> Warren Thomas Reich, “The word “Bioethics”: its birth and the legacies of those who shaped it,” *Kennedy Institute of Ethics Journal* 4.4 (1994): 319-335.



extremely premature infants and the use of ventilators to prolong life without hope of cure, did not arise. Now they are unavoidable. Bioethics is the discipline that has attempted to humanise the effect of the increasingly technological nature of medical care.<sup>72</sup>

The western nursing ethic has been dependent, in different measures, on the influence of Christianity and the post-Enlightenment ethical frameworks of utilitarianism (or what has come to be known as “consequentialism”) and deontology. In more recent times, some influential attempts at blending consequentialism and deontology have contributed to the development of popular principles to guide the actions of practitioners.

Consequentialism makes a determination about what sort of actions are good by attempting to calculate the benefit that is likely to arise from an action minus whatever bad consequences there may be. It is the dominant ethical model in healthcare today.<sup>73</sup> It has its origins in utilitarianism which emerged from a mechanistic understanding of the natural and subsequently the human world. Thomas Hobbes (1588-1679) wrote that “life is but a motion of limbs ... the heart but a spring; the nerves, but so many strings; and the joints, but so many wheels”<sup>74</sup> and shaped his philosophy accordingly. This mechanistic view sought an account of human behaviour reduced to its most basic elements.

These basic elements came to be understood as pain or pleasure. Reflection on a principle for a moral framework led David Hume (1711-1776) to observe that utility is “at least a part” of what leads people to recommend or applaud an action or object.<sup>75</sup> Jeremy Bentham (1748-1832) subsequently articulated a more rigorous utilitarian framework. He collapsed the concepts of pleasure and utility to mean the same thing because, as he argued, utility contributes to pleasure.<sup>76</sup> He thus represented pleasure as the good that humans seek and pain, as its opposite, to be the bad that

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<sup>72</sup> Edmund D. Pellegrino, “The origins and evolution of bioethics: some personal reflections,” Kennedy Institute of Ethics Journal 9.1 (1999): 75.

<sup>73</sup> Veatch & Fry 7.

<sup>74</sup> Thomas Hobbes, Leviathan (Oxford: Oxford University Press, 1996) 7.

<sup>75</sup> David Hume, An Inquiry Concerning the Principles of Morals, ed. Tom L. Beauchamp (Oxford: Oxford University Press, 1998) 80.

<sup>76</sup> Jeremy Bentham, An Introduction to the Principles of Morals and Legislation, ed. J. H. Burns & H. L. A. Hart () 12.

humans avoid. Bentham admitted no appreciation of the different qualities of pleasure. He proposed the notion of a *felicific calculus* by which he thought that all pleasures were the same, hence they could be quantified into greater and smaller amounts. On this basis, it would be possible to know how to act given the quantity of pleasure one was producing and be confident that, if pleasure is the same as usefulness, one's actions were contributing to the greater good.

J. S. Mill (1806-1873), on the other hand, admitted the possibility of higher and lower pleasures. An appreciation of the distinction between higher and lower pleasures is, in Mill's view, the result of an upbringing that has not killed by "hostile influences" the capacity for nobler feeling, which is "a very tender plant".<sup>77</sup> Mill valued the importance of the individual and emphasised the importance of human liberty,<sup>78</sup> and married the principle of utility with a belief in a beneficent creator who could do nothing but approve of people who live their lives according to this principle. There are some permutations of consequentialism. Rule consequentialism generates rules for action based on the principle of maximising good consequences. Act consequentialism requires the performance of acts to be determined by a response to a particular situation which will deliver the best consequence in that circumstance.<sup>79</sup>

The strength of consequentialism is that it gives consideration to the consequences of actions. However consequentialism betrays its humanistic origins by requiring the person to make moral determinations based solely on consequences. Moral determinations are reduced to a formulaic process where the only consideration is quantity of the good which may be achieved. Setting aside the dual difficulties of achieving such a calculation and achieving a level of certainty about outcomes, the consequentialist is faced with the tension of acting in accordance with a principle which may direct action against an individual or a minority for a hoped-for greater good for a majority. In that respect its helpfulness in healthcare ethics, despite its dominance,<sup>80</sup> must be questioned.<sup>81</sup>

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<sup>77</sup> J. S. Mill, *Utilitarianism*, ed. Roger Crisp (Oxford: Oxford University Press, 2002) 58.

<sup>78</sup> Mill, 79.

<sup>79</sup> W. David Solomon, "Ethics: normative ethical theories," *Encyclopedia of Bioethics*, ed. Warren T. Reich, rev. ed., vol 2 (New York: Simon & Schuster Macmillan, 1995) 740.

<sup>80</sup> Peter Singer is a major contemporary exponent of consequentialism. He attributes sentience as the feature of human life which determines usefulness or happiness. He is active in the field of animal rights and challenges the valuing of human life over animal life as specism. Robert Veatch has written more specifically in the areas of medical and nursing ethics.

As for deontology nursing has historically relied on a sense of duty to underpin its ethical practices.<sup>82</sup> This was at first based on a theistic belief in a divine law giver. The nurse in the Nightingale tradition was likely to describe a sense of Christian duty that informed her practice. Duties of loyalty and truth telling were owed to the matron, the doctor and the institution. However, deontology also finds its origins within a rationalistic framework. Immanuel Kant (1724-1804) is the post-Enlightenment exponent of deontology. Kant developed a series of “categorical imperatives” by which he reasoned that all rational beings ought to live. These were human duties, the practice of which were obligatory for good living.<sup>83</sup>

More latterly nurses have described different duties which have a more contemporary flavour than the previously mentioned duties but are nonetheless Kantian in the sense that they are advanced as universal accounts of nursing.

Trust is foundational to functioning human relationships<sup>84</sup>, yet there is disagreement as to what contributes to a trusting relationship. The reasonable expectation is that a person will not be lied to, but is the maintenance of a trusting relationship dependent on full disclosure? Higgs is critical of filtering the truth depending on the practitioner’s perceptions of the person’s ability to cope with certain information. He labels it as a “paternalistic approach” to truth telling which undermines patient autonomy.<sup>85</sup> On the other hand O’Neill points to a healthcare system that is so burdened by a culture of auditing and the demands of transparency that good practice is impeded. Some suggest that good nursing practice is characterised by the practitioner who acts beyond the call of duty.<sup>86</sup> In the matter of truth telling the good nurse will therefore fully disclose all information about diagnosis, treatment implications and prognosis.

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<sup>81</sup> Cheryl H. Gibson, “Underpinnings of ethical reasoning in nursing,” Journal of Advanced Nursing 12.18 (1993): 2004.

<sup>82</sup> S. M. Reverby, Ordered to Care: The Dilemma of American Nursing, 1850-1945 (Cambridge: Cambridge University Press, 1987).

<sup>83</sup> Immanuel Kant, Groundwork of the Metaphysics of Morals, ed. trans. Mary Gregor (Cambridge Texts in the History of Philosophy (Cambridge: Cambridge University Press, 2001) 31.

<sup>84</sup> Onora O’Neill, Autonomy and Trust in Bioethics (Cambridge: Cambridge University Press, 2002) 12.

<sup>85</sup> Roger Higgs, “Truth-telling,” A Companion to Bioethics, eds. Helga Kuhse & Peter Singer (Oxford: Blackwell Publishers Ltd, 1998) 432.

<sup>86</sup> Les Fitzgerald & Stan van Hooft, “A Socratic dialogue on the question ‘What is love in nursing?’” Nursing Ethics 7.6 (2000): 485.

Alternatively, there is increasing awareness that cultural considerations affect both the degree of information passed to a patient and, in some situations, who is informed of the patient's condition.<sup>87</sup> Others remind the reader that the question "How should we tell?" (which is as much about the timing, the context and the manner of the conversation as it is about the content) is the fundamental question to the fostering of a therapeutic relationship.<sup>88</sup>

The notion of advocacy has entered into various codes of nursing and is represented as a duty for nurses.<sup>89</sup> It was proposed as a metaphor that delivers to nursing a moral underpinning for practice.<sup>90</sup> Its implications for nursing can, however, be unclear. Rather than augment practice, it is an additional demand on the role of nursing which can only be achieved if they call upon their full humanity.<sup>91</sup> This is something that not all nurses have the capacity to do. When nurses act as advocates some suggest that they are undermining patient autonomy.<sup>92</sup> Advocacy invites a confrontational tone into the relationships that nurses have with other health professionals which is undermining as it bestows a certain moral superiority on nurses beyond other health professional that is not always merited.<sup>93</sup> Nurses find the role of patient advocate difficult, particularly in the areas of critical care.<sup>94</sup> If the patient ceases to speak for him or herself, as a result of the nurse speaking for the patient, the role of advocate may slip into the role of gatekeeper. The gatekeeper role is one of "restraining people from overusing health care" and is a role that requires delicate judgement in itself.<sup>95</sup> It could be argued that the gatekeeper is a moderately satisfactory metaphor for nursing, were it not for the confusion about identity that the adoption of such metaphors invites. Quilter queries the use advocacy as a source for moral underpinning for nursing. He suggests that nursing risks making itself known more by

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<sup>87</sup> Karine Crow, Lou Matheson & Alicia Steed, "Informed consent and truth-telling: cultural directions for healthcare providers," Journal of Nursing Administration 30.3 (2000): 148-152.

<sup>88</sup> Benedict M. Ashley & Kevin O'Rourke, Ethics of Health Care: An Introductory Textbook, 2<sup>nd</sup> ed. (Washington D.C.: Georgetown University Press, 1994) 216.

<sup>89</sup> Deidre Hyland, "An exploration of the relationship between patient autonomy and patient advocacy: implications for nursing practice," Nursing Ethics 9.5 (2002): 474.

<sup>90</sup> Leah L. Curtin, "The nurse as advocate: A philosophical foundation for nursing," Ethical Issues in Nursing, ed. Peggy L. Chin (Rockville, Maryland: An Aspen Publication, 1986) 11-19.

<sup>91</sup> Verena Tschudin, "Special issues facing nurses," A Companion to Bioethics eds. Helga Kuhse & Peter Singer (Oxford: Blackwell Publishers Limited, 1998) 467.

<sup>92</sup> Carole M. A. Willard, "The nurse's role as patient advocate: obligation or imposition?" Journal of Advanced Nursing 24.1 (1996): 60-66.

<sup>93</sup> Mary Chiarella, "Advocacy in nursing: nonsense or necessity," ACORN Journal Dec. 1994 22.

<sup>94</sup> Judith A. Erlen & Susan M. Sereika, "Critical care nurse, ethical decision-making and stress," Journal of Advanced Nursing 26.5 (1997): 953-961.

<sup>95</sup> Dick L. Williams, "Balancing rationalities: gatekeeping in healthcare," Journal of Medical Ethics 27.1 (2001): 25.

is what is known about advocates than what is known about nurses, and that nursing identity is weakened by remaining indebted to an external metaphor.<sup>96</sup>

The duty of confidentiality informs the everyday practice of nursing. Nurses have access to sensitive information about patients and are responsible for the documentation of such information and for the discreet communication of information. They keep informal notes about patients' immediate needs from "handover" information, the disposal of which is governed by concerns about maintaining patient confidentiality.<sup>97</sup> In truth, no information given to a nurse can be considered confidential. It is a qualified notion that the information will be used, but it will be used for the patient's good.

The limitations of Kantianism in nursing are more to do with a barren interpretation of his philosophy than its reality. It is difficult for nurses to choose between two apparently conflicting duties. As has been argued, this does not present as an impossible dilemma because careful consideration of duties frequently reveals them to be imperfect rather than perfect. Kant defines imperfect duties as those that are owed, either to oneself or to others, which improve life but it would be possible to do without.<sup>98</sup> Paley argues for a rehabilitation of Kantian deontology in nursing ethics.<sup>99</sup> He claims that there is sufficient attention to character within Kant's writing to enable a nurse to think about his or her practice in terms of duties without being paralysed by the tension of being caught between two duties that are seemingly at odds. A second problem is the lack of serious reflection in nursing literature to determine what constitutes an authentic nursing duty. Suggestions vary from duties of professional affiliation<sup>100</sup> to undertaking mandatory overtime.<sup>101</sup> Questions also arise as to who nurses have a greater duty to. Is it to their employer or to the patients or their colleagues? Most agree that the greater duty is to the patient but is this duty

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<sup>96</sup> John Quilter, "Nursing ethics: A new challenge," Bioethics Outlook 3.2 (1992): 6-11.

<sup>97</sup> Michael Hardey, Sheila Payne & Peter Coleman, "Scraps: hidden nursing information and its influence on the delivery of care," Journal of Advanced Nursing 32.1 (2000): 208-214.

<sup>98</sup> Kant, 31-33.

<sup>99</sup> John Paley, "Virtues of autonomy: the Kantian ethics of care," Nursing Philosophy 3.2 (2002): 133-143.

<sup>100</sup> M. L. Dolinger, "Professional associations: ethics, duty and power," Journal of the New York State Nurses Association 31.2 (2000): 28-30.

<sup>101</sup> Bosek, Marcia Sue De Wolf, "Mandatory overtime: Professional duty, harms and justice," JONA's Healthcare Law, Ethics, and Regulation 3.4 (2001): 99-102.

owed to all patients or limited to those in the nurse's direct care?<sup>102</sup> The result is that the word duty is appropriated for actions that are not universalisable and the notion of duty is subsequently devalued.

Beauchamp and Childress<sup>103</sup> argue for an approach which they call "Principle-Based, Common Morality Theory" as their preferred approach to the development of a moral framework for healthcare. "Principlism" differs from the other dominant ethical traditions in that it is not dominated by one over-arching principle, but holds within it a cluster of ideas from which practice is directed. Beauchamp and Childress argue that four principles of respect for autonomy, beneficence, non-maleficence and justice are fundamental to the good practice of healthcare. Common morality ethics is indebted to "ordinary shared moral beliefs for its content, rather than relying on pure reason, natural law, a special moral sense, and the like".<sup>104</sup>

Principlism is an appealing ethical framework for health practitioners in that it presents a simple and readily applicable formula (although to label it as formulaic betrays a shallow understanding of it) for addressing healthcare problems. Principlism has become a part of nursing's ethical matrix. However, it also represents a strain on nurse's perceptions of itself. Nursing makes claims about being connected with people in the way that they attend to people's needs whereas autonomy emphasises individuality which challenges the way that a nurse might wish to engage with the patient. Given the technically ambitious nature of modern medicine, certainty about outcomes can be elusive. The principles of non-maleficence and beneficence can ring hollow when certain treatments confer more suffering than benefit. Johnstone, in her critique of principlism, claims that the demands of the justice principle can also make nurses feel somewhat ineffectual as they reflect on their own perceptions about injustices done to them in regards to financial rewards for work, demanding and unreasonable work loads and lack of community recognition.<sup>105</sup>

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<sup>102</sup> Stephen Wilmot, "Nurses and whistleblowing: the ethical issues," Journal of Advanced Nursing 32.5 (2000): 1054.

<sup>103</sup> Tom L. Beauchamp & James F. Childress, Principles of Biomedical Ethics, 2<sup>nd</sup> ed. (New York: Oxford University Press, 1994) 100.

<sup>104</sup> Beauchamp & Childress, 100.

<sup>105</sup> Megan-Jane Johnstone, Bioethics: A Nursing Perspective, 2<sup>nd</sup> ed. Sydney; W. B. Saunders Balliere Tindall, 1994) 96-97.

In a commentary on his own work, Beauchamp acknowledges that principlism is not an ethical framework that can be adopted without reference to, in particular, the virtues. He points out that the practitioner who follows the rules with no evidence of bringing qualities of character to the decision making process cannot be relied on to have acted rightly. He writes that “ the reactions people have to those in the past who wronged patients - in research, for example - is that they lacked discernment, compassion and trustworthiness, not that they failed to act in accordance with a rule or principle”.<sup>106</sup>

### 3.3.4

G

#### eneration of Codes of Conduct

The establishment of nursing as a profession has not been a straightforward process<sup>107</sup>. The markers of a professional grouping are the development of a unique body of knowledge that is necessary for the common good, rigorous training process, a commitment to ongoing development of knowledge, strong group cohesion and maintenance of common practice standards<sup>108</sup>. The development of practice standards is commonly represented as a code of conduct. It is the means by which an occupational group formalises its moral commitment to the advancement of the communal good.<sup>109</sup> Codes of conduct characteristically include an undertaking that the group will ensure an objectively derived standard of practice for its members: the profession takes responsibility for monitoring the actions of its members and the professional body will foster a culture committed to excellence in practice. In return society confers on the group the status of profession. The profession is given the privilege of making its own determinations about who may enter the profession. Codes of conduct for nursing have evolved as nursing has adopted a more professional identity. These have ranged from pledges made by nurses on their graduation to formal identification with statements about practice and conduct from professional bodies. The International Council of Nurses (ICN) adopted a Code of Ethics for nurses in 1953.<sup>110</sup>

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<sup>106</sup> Tom L. Beauchamp, “Principlism and its alleged competitors,” Kennedy Institute of Ethics Journal 5.1 (1995): 195.

<sup>107</sup> Jane E. Ritty, “The nature of philosophy of science, theory and knowledge relating to nursing and professionalism,” Journal of Advanced Nursing, 28.2 (August 1998): 243.

<sup>108</sup> Sandra Speedy, “Feminism and the profession of nursing,” The Australian Journal of Nursing 4.2 (1987): 20.

<sup>109</sup> Diane C. Viens, “A history of nursing’s code of ethics,” Nursing Outlook 37.1 (1989): 45.

<sup>110</sup> Johnstone, 25.

Australian nurses adhere to a Code of Professional Conduct<sup>111</sup> and a Code of Ethics<sup>112</sup>, both of which were developed by the co-operative efforts of The Australasian Nurse Registering Authorities, the Australian Nursing Council Inc, the Royal College of Nursing Australia and the Australian Nursing Federation. The Code of Conduct was published in 1995 and the Code of Ethics was most recently revised in 2002. The two were developed separately to achieve two distinctive aims. The Code of Conduct was to provide guidance, both for nurses and the members of the public, as to the minimum standards of conduct that could be reasonably expected from nurses<sup>113</sup>. The Code of Ethics was developed to give expression to the ideals of the nursing profession.<sup>114</sup> Most institutions generate their own codes of conduct which, in addition to articulating standards of conduct and ethics, will also contain vision statements and aims of the institution which makes more specific the nurses' obligations to identify with the institution.<sup>115</sup>

Opinions vary as to the value of codes of conduct for nursing. They are criticised as being representative of "the unargued presentation of the do's and don'ts of the profession" and "lack any coherent underpinning in terms of normative ethics" which amounts to "the reification of a more or less arbitrary series on moral intuitions".<sup>116</sup> Another criticism is that they extend a false sense of security to nurses. Nurses can be under the misapprehension that if they act according to "the code" they will be immune from prosecution for their actions. However, courts of law have rejected codes of conduct as authoritative. Nurses have been prosecuted for inadequate practice even when they consider that they have acted according to "the code".<sup>117</sup> Nurses must also accept that one consequence of professional status is acceptance

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<sup>111</sup> Nurses Registration Board NSW, Code of Professional Conduct for Nurses in Australia, 30 Dec. 2002 <[http://www.nursesreg.nsw.gov.au/con\\_code.htm](http://www.nursesreg.nsw.gov.au/con_code.htm)>

For a summary of this code see Appendix 1

<sup>112</sup> Royal College of Nursing Australia, Code of Ethics for Nurses in Australia, 30 Dec. 2002 <<http://www.rcna.org.au/content/codeofethics.pdf>> For a summary of this code see Appendix 2.

<sup>113</sup> Suzanne Cameron, "Development of a code of professional conduct for nurses in Australia," Collegian 2.3 (1995): 29.

<sup>114</sup> Code of Ethics, 2.

<sup>115</sup> Central Sydney Area health Service, Code of Conduct October (1999). This is a statement of the obligations that the employee has to the employer and expresses some of the obligations that the employer has to the employee. The document also points out that it is to be read as an adjunct the existing governing professional standards. Catholic Health Australia, Code of Ethical Standards (Canberra: Catholic Health Australia, 2001). This document articulates a Catholic commitment to health care. It is divided into two parts. The first is an outline of the basic principles of health care as practiced in the Catholic tradition. The second section is a more detailed discussion on specific ethical issues that arise in modern health care.

<sup>116</sup> Andrew Edgar, "The value of codes of conduct," Ethical Issues in Nursing, ed. Geoffrey Hunt (London: Routledge, 1994) 148.

<sup>117</sup> Johnstone, 46.



of responsibility for one's actions. Nurses can no longer point to the doctor as "Captain of the ship" in matters of clinical judgement. The doctor's role has been altered to being a member of a health team which includes nurses who must participate in the decision making process to the capacity of their expertise.<sup>118</sup> In short, codes offer no certainty of protection in a legal defence and can be used as a means to prosecute a practitioner where is evidence of a breach of practice. Where institutional structures to support the implementation of codes of conduct are absent, Codes of Conduct bring added pressure to nursing practice.<sup>119</sup>

Some writers suspect that the desire to generate codes of conduct for nursing arises from simply the desire to enhance the perception that nursing is a true profession. Institutions are also required to produce codes of conduct as part of their accreditation process. Are codes merely accessories that hold little ethical weight beyond the paper they are written on? To characterise codes of conduct thus fails to do full justice to the intent of the writers of the various codes. Further, as has been argued, they do convey merit, in that they represent an objective means for assessing at least a minimum standard of action for an employee or an institution. However, when confronted with the evidence of the peripheral status of codes to the formation of good nursing practice, one is forced to entertain the possibility that the status of accessory may be approaching the truth, at least for some nurses.

The main limitation that codes of conduct represent to nurses is they fail to capture what it is that constitutes good nursing practice. They suggest a minimum standard for practice and at their worst contribute to a defensive attitude to nursing. Nurses who work with colleagues who rely on codes for a minimalist interpretation of nursing activity are rightly nervous of the quality of their work. It is especially troubling to hear the nursing code quoted as a reason to avoid activities.<sup>120</sup> These problems of practice, however, may not be directly attributable to shortcomings in the codes.

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<sup>118</sup> Elsie L. Bandman & Bertram Bandman, Nursing Ethics Through the Lifespan, 2<sup>nd</sup> ed. (London: Appleton & Lange, 1990) 35.

<sup>119</sup> Vered Biton, "The relationship between the application of the nursing ethical code and nurses' work satisfaction," International Journal of Nursing Practice 9.3 (2003): 154.

<sup>120</sup> It is not uncommon for nurses to refuse to be involved in certain aspects of care by claiming that the practice is not "safe" (No. 1 in the Code of Conduct). They think that they are excused from participating in procedures they are not familiar with under the guise of concern about patient well-being. However, a complete understanding of the demands of safe practice reveals that the nurse is required to "maintain the competence necessary for current practice". A nurse has no defence for refusing to act on the grounds of safety, if it is revealed that the nurse has failed to take the appropriate measures to keep his or her practice current.

Rather it is more likely a problem with the nurse or with the way the code has been has been communicated or implemented in past.

These considerations aside, codes of conduct are an important part of the structures that nurses rely on to inform their activities. Their strength is that they, more than consequentialism or principlism, address the nurses "ethical mandate".<sup>121</sup> This mandate relates to the specific aspect of patient needs that nurses bring their expertise to. It is found not so much in the domain of cure. Rather the nursing mandate is directed towards helping patients as they respond to their illness and implement their course of treatment. The nursing codes address specific nursing dilemmas and offer some assistance to nurses in their attempts to fulfil this aim. It is possible that the limitations of the codes may have more to do with the way they are promoted than their substance and they merit continuous attention to creative ways to incorporate them into the consciousness of all nurses.

### 3.4

E

#### **valuation of Nursing as a Science-Based Activity**

The biomedicalisation of nursing has not been without its critics. It is criticised as inadequate for the nursing practice because it focuses insufficiently on the experience of illness or disability.<sup>122</sup> Some advocate the rediscovery of a healing tradition for nursing which demotes an interest in the biosciences and promotes the relationship that nurses establish with their patients as central to the healing process. This is achieved by means of "touching, listening, crying, laughing, using music, dancing, using colours and holding/hugging".<sup>123</sup> The healer is one who can transform a "biotechnologically driven health care system into a personal, relationship-centred system".<sup>124</sup> Although it is suggested that human considerations can be combined with a scientific regime, a hostile attitude to a biomedical model for nursing is betrayed by

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<sup>121</sup> Gibson, 2004.

<sup>122</sup> B. Hedelin & I. Jonsson, "Mutuality as background music in women's lived experience of mental health and depression," *Journal of Psychiatric and Mental Health Nursing* 10 (2003): 317.

<sup>123</sup> Christine Jackson, "Healing ourselves, healing others," *Holistic Nursing Practice* 18.2 (2004): 74.

<sup>124</sup> Jackson, 68.

reference to the health care environment as one which exerts a “toxic” effect on nurses and renders them at risk of becoming an “endangered species”.<sup>125</sup>

Gortner defends the centrality of the sciences for good nursing practice. She argues that the values of “scepticism, disinterest and communality” which underpin a philosophy of science provide nursing with a means of achieving its humanistic goals.<sup>126</sup> She criticises the “social philosophy (that) has become increasingly popular as a conceptual base for contemporary nursing” which conceptualise humans as “social beings” rather than as “living organisms” and calls for a return to a realistic position about the focus of nursing activity.<sup>127</sup> Lauzon echoes her view and argues that there is no incompatibility between the human sciences and the natural sciences. She points out that the same scientific concepts of objectivity in investigation, systematic gathering of data and aims of predictability and control that have yielded knowledge about the natural or the inanimate world will yield knowledge of the human world and sustain an ethical and humane practice.<sup>128</sup> Barnard and Sandelowski affirm this position and argue that when people experience treatment as dehumanising it is a problem of technique rather than technology.<sup>129</sup>

There are many factors which make the retention of biomedical knowledge crucial to the continuing good practice of nursing. One of these is the ongoing proliferation of medical knowledge that continues to be generated by researchers. Nurses will be excluded from significant participation in health care provision if they neglect to maintain a sound biomedical knowledge base. A second factor is that once again infectious agents are presenting a serious threat to global health. This threat is explained by a cluster of features that have become characteristic of modern life: humans are living in close proximity to each other; international travel facilitates the spread of disease; the use of antibiotics has given rise to resistant organisms and there are increasing numbers of people with compromised immune systems which increases their susceptibility to infectious agents. Given these circumstances, nurses

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<sup>125</sup> Jackson, 67.

<sup>126</sup> Susan R. Gortner, “Nursing values and science: toward a science philosophy,” Image: Journal of Nursing Scholarship 22.2(1990) 102.

<sup>127</sup> Susan Gortner, “Nursing’s syntax revisited: a critique of philosophies said to influence nursing theories,” International Journal of Nursing Studies 30.6 (1993): 478.

<sup>128</sup> Sylvie Lauzon, “Gortner’s contribution to nursing knowledge development,” Image: The Journal of Nursing Scholarship 27. 2 (1995): 100.

<sup>129</sup> Alan Barnard & Margarete Sandelowski, “Technology and humane nursing care: (ir) reconcilable or invented difference?” Journal of Advanced Nursing 34.3 (2001): 367-375.

have significant contributions to make in the areas of health promotion, vaccination programmes and the implementation of hygiene and environmental control programmes.<sup>130</sup> In these uncertain times a third medical challenge is that of bioterrorism. Nurses need a working knowledge of the effects of the various biological agents that are used in such attacks and the interventions that are required. These include infection control measures, antibiotic treatment protocols, supportive treatments such as ventilation and parenteral therapy and monitoring of the infective process in the human body.<sup>131</sup>

Biomedical knowledge is not sufficient for good nursing, but it is necessary. That is to say, a biomedical account is not a complete account of what it means to be a nurse, but nursing cannot afford to depart from its traditional associations with the biosciences. Rafferty warns against a kind of nursing “fundamentalism” that drives the quest for cultural autonomy which may result in occupational isolationism.<sup>132</sup> An alliance with the biosciences demonstrates that nursing is a resilient profession, sufficiently secure in its own identity so that it can absorb knowledge from all relevantly useful sources and implement that knowledge for the benefit of the patient.

The accompanying ethical traditions that have arisen as a result of the dominance of science in western culture have also found a place in nursing culture. Nursing practice is enmeshed with medicine and is witness to the accompanying dilemmas that present themselves as a result of western medicine. Nursing practice is weakened if nurses act in a manner that suggests blindness to the moral implications of their role. However, the question as to whether the objectively derived and rationally explicated ethical frameworks of utilitarianism and deontology, or the developing body of codes of conduct, sufficiently sustain nursing practice must be posed. It has emerged from the preceding discussion that, with some qualifications, these frameworks do inform the moral tone of nursing activity. They give the nurse an appreciation of the influences that have contributed to nurses’ moral culture. They also identify moral issues. Notions of duty and utility are rich and complex. An

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<sup>130</sup> Syed A. Sattar, Jason Tetro & V. Susan Springthorpe, “Impact of changing societal trends on the spread of infections in American and Canadian homes” American Journal of Infection Control 27.6 4-21.

<sup>131</sup> Kevin P. O’Connell, Bernadette C. Menuey. & Dawn Foster, “Issues in preparedness for biological terrorism: a perspective for critical care nursing,” AACN Clinical Issues 13.3 (2002): 452-469.

<sup>132</sup> Anne Marie Rafferty, “Art, science and social science in nursing: occupational origins and disciplinary identity,” Nursing Inquiry 2 (1995): 145.

appreciation of these concepts enhances the nurse's ability to reflect intelligently on the range of ethical issues that present themselves in daily practice.

Bioethics provides a framework that assists practitioners towards a determination of good or right actions. Euthanasia, abortion, truth-telling, compulsory psychiatric treatment are "the key moral issues in health care"<sup>133</sup> and nurses are playing an increasingly significant role in assisting people to make determinations in these matters, particularly in regards to genetic counselling and organ donations.<sup>134</sup> Nursing ethics textbooks that examine the ethical dilemmas for nurses consistently identify these issues as the ones that present profound ethical challenges for nurses.<sup>135</sup> However, these issues are primarily medical issues. Although it is true that there are more roles for nurses to play in these areas, the roles themselves can be described as quasi-medical or at least one or two steps away from a more recognisably nursing role.<sup>136</sup> Nurses do not routinely have the power or the expertise to admit a person for psychiatric treatment or perform an abortion or harvest body organs for transplant purposes. Chambliss argues that bioethics is an ethic for medical practice but it fails to answer the questions nurses ask themselves about their practice. He writes:

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<sup>133</sup> Ian E. Thompson, Kath M. Melia & Kenneth M. Boyd, Nursing Ethics, 2<sup>nd</sup> ed. (Edinburgh: Churchill Livingstone, 1988) 93.

<sup>134</sup> Jack Hanford, "Guest commentary: bioethics for nurses from a faith-based perspective," Ethics and Medicine, 17.2 (2001) 69.

<sup>135</sup> Euthanasia, abortion suicide and quality of life issues are chosen by Johnstone. Johnstone, 290-421. Veatch and Fry discuss abortion, genetic counseling, psychiatric treatment, human experimentation, refusal of consent and treatment of the dying patient. Interestingly, although this is a nursing textbook, the dilemma describing treatment of the dying is entitled "The patient in conflict with the physician and family". The chapter is a discussion about the difficulties that a physician, rather than the nurse, encounters when caring for a dying patient. Veatch & Fry, 286-288. Fitzpatrick addresses the problems of euthanasia, abortion and genetic counseling. She makes the point that nurses rely on good character to make judgments about the kinds of actions they will participate in and to what extent their identification with an institution limits or enhanced their opportunities to do good. F. J. Fitzpatrick, Ethics in Nursing Practice: Basic Principles and Their Application (London: The Linacre Centre, 1988)133. Bandman and Bandman identify quality of life, prevention of harm, truth-telling, conflict of interest and choice of therapy as issues that nurses must confront in their moral deliberations. Bandman & Bandman, 4-5.

<sup>136</sup> This is a not uncontroversial point to make. Nurses debate amongst themselves as to what constitutes an authentic nursing role. When nurses move to administration or education or become involved in research there is divided opinion as to whether that represents an expansion of the nursing role or whether it is a quest for enhanced personal status by association with a role that is perceived as more prestigious. Chambliss describes it as "a kind of *drift to medicine*". Daniel F. Chambliss, Beyond Caring: Hospitals, Nurses and Social Organization of Ethics (Chicago: The University of Chicago Press, 1996) 78.

“For doctors, the dilemma may be, “Do we save this baby?” For nurses, the problem is, “How can I care for this baby who is needlessly suffering?” the doctor often decides; the nurse more often does.”<sup>137</sup>

Bioethics does not assist a nurse in establishing a moral tone for practice which aims to meet the needs of the person holistically. Questions of good practice based on a bioethical approach remain limited to “What must I do?” A nurse may do the right thing but if there has been no reflection on how to go about a particular action then the nurse will be rightly disturbed about whether a person has been attended to in the best possible way.

Science has also been a means to examine the activity of nursing with the result that nursing can be described in a systematic way. The generation of theories of nursing has been a qualified success. Some are more convincing than others with the consequence that some have been more readily applied and adopted than others. However, it appears that, despite widespread adoption of nursing models, there remains uncertainty and a level of ambivalence about the place of nursing models in clinical areas. Nurses are left confused when they are told that “students are no longer learning Roper, Logan and Tierney, they were (sic) learning Minshull”.<sup>138</sup> Nursing models may also be interpreted and applied to practice in ways that fail to represent the theory at their optimal. When nurses learn that their practice has not been a true reflection of the ideas of the theorists they can be left feeling foolish. This gives rise to comments such as “Roper Logan and Tierney was the be all and end all and then to find out that you hadn’t even been doing that right made me feel really bad”.<sup>139</sup> When models of nursing are adopted in a manner similar to fashion changes they fail to do the very thing they promise which is to offer a sense of certainty about nursing practice. When they undermine the self-confidence of practitioners they betray this promise even further.

There is some evidence that the increasingly sophisticated attitude to the activity of nursing has been accompanied by an anxiety that nursing has lost some quality that

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<sup>137</sup> Chambliss, 87.

<sup>138</sup> Peter Wimpenny, “The meaning of models of nursing to practicing nurses,” Journal of Advanced Nursing 40.3 (2002): 350.

<sup>139</sup> Wimpenny, 350.

did not lend itself to the quantifiable framework they were applying to nursing. Aita charts the vacillation expressed by leading American nurses who were excited by the possibilities that science represented to nursing but were concerned about the effect that a culture of science was having on nursing's moral core.<sup>140</sup> Traditionally, nurses had identified with the suffering of their patients through compassion, however, as aspiring professionals they assumed a posture of coolness and aloofness.<sup>141</sup>

The development of scientific theories of nursing has been dependent on adopting an attitude of detachment from the subject matter of nursing. This in turn has contributed not only to the professionalisation of nursing but the absorption of a professional culture within nursing. This professional culture is likewise dependent on the cultivation of a detached attitude to the practice of nursing.

Cocking and Oakley identify some of the problems that detachment presents to someone engaged in a professional practice and use nursing as one example. They argue that when detachment serves to advance the good practice of nursing, then a nurse, and presumably the practice of nursing, is not compromised.<sup>142</sup> This insight is echoed by Chambliss who describes nurses who are able to set aside feelings of distress in order to complete their care for the patient.<sup>143</sup>

Some argue that the development of professional ethics in nursing has been motivated by aspirations to professionalisation. It is as though by acquiring the trappings of professionalism, nurses become professional. Notions of professionalism aside, nursing is a sufficiently complex activity to warrant a coherently expressed ethic. Those who argue for the articulation of an ethic for nursing do so on the basis of the complex demands that the practice of modern nursing places upon its practitioners.<sup>144</sup> Nurses must decide on a daily basis as to the manner of their participation in a range of invasive, painful, sometimes disfiguring

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<sup>140</sup> Virginia A. Aita, "Science and compassion: nursing ideas 1940s-1960," Scholarly Inquiry for Nursing Practice: An International Journal 14.2 (2000): 115-138.

<sup>141</sup> Aita, 129.

<sup>142</sup> Dean Cocking & Justin Oakley, "The ethics of professional detachment," Journal of Law and Medicine, 7.2 (1999): 153.

<sup>143</sup> Chambliss, 71.

<sup>144</sup> Megan-Jane Johnstone, "Professional ethics in nursing: a philosophical analysis," The Australian Journal of Advanced Nursing 4.3 (1987): 14.

interventions and they need a systematically determined expression of a moral framework to direct their practice.

The development of a professional ethic arises amongst a professional group, not simply on the basis of the possession of a distinct body of knowledge, but “when highly valued aspects of human life depend on such expertise” and when “acquiring such expertise requires lengthy theoretical education”.<sup>145</sup> This occurs when the community recognises that certain sacrifices have been made for the acquisition of such an education. As this education is to be applied for the common good, the community confers a certain licence on the professional group to set its own normative standards for practice. The community must be assured however, that the profession is sufficiently detached from its own interests to give proper attention to the interests of those whom they serve.

The community is likely to place restrictions on a profession’s licence to determine the form of its practice if there is a perception that the profession is making “an over-ambitious”<sup>146</sup> claim for its mandate to practice. In short, the development of a professional ethic is dependent on the demonstration of certain levels of detachment from personal interests and the pursuit of ongoing education to maintain the mandate for professional licence and self determination.

Nurses balance detachment and engagement in their practice<sup>147</sup> although this is not easily achieved.<sup>148</sup> Nurses understand the need for such a balance yet they comment that they receive little guidance in their formal education as to how to achieve a balance. They attribute their ability to strike a balance between detachment and engagement to their upbringing and background which contributed to their being able to deal with difficult situations. They also recognise that “the self which is private person and the self which is nurse are constantly interacting and changing one

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<sup>145</sup> David T. Ozar, “Profession and professional ethics,” Encyclopaedia of Bioethics, ed Warren T. Reich, rev. ed., vol 3 (New York: Simon & Schuster Macmillan, 1995) 2103.

<sup>146</sup> Dingwall & Allen, 64.

<sup>147</sup> Betty Carmack, “Balancing engagement and detachment in caregiving,” Image – The Journal of Nursing Scholarship 29.2 (1997): 139-143.

<sup>148</sup> Angela Henderson, “Emotional labour and nursing: an under-appreciated aspect of caring work,” Nursing Inquiry 8.2 (2001): 134.



another”<sup>149</sup> therefore the activity of nursing impinges on the personal development of the nurse.

There is some acceptance that the model of detachment necessary to foster the formation of a professional ethic need not make a complete claim on the person in order to fulfil the role of a professional. This is particularly so in nursing. The nurse properly distances him or herself from inclinations that would deliver personal advantages but this need not stop the nurse from gaining proper levels of satisfaction in his or her work. Strategies employed in the past such as task allocation and frequent rotation from ward to ward which were thought to foster detachment from the carrying out of disturbing tasks were found to increase the levels of anxiety and reduce the sense of meaningfulness thought to be derived by the establishment of relationships with patients that nurses gained from their work.<sup>150</sup> Patients also prefer to be cared for by nurses who are engaged rather than detached. Engagement is characterised as helpfulness, cheerfulness kindness, and as being consultative, available, friendly and gentle.<sup>151</sup> Thus a level of intimacy or engagement with patients is necessary for the practice of good nursing. It is recognised that there is a cost to clinical judgement of over-involvement with patients and some criticism of nursing models that advocate intimate relationships with patients that do not comment on the possibility of over-involvement.<sup>152</sup>

This presents a dilemma for nurses. On the one hand nurses claim to have particular knowledge on the experience of illness based on their engagement with it. Carper identifies four “patterns of knowledge” that form the basis of nursing’s “body of knowledge”.<sup>153</sup> She describes “personal knowledge” as that which nurses acquire on the basis of their relationships with patients. They come to understand how the illness is affecting the patient and they use that knowledge to initiate therapeutic interventions. This form of knowledge is “the most problematic” and “the most difficult to master and to teach” in addition to being the “most essential to understanding the

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<sup>149</sup> Henderson, 135.

<sup>150</sup> Angela Williams, “A literature review on the concept of intimacy in nursing,” Journal of Advanced Nursing 33.5 (2001): 661.

<sup>151</sup> Debbie Kralik, Tina Koch & Karen Wotton, “Engagement and detachment: Understanding patient’s experiences with nursing,” Journal of Advanced Nursing 26.2 (1997): 399-407.

<sup>152</sup> Williams, 664.

<sup>153</sup> Barbara A. Carper, “Fundamental patterns of knowing in nursing,” Advances in Nursing Science 1.1 (1978): 13-23.

meaning of health".<sup>154</sup> Lawler also describes the particular knowledge that nurses have of the body as a result of their engagement with the body and calls this knowledge "somology". She claims that this knowledge is acquired on the basis of the daily intimate care that nurses proffer to patients. Both claim that this special knowledge about the patient substantiates the claim that nursing is a distinctive professional group. On the other hand nurses also rely on a scientific account of their practice which depends on detachment and the cultivation of an objective account of both nursing and the patient to substantiate claims of professionalism.

There is a measure of truth in both claims which is problematic while ever nursing remains fixed in a scientific framework because science cannot admit seemingly contradictory positions and still retain a level of coherency. Nurses have demonstrated that they are able to be scientific in their approach to their work and make judgements about the degree of involvement that best serves their work and the patient but they do not derive this ability solely from science. It is derived from an amalgam of beliefs, environment, upbringing and culture. Nurses need to be able to give a systematic account of this blend of influences but a scientific framework has not proved to be fully sufficient for the task.

### 3.5

C

#### **onclusion**

The philosophy of science has considerably advanced the practice of nursing. It has contributed to a clearer understanding of the activity of nursing, and has been the means to raise practice to increasingly sophisticated levels. It is not, however, a complete account of what it means to be a nurse. Science does not fully describe nursing activity nor do the ethical frameworks that apply to bioethical dilemmas provide complete guidance in either the areas of nursing actions. Science has also been less than adequate in terms of supporting the development of a culture of nursing that is able to foster the development of good nurses. In terms of influence in nursing culture, science can at best be relied upon to be clear about what nurses should or should not do. A scientific framework gives no insight into how scientific knowledge can be interpreted and put into practice, both in order for nurses to think

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<sup>154</sup> Carper, 18.

of their work meaningfully and in order that patients' experiences of illness can be tempered by the way that nurses attend to them.

The response to the perceived limitations of a scientific framework for the underpinning of nursing was a turn to an ethic of care as a means to restore the emotional element of nursing activity to a prominence which some, although not all, nurses thought had been eliminated from nursing.

## 4 Nursing as a Care-Based Activity

The concept of care is foundational to community life and has particular applications in nursing. Care is the natural focus of interest within nursing because care is the common thread contained in all nursing activity<sup>1</sup>. Nurses have turned to the care theorists to articulate a place for the emotional aspect of nursing that both contextualises and personalises nursing activity.<sup>2</sup>

The concept of care contains within it a range of senses and qualities. It can be thought of as a burden where one might refer to care as troubles or worries or as an action.<sup>3</sup> A person can also be described as caring. Nursing contains within it this threefold sense of care. The burden of care can be the motivation for performing an act of care that means that one is described as a caring person. There has been an evolution in the meaning of care from taking thought of another to a notion that communicates a form of love<sup>4</sup>.

There are some distinctive strands of thought that can be identified in the nursing literature on care. The feminist perspective reinterprets the meaning of care and relocates it within the female domain. Noddings and Gilligan describe caring as a characteristically female activity. Nurse academics have applied this approach to nursing with the aim of strengthening the claim that nursing is a profession with its own unique body of knowledge.

Cooper states that nurses possess a “special intimacy with suffering” which is why nurses must not only “value” but also to “vocalise” their knowledge.<sup>5</sup> Davies

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<sup>1</sup> Barbara A. Carper, “The ethics of caring,” Ethical Issues in Nursing, ed. Peggy L. Chin (Rockville, Maryland: An Aspen Publication, 1986) 1. Patricia Benner & Judith Wrubel, The Primacy of Caring: Stress and Coping in Health and Illness, (Menlo Park, California: Addison-Wesley Publishing Company, 1989) 2. Philip J. Warelow, “Is caring the ethical ideal?” Journal of Advanced Nursing 24 (1996): 655.

<sup>2</sup> Suzanne Jaeger, “Teaching health care ethics: the importance of moral sensitivity for moral reasoning,” Nursing Philosophy 2.2 (2001): 131-142.

<sup>3</sup> Stan van Hooft, Caring: An Essay in the Philosophy of Ethics (Colorado: University Press of Colorado, 1995), 29-31. Warren Thomas Reich, “Care; History of the notion of care,” Encyclopedia of Bioethics, ed. Warren T. Reich, rev. ed., vol. 1 (New York; Simon-Schuster Macmillan) 319.

<sup>4</sup> Margaret J. Dunlop, “Is a science of caring possible?” Journal of Advanced Nursing 11 (1986): 662.

<sup>5</sup> Fiona Cooper, “Nursing as a profession,” Contemporary Nurse 10 (2001): 203-204.

expresses concern about the uncritical embrace of a form of professionalism that seeks to entrench occupational power. In her view this perpetuates a chauvinistic model which renders professional activity as essentially competitive. She is sympathetic to the idea that nurses may have some unique insights into the notion of care but she suggests that they ought not to regard themselves as holders of a "monopoly of care".<sup>6</sup> She agrees that the notion of care is at the core of the nurse's identity, but suggests that a more generous and inventive approach to the formation of a professional identity may result in a more proper and helpful account of care.

This does not mean however, that there is a unified interpretation of the meaning or significance of caring within nursing. There are many different ways of thinking about the concept of care in the nursing tradition. These differences reflect the various pressures and influences that have been exerted on nursing from classical times to the present.

Caring may be regarded variously as the domain of a spiritual, psychological, bodily or feminist inquiry. An examination of the spiritual nature of care reveals a progression from a classical account of care with an emphasis on orthodoxy to the rather more nebulous account of spiritual care found in contemporary descriptions. The feminist interpretation of caring has delivered to nursing a means both to form an ethical basis and to analyse the practice of nursing. The bodily and psychological aspects of care have been the focus of considerable nursing research. This endeavour has yielded much material for theorising and for the formation of models of care. A spiritual account of care has underpinned nursing's claim to be a vocation, the latter two accounts of care have contributed to nursing's claim for professional status. The concept of care as it applies to nursing has been appropriated for its spiritual qualities, its applicability for the underpinning of an ethical formation for nursing and the psychological appreciation of care has lent itself to a scientific and ultimately professional notion of care.

These notions are not without their limitations. The fragmentation of contemporary spirituality does not lend itself to the formation of a coherent moral basis for the formation of the value of care. It is arguable whether the feminist ethic of care can be

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<sup>6</sup> Celia Davies, "A new vision of professionalism," Nursing Times 13.92 (1996): 56.

appropriately applied to nursing which in some ways can be regarded as aberrantly dominated by females since the last century. Finally, a scientific account of care is a method of inquiry which results in a diminished explanation of the concept of care.

#### 4.1

O

### **Origins of a Philosophy of Care**

The articulation of a philosophy of care in nursing has been dependent on the absorption of the ideologies of phenomenology and feminism. These two frameworks have challenged the dominance of rationally derived and objectively determined knowledge and, it is claimed, have been a means to identify the less quantifiable aspects of nursing activity that have not been well described by science.

#### **Phenomenology**

Phenomenology has its origins in the work of German philosophers Edmund Husserl (1859-1938) and his student Martin Heidegger (1889-1976).<sup>7</sup> The essence of phenomenology is to encourage an engagement with the world so that the observer gains an awareness of the essence of that which is being observed. Husserl suggested the practice of “bracketing” which is a process of suspending one’s own essence from the process of observing phenomena in order to understand what is observed more fully.<sup>8</sup> Heidegger departs somewhat from the position articulated by Husserl in that his work is described as hermeneutic phenomenology. He rejects the need to bracket oneself from phenomena in order to discern its essence. Heidegger argues that the connected nature of existence demands from the observer an interpretation which takes account of the observer’s existences. Hans-Georg Gadamer (1900-2002), another exponent of hermeneutic phenomenology, explains that “to try to eliminate one’s own conceptions in interpretation is not only impossible, but manifestly absurd”.<sup>9</sup>

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<sup>7</sup> Marilyn Annells, “Hermeneutic phenomenology: philosophical perspectives and current use in nursing research,” *Journal of Advanced Nursing* 23.4 (1996): 706.

<sup>8</sup> Annells, 706.

<sup>9</sup> Annells, 707.

Nurses have, therefore, engaged in phenomenological research because it is perceived that phenomenology assists in the disclosure or the revelation of aspects of nursing activity such as caring that had hitherto remained difficult to capture in scientific research. Some of the aspects of nursing that are particularly suited to examination by phenomenological means are “the experiences of nurses and patient existing in a health attainment/maintenance environment; a valuing of whole persons who create personal meanings; a consideration of contextually meaningful experience; a seeking to understand daily living and practical concerns, and the consideration of nurses and patients as entities of beings of Being”.<sup>10</sup> Significantly, the notion of “truth” is regarded as not accountable to objective assessment but “as a contingent social construction”.<sup>11</sup>

In a further examination of phenomenology in nursing, Annells identifies three classifications of phenomenology that can be applied to distinct aspects of nursing practice.<sup>12</sup> A **positivist** approach retains the notion of bracketing and adopts a position of “modified realism”. **Critical theorism** applies the work of Jurgen Habermas (1929- ) to phenomenology which makes an appeal for “emancipatory social science inquiry”. Nurse researchers have made use of this form of inquiry to assist co-participants in an emancipatory process against oppressive forces in their lives. **Constructivism** emphasises the relative nature of truth and the ongoing nature of interpretive activity in which the researcher is involved in.

### **Feminist Care Theory**

Feminist care theory has emerged from the works of Carol Gilligan and Nell Nodding. Their research has been appropriated by nursing because they describe the existence of a particularly female way of acting ethically which contrasts with a male understanding of ethics. Carol Gilligan’s aim in her research was to hear the female voice in terms of moral development.<sup>13</sup> Her project emerged from her association with a similar project to examine the ethical development of children but whose subjects were confined to young boys. These young boys consistently articulated their ethical development in terms of justice. When this tool of moral development was used to

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<sup>10</sup> Annells, 709.

<sup>11</sup> Annells, 712.

<sup>12</sup> Marilyn Annells, “Evaluating Phenomenology: usefulness, quality and philosophical foundations,” *Nurse Researcher* 6.3 (1999): 13.

<sup>13</sup> Carol Gilligan, *In a Different Voice* (Cambridge, Massachusetts: Harvard University Press, 1982) 2.

measure female moral development, girls were identified as lagging behind the boys. When Gilligan interviewed young girls she identified themes of care and relationship that informed their ethical decision making processes. At the start of her writing she says that this other form of ethical reasoning need not necessarily be limited to the female<sup>14</sup> and should be understood as a thematic study where care is articulated more frequently by females. However, as her writing progresses, she identifies the ethic of care with a female way of doing things and contrasts this with the voices of men that have been listened to for centuries.<sup>15</sup>

There is, however, the seed of trouble that care represents to feminists contained within her writing. She records the early feminist's declaration that liberty is the mother of virtue and "self-development is a higher duty than self-sacrifice"<sup>16</sup>. Her subjects then express the tension they feel, as they contemplate an action that is not caring. They are uneasy at the thought of behaving selfishly. Selfishness is, in the minds of her subjects, at odds with care. On the one hand, to advance an ethic of care as essentially female recognises values the unique contribution of women to the well being of humanity. On the other hand, feminists are suspicious of care because care is nourished by the values of selflessness and service for these two qualities make women vulnerable to the exploitation that has characterised male/female relationships through history<sup>17</sup>. The advancement of women in these terms only becomes possible with the jettisoning of care.

Another version of an ethic of care that is uniquely, almost mysteriously female and certainly superior to other ethical traditions, which can now be labelled male is found in the writing of Nell Noddings. Noddings' sphere of interest was in education and her intention was to describe a feminine ethic.<sup>18</sup> She regarded teaching as essentially relational and described it in terms of engrossment and immersement in the interests of the other. In this she relies of the insights of Buber who describes the 'I-Thou' relationship between people as having the overarching priority in ethical considerations. This position necessarily involved rejection of a rule or principle based system of ethics.

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<sup>14</sup> Gilligan, 12.

<sup>15</sup> Gilligan, 172.

<sup>16</sup> Gilligan, 129.

<sup>17</sup> Michael J. Quirk, "Ethics: moral epistemology," *Encyclopedia of Bioethics*, ed. Warren T. Reich, rev. ed., vol. 2 (New York: Simon & Schuster Macmillan, 1995) 733.

<sup>18</sup> Nell Noddings, *Caring: A Feminine Approach to Ethics and Moral Education* (Berkeley: University of California Press, 1984).



At the outset of her discussion Noddings rejects any notion of the divine<sup>19</sup> and presents the reader with a secular account of care. She does, however, rely on mystery which provides her account of care with the same unarguable nature that an account of care that is reliant on a notion of God possesses. Her description of the carer and the one cared for reveal an exchange on a level that is elevated beyond mere social exchange. She says that the “one-caring”, as she gives to the other, is cared for by the “one-cared-for”. Thus, all people need to know how to be cared for, as well as how to care. This kind of metaphysical exchange is what sustains and enables the “one-caring” to continue to be engrossed and immersed in the experience of the other without being drained in his or her ability to give.

Noddings relies on the classical myth of Ceres (Demeter) and Proserpine (Persephone) to explain the essentially female nature of care. Ceres and Proserpine were mother and daughter. Proserpine was kidnapped by the God Zeus and taken to the underworld (Hades) to live. Ceres had responsibility for the care of the earth, but so distraught was she by the loss of her daughter that she ceased her care of the earth and crops failed. She persuaded Zeus to return her daughter to her for half of the year. From then on Proserpine’s presence with her mother was the cause of summer and winter and her return to Hades brought autumn and winter to the earth. This myth allowed Noddings to align her insights with an overarching myth for western culture and made some connections between care and the female nature. In this way Noddings succeeded in keeping care within the female domain and describing it in terms which made care seem superior to other approaches to ethics. She argues against a systematic, universal system of ethics and describes ethics in terms that elude rational analysis. It is hard to argue against an ethic of care in purely rational terms when the locus for care is in the female and described in mysterious terms.

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<sup>19</sup> Noddings, 4, 97.

## 4.2

T

### **Theories of Nursing as a Care-Based Activity**

#### 4.2.1

N

#### **Nursing as Sensitive to Culture**

Madeline Leininger's contribution to care theory has been twofold. She was an early researcher in investigating the centrality of care for nursing practice. Second to that she perceived at an early stage in her nursing career that ethnicity was a significant and frequently overlooked factor in the way that nurses organised their care for patients.<sup>20</sup> Subsequently the focus of Leininger's work has been to bring a cross-cultural emphasis to the provision of care in nursing. Her theory of Culture Care Diversity and Universality depends on the nurse being guided by the cultural beliefs of the person. Nursing actions or interventions are then shaped on the basis of cultural expectations in order for the person to perceive that what is being done for him or her is care in his or her own terms.

The key concepts in Leininger's theory of nursing are "care" and "culture". "Care" is described as an abstract phenomenon to do with meeting the needs of other humans who are not in a position address their own condition. As such it is a powerful human motivation. Care also refers to the acts that assist and support humans in their need. "Culture" is the learned beliefs that emerge as patterns of living for distinct groups of people. Culture informs or determines the way people care for each other. Within cultures "generic care systems" develop that utilise indigenous remedies or practices.<sup>21</sup>

Leininger's theory of care is presented in the Sunrise Model which represents the social factors that influence care and health as a semi-circle as a means of depicting

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<sup>20</sup> Alice Z. Welch, Judith E. Alexander, Carolyn J. Beagle, Pam Butler, Deborah A. Dougherty, Karen D. Andrews Robards Kathleen C. Solotkin & Catherine Velota, "Culture care: diversity and universality theory," *Nursing Theorists and Their Work*, 4<sup>th</sup> ed. Ann Mariner Tomey & Martha Raile Alligood (St Louis: Mosby, 1998) 439.

<sup>21</sup> Welch et al, 445-446.

"the rising of care"<sup>22</sup> in addition to a second semi-circle which represents the multiple caring systems developed by cultures to meet health needs.<sup>23</sup>

By its very nature Leininger's model has a wide applicability and has been used to study more than one hundred cultures with more studies in progress.<sup>24</sup> It has been criticised however, for its objective assumptions about the gathering of information by which it is assumed that interactions between health workers and individuals can avoid overtones of inequality in the gathering of culturally significant information.<sup>25</sup>

#### 4.2.2

N

##### **nursing as Scientific Care**

Jean Watson further developed theories of care in nursing. She regards care as the moral underpinning for the activity of nursing and advances the notion that professional nursing care is achieved by a weaving together of the sciences and humanities in order to achieve a holistic understanding of care. She appropriated psychological insights from Carl Rogers who emphasised the therapeutic benefits of relationships. The influence of Maslow can be detected in her inclusion of lower order and higher order needs. Her first book, *Nursing: The Philosophy and Science of Caring*,<sup>26</sup> was published in 1979. Other books have been *Nursing: Human Science and Human Care-a Theory of Nursing*<sup>27</sup> and more recently *Assessing and Measuring Caring in Nursing and Health Science*.<sup>28</sup> She has continued to contribute to nursing philosophy with various books and papers.

Significantly, Watson makes a distinction between care and cure. She typifies medicine as being more concerned with cure and nursing with care thus, in her view, adding her voice to others who claim that a systematic articulation of the claim to

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<sup>22</sup> Marilyn King & Andrea Averis, "The application of Leininger's Sunrise Model to the culturally appropriate care of indigenous Australians," Nursing Theory in Australia: Development and Application, ed. Jennifer Greenwood Sydney: Harper Educational Publishers, 1996) 185.

<sup>23</sup> M. M. Leininger, Culture Care Diversity and Universality: A Theory of Nursing (New York: National League for Nursing Press, 1991) 43.

<sup>24</sup> Welch et al, 453.

<sup>25</sup> King & Averis, 208.

<sup>26</sup> Jean Watson, Nursing: the Philosophy and Science of Caring (Boston: Little, Brown, 1979).

<sup>27</sup> Jean Watson, Nursing: Human Science and Human Care (Norwalk, Conn: Appleton-Century-Crofts, 1985).

<sup>28</sup> Jean Watson, Assessing and Measuring Care in Nursing and Health Science (New York: Springer Pub., 2002).

care is further cause to recognise nursing as a distinct profession of care. Latterly her work has become increasingly post-modern. She has rejected the limitations of a linear approach to theorising and prefers to move towards the establishment of a more open system of knowledge development which holds within it the means to cope with change and redefines the demands of nursing for the coming eras.

In Jean Watson's influential book *Nursing: The philosophy and science of caring*, her opening statement is that for nurses, 'change is the order of the day'<sup>29</sup>. That having been said care remains, for Watson, a core activity. However, in her terms the notion of care changes from containing a clinical, therapeutic and body-centred focus, to one that is disembodied, relational and involved in the patient's world. The main sphere of the nurse's interest must become, in Watson's view, conducted at the psychological and relational level. Watson does not reject the biophysical nature of nursing activity, but in the name of holistic care, elevates the most mundane of activities, even eating, to a sociological, developmental and relational act. Watson introduces her section on nutritional needs by directing the reader's attention to the significance of food as it relates to "personality and social development"<sup>30</sup>. This is something of a departure from everyday nursing practice which has traditionally concentrated on of the importance of nutrition for its own sake.

Watson identifies ten "carative factors" as the components of care. They are the development of relationships by effective communication; sharing of feelings; adoption of the nursing process to solve problems effectively; education of patients; providing support; the meeting of the whole range of human needs and, perhaps most elusively fostering the patient's participation in his or her own ontological journey.<sup>31</sup> They have been articulated to identify a philosophical basis for the science of caring in nursing and are grounded on the belief that humans are at their best when they help each other and that hope is essential to a sense of well being. Watson believes that it is possible to cultivate suitable sensitivities in nurses by education to foster a will to help and to nurture hope in the lives of patients.

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<sup>29</sup> Jean Watson, *Nursing: The Philosophy and Science of Caring* (Boulder, Colorado: Colorado Associated University Press, 1985) 1.

<sup>30</sup> Watson, 113.

<sup>31</sup> Tracey J. F. Patton, Deborah A. Barnhart, Patricia M. Bennet, Beverley D. Porter, & Rebecca S. Sloan, "Jean Watson: philosophy and science of caring," *Nursing Theorists and Their Work*, eds. Ann Marriner Tomey & Martha Raile Alligood (St. Louis: Mosby, 1998) 145.

As Watson's framework for nursing has become more abstract it has increasingly difficult to apply in clinical situations. In a recent article on the place of love in nursing Watson argues that love is a central feature in nursing practice and the expression of love in nursing reasons that this represents a return to an authentic nursing. The following is characteristic of her style:

'When a nurse enters into a patient's room, a magnetic field of expectation is created. In this deeper, more expanded way of thinking about the power, beauty, and energy of love, a *caring moment* becomes an energetic vibrational field of cosmic love that radiates reciprocity and mutuality, which transcends time, space, and physicality confirming and sustaining our humanity and our connection with the Levinas' *Infinity* of the entire universe.'<sup>32</sup>

It would be easy to mock the flowery language and to dismiss such reflections as the ponderings of an academic who has been away from practice for too long. Her writing, however, deserves more serious attention than that. When the act of nursing is described in this way the nurse is, in a sense, deified. Watson is indicating that the act of caring joins the nurse to the infinite. In doing so, the nurse becomes a kind of cosmic force. This is a different position to take from traditional Christianity where the act of love or compassion is modelled on the love that the creator has for humanity because the person retains his or her humanity. The kind of transformation that might occur has to do with character transformation. Perhaps the person becomes a little more god-like but the carer always retains his or her humanity. The act of deifying nurses has the corresponding effect of dehumanising them at the same time<sup>33</sup> with the accompanying consequence of exaggerating the difference between the patient and the nurse which is clearly counter to her intent.

#### 4.2.3

N

#### **nursing as Intuitive Practice**

A third account of nursing as a care-based activity is to be found in the work of Patricia Benner who has, in a sense, applied Gilligan's work to nursing as Nodding's applied it to education. The focus of her research was to give an account of the

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<sup>32</sup> Jean Watson, "Love and caring: ethics of face and hand-and invitation to return to the heart and soul of nursing and our deep humanity" *Nursing Administration Quarterly*, 27.3 (2003): 201.

<sup>33</sup> I am grateful to a work colleague for this insight.

embedded knowledge that nurses demonstrate in their daily work yet do not document or record very well. The other goal was to analyse that knowledge and to show that nurses develop unique insights on care that are unavailable to other health care workers.

Benner's book *From Novice to Expert*<sup>34</sup> has been enormously influential within nursing. She identifies three main levels of practice within nursing that reflect stages of professional development. They are the novice or beginner, the competent and the expert. The novice nurse exhibits a formal pattern of knowledge application. The competent nurse expresses her decision-making practices formally but also shows evidence of mastery in her clinical situation. The expert practices at an almost intuitive level. Her knowledge is so embedded within her, so much a part of her that she has difficulty articulating her reasons for her actions, yet she is rarely wrong. She simply knows. Benner's insights can be used as a means to challenge the dominance of managed care in nursing. Whittemore makes the economic argument that, where managed care fragments nursing services, a nurse's ability to know the patient is impeded and may result in an increase in costs to the health system. Whittemore argues that nurses who do not "know the patient" make judgements that "err on the cautions side, make a more conservative decision and possibly contribute to an increased cost".<sup>35</sup>

Benner has achieved an authoritative status within nursing because she describes a recognisable phenomenon within nursing. Many nurses practice at different competency levels. There is no shortcut to expert status and not all nurses become expert in Benner's terms. The terms do not reflect an automatic progression. Some new graduates may very rapidly demonstrate expert qualities while some nurses of long standing may never progress beyond competency. A particular emphasis in her writing is that no one becomes an expert without being embedded in practice.

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<sup>34</sup> Patricia Benner, *From Novice to Expert* (Menlo Park, California: Addison-Wesley Publishing Company, 1984).

<sup>35</sup> Robin Whittemore, "Consequences of not *knowing the patient*," *Clinical Nurse Specialist* 14.2 (2000): 79.

## 4.3

E

### Effects on Nursing Practice

#### 4.3.1

T

#### The Secularisation of Care

Traditionally, Western culture has held that the act of caring for another human being in need was inherently spiritual. This belief finds its origins in classical philosophy, mythology and Christianity. The philosopher Seneca taught that when humans care they are placed “on a level with God”. In the Greek creation myth it is the goddess Care (Cura) who fashions the first human and who is given the responsibility of nurturing humans while they are alive.<sup>36</sup> It was thought that when humans cared for each other they were behaving like gods.

Christian teaching concurs that caring is a spiritual activity. For the Christian, care is both an expression of the divine in the carer and a recognition of the divine in the person being cared for. Therefore any lowly or mundane task performed for another person becomes, by this account of care, infused with sacred significance. Hanford thinks that the ideals of nursing expressed by Florence Nightingale reflect a Christian ethos of care and service and are the ones that confer on nursing an enduring and sustaining ethic.<sup>37</sup>

The notion of vocation has been linked to a conviction that the task being undertaken is in response to the call from God. This sense of vocation is conveyed by the words of Martin Luther, the Christian reformer, who said “God himself will milk the cows through him whose vocation that is”<sup>38</sup> and it has been expressed in the convictions of many nurses in history. Bradshaw laments the current departure from the Nightingale ideal that considered nursing to be a vocation or a calling. This sense of calling was “grounded in an objective moral framework”<sup>39</sup> that underpinned the ethos of nursing. Belief in a deity lent coherency to the notion that caring for another person was, of itself, a spiritual act and an extension of one’s belief in the reality of a divine being. It

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<sup>36</sup> Warren Thomas Reich, “Care,” *Encyclopaedia of Bioethics*, ed. Warren T. Reich rev. ed., vol. 1 (New York: Simon-Schuster Macmillan, 1995) 320.

<sup>37</sup> Hanford, 74.

<sup>38</sup> A. Campbell, “Nurses and theology: the professional spirit,” *Nursing Times* 81.17 (1985): 24.

<sup>39</sup> Ann Bradshaw, “What are nurses doing to patients? a review of theories past and present,” *Journal of Clinical Nursing* 4.2 (March, 1995): 89.

was the physical, bodily and emotional care that the nurse gave to the patient that was considered a spiritual act that arises from this traditional framework.

Some reference has been made to Nightingale's spirituality as one that might sustain modern nursing. Nightingale espoused Christian beliefs, however, closer examination of her beliefs reveals them to lack coherence. She was raised a Unitarian, which is part of the non-conformist tradition which partly explains her lifelong determination to live according to her own vision. She is described as possessing a fervent faith combined with an "intense egotism" that fuelled the individualistic zeal for reform prevalent at the time.<sup>40</sup> Nightingale lacked interest in organised religion; was drawn to a more mystical expression of her faith but was also deistic in that she scorned prayer as a means to address the social ills of her day.<sup>41</sup> It is not possible to hold these three patterns of spirituality together in a coherent way<sup>42</sup> and attempts to integrate a contemporary spirituality into modern nursing based on her writings have resulted in a level of confusion about spiritual care amongst nurses that reflects Nightingale's theological confusion. Macrae's analysis of Nightingale's spirituality demonstrates this point. She writes that Nightingale speaks to today's nurses because her writing contains a mystical element that describes the possibility of a union with God through maintaining harmony between one's inner voice and the work that one does. The outcome is that a nurse "may put aside desire for specific results and focus on the quality of nursing itself"<sup>43</sup> (Macrae's words, not Nightingale's). However, when one becomes one's own reference point, both in the spiritual and the professional life, it becomes impossible to make an objective assessment of either the wisdom or the standards of one's care. Nurses will find that they may claim to be acting in accord with their inner voice in the way that Nightingale recommended but would be failing in achieving the kind of standardisation in practice that Nightingale also recommended.

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<sup>40</sup> Hugh Small, Florence Nightingale: Avenging Angel (New York: St. Martin's Press) 6.

<sup>41</sup> Janet Macrae, "Nightingale's spiritual philosophy and its significance for modern nursing," Image: Journal of Nursing Scholarship 27.1 (1995): 9.

<sup>42</sup> Deism is a belief in God that is derived from an appreciation of God as creator but does not accept the special revelation of God as found in the Bible. Therefore, God is perceived as a kind of master mechanic, removed from human affairs. Morality is determined by reference to what seems to be naturally right. It was influential in the 18<sup>th</sup> century. J. C. A. Gaskin, "Deism," The Oxford Companion to Philosophy, ed. Ted Honderich (Oxford: Oxford University Press, 1995) 183. It is distinguished from theism because theism is the belief that God is not only creator but also active in the world through special revelation. Richard P. McBrien, "Theism," Encyclopaedia of Catholicism (New York: Harper Collins Publishers, 1995) 1248. Mysticism is an experiential way of knowing God that, in some forms, is compatible with theism. It is not, however, compatible with deism as there is no place in deistic thought for engagement between God and humans. George I. Mavrodes, "Mysticism," The Oxford Companion to Philosophy, ed. Ted Honderich (Oxford University Press, 1995) 599.

<sup>43</sup> Macrae, 10.



Despite the separation of care based theories from a religious context, writers continue to explore spiritual concepts in nursing. Raatikainen discusses the importance of a sense of vocation to modern nurses. She describes a vocation, as “a deep internal desire to choose a task or profession which a person experiences as valuable and considers her own”.<sup>44</sup> In contrast to Nightingale, who thought that professional aspirations were incompatible with understanding nursing as a vocation, Raatikainen sees no conflict between understanding nursing as a vocation and a profession. She makes connections between the expert practitioner and those nurses who experience a sense of call. They characteristically demonstrate a lifetime commitment to their work, are motivated by altruism and service and demonstrate an astute understanding of their patient’s needs. Raatikainen appropriates spiritual experiences such as “hearing a voice”<sup>45</sup> and excluded any account of the divine for nursing without any perceived need for a deity in her investigations. The calling that Raatikainen describes is one that emerges from within the practitioner. The nurse feels compelled from within to choose a task that involves lifelong service to others. When a sense of vocation no longer includes a belief in a deity, the nurse needs to find her motivation from within. If the person was answering the call of the role of the nurse itself, the notion of a vocation might still have some currency. However, the notion of answering a call from oneself is too entangled with the servicing of one’s own aims in life that it is disqualified from being recognised as a calling.

Watson also affirms the spiritual aspects of human expression. There remains a concern to develop theories in ways that enable nurses to care for people at a spiritual level. Watson suggests that spiritual awareness is part of the nurse’s practice of care. She recommends that the nurse ought to be “familiar with the religious and spiritual influences in a person’s life” with particular reference to “world religions” not simply those of the “nurse’s country”.<sup>46</sup> She describes spiritual care as that which occurs when the nurse invites a chaplain to attend the patient or when the nurse arranges an environment that is more spiritually comforting to the patient by the provision of flowers, candles etc. Watson suggests that the nurse’s spiritual formation is aided by practices such as engaging with different cultures and the study of humanities, literature and the arts in order to arouse “compassion and other

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<sup>44</sup> Ritva Raatikainen, “Nursing care as a calling,” Journal of Advanced Nursing 25.6 (1997): 1111.

<sup>45</sup> Raatikainen, 1112.

<sup>46</sup> Watson, 92.

emotions”.<sup>47</sup> The nurse finds simple and practical guidance to caring for a patient’s needs from this approach. This is, however, an essentially rudimentary spirituality which finds its expression limited to ritualistic and aesthetic forms.

Van Hooft defines spiritual care as that which gives meaning to human life. He presents faith as a quality that is necessary to a meaningful life but which exists beyond a religious framework. Faith is an affirmation of the self that is “without rational justification and without external reassurance”.<sup>48</sup> He asserts that faith that makes claims about universal truths is one whose “time has passed” however much the “human quest for faith remains”.<sup>49</sup> Spiritual care, in his terms, is a means of completing the self-project that all are engaged in to lead meaningful lives. He writes:

“We do not enter into relationships with others from the basis of our formed individuality. Rather our individuality is formed by the relationships with others that we enter into”.<sup>50</sup>

Nursing takes the implications of the spiritual nature of care seriously. However spirituality as expressed in secular nursing is unconnected to belief in a divine being. This leaves the spiritual aspect of care in nursing in a confused and diminished state. Nurse writers have drawn on traditions within nursing such as the vocational ideal and Nightingale in addition to sophisticated portrayals of the spiritual nature of care to encourage nurses to aspire to advanced levels of sensitivity when dealing with their patient’s spiritual needs. However, by detaching a sense of spirituality from its moorings of orthodox theology nurses are ill-equipped to offer anything more than the most basic of assistance in spiritual matters. A secular interpretation of spirituality in terms of emotions and aesthetics does not seem to be sufficient to answer the call “to my infinity”.<sup>51</sup> The spiritual nature of care has the potential to sustain the motivation of nurses and to aid in the moral and ethical formation of the profession. However the portrayal of spiritual care offered by secular writers has simultaneously complicated that nature of spiritual care and limited the heritage that nurses have to draw on to deliver the kind of care that they may aspire to.

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<sup>47</sup> Watson, 10.

<sup>48</sup> Van Hooft, 69.

<sup>49</sup> Van Hooft, 73.

<sup>50</sup> Van Hooft, 91.

<sup>51</sup> Van Hooft, 95.

### 4.3.2

T

#### **he Feminisation of Care**

The claim that nurses possess a form of knowledge that is related to their status first as female and also as carers would, if true, support the case for regarding nursing as a profession its own right. The task for nurses was to demonstrate that they were in possession of a unique body of knowledge, amassed independently of other knowledge traditions. Up until this point nursing knowledge could only be described as derivatory. Nursing has been traditionally reliant on medicine for its scientific base with some input from the psychologists and sociologists for teaching in the humanities. Feminism provided the tool to identify unique insights into knowledge about caring that would deliver professional status to the occupation of nursing.

Feminism not only provided a means to identify and describe the “invisible” work of nurses it also became a voice to critique ways of working that did not seem to be caring. Feminism is first of all an ideology that values experience over theoretical deliberations. The claim is made that to formulate philosophies and value systems in this way is a particularly female way to operate. Correspondingly, abstract and hypothetical thinking is a male way of processing ideas. If this is accepted the feminist claim that there is such a thing as female knowledge which is an alternative to male knowledge and, depending on the circumstances, the knowledge system of choice can be accepted. It is clear why feminist ideology is attractive to those nurses who are committed to the advancement of nursing as a profession.

Feminism is not limited to the formation of new ways of knowing. It also encompasses a commitment to address issues of injustice made on the basis of gender.<sup>52</sup> In the past, nurse-doctor relationships have had a heavy, gender-loaded quality to it. They reflected the traditional male-female relationships and it is this weight of authority, by virtue of gender alone, that nurses now no longer accept. Within nursing this kind of activism is most often expressed as advocacy.<sup>53</sup> This is a very important value for nurses and it is most often expressed when nurses interact

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<sup>52</sup> Speedy, 21.

<sup>53</sup> Curtin, 12. Mary Ellen Wurzbach, “The moral metaphors of nursing,” Journal of Advanced Nursing, 30.1 (1999): 95.

with other members of the health team on behalf of patients. Increasingly nurses find themselves advocating at the level of policy formation and social commentary<sup>54</sup>.

In contrast to this view Berrigan asserts that nursing knowledge can be generated independently of other knowledge traditions.<sup>55</sup> She attributes the source of nursing knowledge as arising from patients, other nurses, educators and folklore. The attainment of professional status seems to necessitate a distancing from the medical profession and reliance on medical models of care. She repeats the feminist position on knowledge generation that a positivist appreciation of knowledge reflects male bias and that women possess knowledge about caring and relationships. This kind of knowledge is generally undervalued in society and within the medical community.

Dunlop has some sympathy with a feminist analysis of knowledge generation but expresses scepticism regarding the independent generation of nursing knowledge.<sup>56</sup> She thinks it is unreasonable to make a claim for nursing to be the exclusive domain of caring. It is demonstrably not so. Nurses are not the only people who practice care in the community. She is also uncertain as to whether a true science of caring can be fashioned. The works of Watson and Leininger have attempted to give a scientific account of care. There is no argument with their process but she is not sure that what they have described is care. Similarly Dunlop has no argument with the phenomenological examination of care but it is not clear that what has been produced is science.

Dunlop reminds the reader that Benner makes no claim to be presenting an account of care that can be universalised. By using exemplars and paradigm cases Benner has provided a picture of what it is to be a good nurse in a particular context. That picture has care at its centre with nurses providing care in ways that are visible to the detached observer and in ways that need to be uncovered by a more involved appreciation of the context of care.<sup>57</sup>

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<sup>54</sup> Darlene Weis & Mary Jane Schank, "An instrument to measure professional nursing values," Journal of Nursing Scholarship, 32.2 (2000): 203.

<sup>55</sup> Liz Berrigan, "Nursing practice draws upon several different ways of knowing," Journal of Clinical Nursing 7.3 (1998): 209-217.

<sup>56</sup> Dunlop, 665.

<sup>57</sup> An interesting and troubling further effect of the feminisation of nursing's self-conception is the fascination that some writers have demonstrated with the place of "magic" in nursing practice. Mary L. S. Hermann, "Keeping the magic alive in nursing care," Nurse Educator 28.6 (2003): 245. Verena Tschudin, "Myths, magic and reality in nursing: a personal perspective," Nursing Ethics 5.1

#### 4.4

#### E

### valuation of Nursing as a Care-Based Activity

Contrary to the hope that an ethic of care would deliver to nurses an authentic and therefore sound basis for claims of professional status, the care ethic is revealed to be an uncertain foundation on which to base claims of professional, or indeed moral, authority. Nurses cannot claim to be the distinctive community group that cares for two reasons. The first is that many other groups in the community provide levels of care and support to the sick. The care provided to patients in acute-care settings by families is vital to the well-being of patients and frequently invisible to the professionally trained nurse's eye.<sup>58</sup> Most of the care that occurs in our community still occurs in the domestic and informal setting thus the notion that nurses have a monopoly on care is justifiably challenged.

The second challenge to this claim is that sometimes nurses are uncaring to patients. Bradshaw points out that nurses have paid much attention to narrative accounts as to how they deliver care, but this differs from paying attention to the patient's perceptions of care.<sup>59</sup> Patient narratives sometimes tell a similar story. Stuart Diver, in his book *Survival*, contrasts his experience of care from the rescue workers at the scene of the Thredbo disaster with his experience when he was transferred to first the emergency clinic and then the hospital in Canberra. He says of the rescue workers that "they had been such a crucial part of my life and living"<sup>60</sup> and then describes feelings of "absolute total loneliness"<sup>61</sup> in the hands of the professional carers. The rescue workers conveyed a sense of total care towards Stuart Diver that

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(1998): 52-58. There are two bases on which to claim the place the existence of some kind of magical ingredient in nursing practice. The first is the assumption that the less quantifiable, therefore mysterious, therefore magical nature of care can only be elucidated by a "female" or qualitative means as opposed to a "male" approach which is more focussed on understanding in numeric terms. The second is the acceptance in nursing culture that modern nurses are participating in an ancient "witches and midwives" tradition. Mary Chiarella, "The magic of nursing: from witches to warriors to workers and wonderers," *Australian Nursing Journal* 3.3 (1995): 22-24. Nurses who claim some kind of continuity with these women betray the memory of these women who were falsely accused and went to their deaths denying their status as witches. They also contribute to the trivialisation of nursing culture.

<sup>58</sup> Gayle Burr, "Giving each other energy: Harnessing valuable resources for clinical practice," *Forty-Ninth Annual Oration, The New South Wales College of Nursing University of Sydney* 12 Oct. 2001.

<sup>59</sup> Bradshaw, "What are nurses doing to patients?" 81-92.

<sup>60</sup> Stuart Diver, *Survival*, (Sydney: Pan Macmillan, 2000) 151.

<sup>61</sup> Diver, 162.

sustained him during his time in the rubble as he awaited rescue. When he was with the professional carers he felt objectified by the carers who saw him as a body system that needed to be fixed. His gratitude for the carers is not expressed until a nurse finally washes him after some time at the hospital centre. He describes this as the first real warmth he experienced at the hands of his carers.<sup>62</sup> Whatever the professional carers thought they were doing for Stuart Diver, it was some time before it translated as care to him.

It is perhaps in relationship with the other professions that nurses behave most poorly. This is particularly true in relation to doctors. Bradshaw describes the current relationship between nurses and doctors as “alienated” as a result of the “new orthodoxy”.<sup>63</sup> Nursing literature is saturated with negative references to doctors. For example, in *Who Cares? The Changing Healthcare System*, Judith Lumby provides a rich account of nursing in the Australian context. She describes the commitment that nurses demonstrate to the ethic of care. Parallel to this, however, is a thread of criticism directed towards doctors that portrays them as consistently uncaring. This is troubling evidence of a profession that articulates its identity by demonstrating a critical attitude towards a collegial group.<sup>64</sup>

Advocacy and critique have contributed to the shaping of nursing as a distinct sphere of caring activity. The paradox of this position is that the claim to care is based on competitive and non-caring attitudes to other professional groups. It is on the one hand a demonstration of care for the needs of the disadvantaged. However advocacy also requires a confrontational, sometimes combative, approach as the nurse advocates on behalf of the patient. Other professional groups are sometimes unable to appreciate the uniquely caring qualities of nurses when they are the recipients of nursing advocacy. Care for one does sometimes require the criticism of the other and is a legitimate part of the nurse’s role. Criticism of others weakens the claim of the professional nurse that caring is the distinguishing characteristic of the nurse. By staking a claim to be the unique carers in society nurses make themselves vulnerable to criticism when they are found to be uncaring. If caring is the basis of

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<sup>62</sup> Diver, 164.

<sup>63</sup> Ann Bradshaw, “Has nursing lost its way? Nursing and medicine: Cooperation or conflict?” *British Medical Journal* 311.7000 (1995): 304.

<sup>64</sup> Judy Lumby, *Who Cares? The Changing Health Care System* (Sydney: Allen & Unwin, 2001).

the claim to be professional and nurses are found to be not caring, then nurses are not professional.

Several writers have argued that the care framework is insufficient for sustaining complex practice in nursing. The first to be considered are Paley and Glazer. On Paley's account it is unsurprising that the care ethic, founded as it is on an application of Husserlian phenomenology, is insufficient to sustain practice given that he claims that most nurse philosophers rely on "second-hand" accounts of Husserl's work and have a limited and frequently mistaken understanding of the main concepts of phenomenology.<sup>65</sup> Glazer argues that the postmodern philosophy which is underpinned by phenomenology not only fails to sustain good practice but actually invites nursing practices that can be considered dubious at best. She documents the enthusiasm that nurses have demonstrated for complementary therapies such as "therapeutic touch" and in the process they seem to have forgotten that "reaching the right answer requires not just compassion for the individual but also scientific rigour".<sup>66</sup>

Nelson<sup>67</sup> criticises the relatively recent fusing of feminism and bioethics that has come to underpin an ethic of care in nursing. She acknowledges that the postmodernist insight that there is no such thing as "pure reason" divorced from local practice<sup>68</sup> has some merit. However, to reject the pursuit of objective truth from which generalisable principles can be derived is to exchange a framework that can be criticised for its inhumanity when applied without due regard to the particulars of a situation, in favour of one that is potentially complicit with evildoing because the carer is committed to a form of care that is both blind and indiscriminate.<sup>69</sup> The carer has forgone the means by which he or she can assess the good or otherwise of an action.

Further to this difficulty, Nelson points out the invitation to slavishness that is contained within a commitment to an ethic of care. Care, as described by Noddings,

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<sup>65</sup> John Paley, "Husserl, phenomenology and nursing," Journal of Advanced Nursing 26.1 (1997):187.

<sup>66</sup> Sarah Glazer, "Therapeutic touch and postmodernism in nursing," Nursing Philosophy 2.3 (2001): 202.

<sup>67</sup> Hilde L. Nelson, "Against caring" The Journal of Clinical Ethics, 3.1 (1992): 8-15.

<sup>68</sup> Nelson, 9.

<sup>69</sup> Nelson, 9.

is unidirectional in that it asks for nothing in return.<sup>70</sup> It is ironic that an ethic of care which is advanced by feminists is so potentially harmful to women. Noddings defends this claim by including an account of self-care. Her placement of self-care is, however, limited in that it enables the caregiver to “care better for others” and “self care becomes the servant of patient care”.<sup>71</sup>

Kuhse also argues that an ethic of care will not support nursing excellent practice. She outlines some of the disastrous consequences for patients and clinicians that have occurred as a result of adherence to an ethic of care. She identifies the irony that although an ethic has held out the promise of professional advancement nurses practice according to the tenets of care find themselves ill-equipped to “assert their moral point of view or to criticise grave wrongs on behalf of those for whom they care”.<sup>72</sup> Kuhse emphasises that ethics is more than feelings or dispositions. It must be concerned with the rightness of wrongness of actions for which “there is no substitute for the reasoned application of universal principle or norms”.<sup>73</sup>

By locating accountability for the nurses’ actions entirely in experience and rejecting objectivity as fundamentally inhuman, the care-ethic denies a reliable means of helping or assisting another person to a state of well-being. Neither is nursing well served by a persistent belief in the innately caring nature of women. To do so is to absorb part of Nightingale’s beliefs about women without achieving her consistency that if it is accepted that care is a female trait then care takes on the nature of a vocation because to be caring is to answer the call of one’s destiny which is bound up in gender. Nightingale is at least consistent in her understanding of the demands that a lifetime commitment to care demands. The care ethicists are not convincing when they claim that caring is a form of empowerment.

It seems counter-intuitive to reject care as an underlying motif for the formation of a nursing ethic. The motivation to care for the vulnerable sick is at the heart of every action that a nurse undertakes. Care also unites a range of nursing activities from management to education to research to the many aspects of clinical care that

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<sup>70</sup> Nelson, 10.

<sup>71</sup> Nelson, 11.

<sup>72</sup> Helga Kuhse, “Caring is not enough: reflections on a nursing ethics of care,” The Australian Journal of Advanced Nursing 11.1 (1993): 32.

<sup>73</sup> Kuhse, 34.



nurses engage in daily. It must, however, be rejected as an ethic care as it is articulated in modern nursing literature because it rejects an objective account of caring activities.

Setting aside personal reservations about the rejection of an external deity, it is particularly troubling to observe care advanced as bestowing a form of spirituality on the activity of nursing. When nursing begins to describe itself in terms of supernatural powers without reference to a higher being the potential for causing harm increases significantly and the possibility of being taken seriously as a professional group diminishes.

These reservations about the sustainability of an ethic of care for nursing have, at their core, a demonstrable concern that the removal of any kind of objective accountability for nursing betrays the activity of nursing and the vulnerable sick who, admittedly need care and in truth need more than care. The care ethicists need not be anxious that an objective account of nursing eliminates a caring element from nursing. It will be demonstrated that a virtues-account of nursing, which is fundamentally rational, describes nursing in a realistic way and accommodates the affective aspects of nursing without sacrificing coherency.

#### **4.5**

**C**

#### **Conclusion**

A philosophy of care has awakened considerations of the affective aspects of nursing that, while not ignored within nursing practice, became of a secondary nature as science became the dominant means to explain and describe nursing. Both approaches, however, have their limitations. In summary, a scientific account of nursing is a diminished account of what it means to be a good nurse because it reduces nursing to a series of techniques to be mastered. Similarly, the care ethic falls short of providing a complete account of nursing activity. It is unsustainable to argue both that, in the first place nurses are the exclusive carers in society and that care alone is sufficient to sustain the demands of complex modern practice.

## 5 Nursing as a Virtues-Based Activity

The two frameworks of nursing outlined thus far have not offered an adequate account of what it means to be a good nurse. Kitson outlines the dilemma that the rift between science and care in particular represents for nursing in her claims that nurses have yet to reconcile the “dialectic tension between the scientific basis on nursing and its moral base of care”.<sup>1</sup> She describes the strategy of pursuing recognition and respect for nursing through the “nursing-as-science-alone route” as “dangerous” and expresses some frustration with the notion of care that has not been adequately captured in the nursing theories. She refers to “professional care” as mysterious and ill-defined.<sup>2</sup>

Other writers point to the range of opinions held amongst nurse ethicists as to the best ethical framework for nurses. Fry discusses the location of nursing ethics within a wider philosophical framework. She summarises the disagreements between ethicists. Veatch believes that “nursing ethics is a legitimate term referring to a field that is a subcategory of biomedical ethics”.<sup>3</sup> Others state that nursing ethics is distinct from biomedical ethics as it describes “the moral phenomena found in nursing practice”.<sup>4</sup> Fry explains that “theories of biomedical ethics, as currently formulated, are not directly applicable to the development of a theory of nursing ethics”.<sup>5</sup> Allmark echoes Fry’s comments as he attributes the difficulties of teaching ethics to nurses to, at least in part, the inappropriateness of the biomedical ethical models to adequately describe good nursing.<sup>6</sup> There is a temptation to create a melange of the two distinctive ways of thinking about nursing and present that as distinct nursing ethic. However, given the underlying incompatibilities of these two frameworks, the process of articulating a sound nursing ethic would not be significantly advanced.

Scudder and Bishop acknowledge that an explicit philosophy of nursing has yet to be fully developed. They suggest that virtue ethics is a way of thinking about nursing which helpfully holds what is best about what science offers to the advancement of

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<sup>1</sup> Alison L. Kitson, “John Hopkins address: Does nursing have a future?” Image-the Journal of Nursing Scholarship 29.2 (1997) 112.

<sup>2</sup> Kitson, 113.

<sup>3</sup> Veatch & Fry, 1.

<sup>4</sup> Fry, 11.

<sup>5</sup> Fry, 20.

<sup>6</sup> Peter Allmark, “Uncertainties in the teaching of ethics to students of nursing” Journal of Advanced Nursing 22.2(1995): 374.

both the practice of nursing and its standing as a profession together with the caring elements of nursing which provides nursing with its moral core.<sup>7</sup> In other words, nursing that does not care or exhibit some kind of emotional commitment to the practice of nursing cannot be called nursing and has no justification for contemplation of ethical imperatives that inform the practice of nursing. Nurses also need to recognise that the significance of an objectively derived knowledge base extends beyond the benefits of achieving professional status for nursing. The existence of a verifiable knowledge base serves to underpin the claims of nursing that nursing is a fundamentally good activity. Scientific knowledge contributes as significantly as an articulated commitment to the centrality of care within nursing to the ongoing expression of nursing as a moral activity.

The description of nursing as a virtues-based activity holds these two touchstones of nursing together in such a way as to enhance the practice of nursing and that nursing can make an authentic claim to professional standing. It is likewise a corrective to the perception that a complete account of nursing is to be found in the description of nursing as a science and a reminder that abandonment of objective standards of practice cannot be justified in the name of care. This summary has echoes of the ongoing debate between science and care that has occurred within nursing over the past half century. An understanding of nursing in terms of virtue ethics holds the promise of holding the two together in a complete description of nursing rather than contributing to the ongoing polarisation and fracturing of nursing that seems likely if the two cannot be drawn together in some coherent way.

This proposal depends on an examination of the writing of Aristotle as one who first articulated a theory of virtue as fundamental to a moral framework. Medical ethicists such as Thomasma and Pellegrino and philosophers such as Cocking and Oakley have built significantly on the works of Anscombe, and MacIntyre to move towards an articulation of medical ethics in terms of virtue ethics. There is an abundance of nursing literature (both historical and contemporary) that refers to the place of virtues in nursing. However, there has been little attempted, in a systematic way, to examine nursing in terms of virtue ethics. This thesis is intended to demonstrate the appropriateness of understanding nursing in terms of virtue theory and to contribute

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<sup>7</sup> John R. Scudder & Anne H. Bishop, "Nursing, theories and philosophies of," Encyclopedia of Bioethics, ed. Warren T. Reich, 2<sup>nd</sup> ed., vol. 4 (New York; Simon & Schuster Macmillan, 1995) 1818-1821.

to nurses' understanding of themselves in a way that will enhance their practice and their sense of significance in the healthcare environment. More weight has been given to the exploration of these theorists than to the theorists in the previous sections with the aim of achieving a fuller treatment of virtue theory and its applicability to nursing.

## 5.1 O origins

### 5.1.1 A Aristotle "Nicomachean Ethics"

Virtue ethics is Aristotelian in its origins. The *Nicomachean Ethics* is Aristotle's description of how to live well. It has been a source for much ethical reflection in western culture. The influence of Aristotle on the writing of Aquinas and its subsequent adoption in the medieval church and the modern Roman Catholic Church is well documented. The influence on religion aside, Aristotle's writing continues to provide insights for the modern person in the matter of living well and being good.

Aristotle reasoned that all of life had a point to it and it was from this point or *telos* that a person could make a judgement about the moral quality of his or her actions and identified that *telos* as *eudaimonia* or a state of blessed happiness or flourishing.<sup>8</sup> He advanced the notion that, for a human to live well or to flourish, that person's life would be characterised by qualities of goodness. Goodness and human flourishing were, in Aristotle's mind, inseparable. Having established this as a starting place for his discussion of the good life, Aristotle develops his thinking in practical terms. He rejects the empty discussions of the philosophers who pursue knowledge for its own sake.<sup>9</sup>

A first objection to Aristotle's thinking can be raised at this point. Those who reject Aristotle's view often do so on the basis that this is too arbitrary a foundation on which to form a framework for morality. People are too liable to describe a *telos* for themselves that serves their own, at times flawed, at other times noble, purposes.

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<sup>8</sup> Aristotle, I.2 1094a.

<sup>9</sup> Aristotle, II.4 1105b.

However, in reply it can be said that Aristotle was admitting no such self-serving *telos* of what it meant for a human being to live well. He describes the characteristic activity of a human being as “an activity of the soul in accordance with reason”.<sup>10</sup> Aristotle is declaring that that which marks a human being out as distinctively human is the work of reason on the activity of the soul and this will yield the insight that the good is that at which humans must aim. There is no licence here to invent a convenient human *telos*. It is derived after serious reflection on the human condition.

Reason plays its part in the activity of the soul by bringing order to the activity of the spirit so that people will know, not only what the right thing to do is, but also how to do the right thing in relation to “the right time, about the right things, towards the right people, for the right end, and in the right way is the mean and the best and this is the business of virtue”.<sup>11</sup> This is known as Aristotle’s principle of the mean. Reason guides a person to express the right amount of “fear, confidence, appetite, anger, pity” in every situation.

A virtue is, therefore, a quality of character that is a mean between an excess or deficiency of the spirit. For example, generosity is the virtue in the sphere of wealth that is a mean between wastefulness and stinginess.<sup>12</sup> Other virtues such as courage, temperance, even-temper, wit and friendship have their own excesses and deficiencies. Virtues are both something to aim for in themselves as goods and they are those qualities that enable a person to achieve overall goodness in life. A person cannot flourish independent of the virtues.

Neither can a person be inclined towards virtue if that person is not already good. This is a very difficult concept to justify as it makes the acquisition of the virtues seem to be the result of inheritance or fate or good or bad luck. If this were true, actions of any kind lose their moral significance apart from their consequences as they would cease to reflect the deliberations or the intentions that the person may hold for an action. People would be able to claim that they couldn’t help but act in the way that they do because “That’s just the way they are”. Aristotle does not accept that people can evade responsibility for their actions by such an appeal. Adults must

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<sup>10</sup> Aristotle, I.7 1098a.

<sup>11</sup> Aristotle, II.6 1106b.

<sup>12</sup> Aristotle, IV.1 1119b.

exercise their rational ability to determine what actions they will take in life and until a person reaches maturity he or she must practice the virtues with the encouragement and education of teachers and parents. He argues that until reason is able to take its proper role in the person “virtue of character is a result of habituation”.<sup>13</sup> He is suggesting that a person will adopt the attributes that he or she makes a habit of practicing and it is fundamental to the formation of good character that these habits of virtue are fostered from the earliest days.<sup>14</sup> If a person is well-raised and well-schooled that person, at first out of habit and then as a result of reflection, cultivates the sorts of attributes necessary for a flourishing life. Aristotle provides another guide to knowing how to achieve the mean in a person’s actions. He suggests that “we must consider the things towards which we are particularly prone” and then “we should drag ourselves in the opposite direction because we shall arrive at the mean by holding far off from where we would miss the mark”.<sup>15</sup> A person must be capable of a measure of self-reflection to achieve the virtues, but these are not habits and practices which are beyond the reach of reasonable people. As Aristotle argues that rationality is a distinctively human activity, it is proper to expect that people can and will exercise their reason in regards to their behaviour.

This brings the discussion to a third objection towards Aristotle. It is not an emphasis that is found in reading the *Nicomachean Ethics*, but it is a feature that is difficult for modern readers to accept and therefore attracts a disproportionate comment beyond the significance to be found in the text. Modern commentators complain that Aristotle was both elitist and insular in this vision for an ethical society. It is argued that he was in fact, no more than a product of his time and the place in which he lived and on those grounds need not be taken seriously.<sup>16</sup> It is true that Aristotle can be criticised for being dismissive of slaves, women, youth<sup>17</sup> and non-Athenians as incapable of sufficient rationality to order their passions. His comment that the brutish person is chiefly to be found amongst “non-Greeks” and the diseased and the disabled,<sup>18</sup> betrays a contempt for people of difference and a lack of compassion for the disadvantaged that astounds the modern person. A more careful reading of the text, however, reveals that his criticism is directed to those who are enslaved by their passions of whom he considered that those groups provided examples, but were not

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<sup>13</sup> Aristotle, II.1 1103a.

<sup>14</sup> Aristotle, II.1 1103b.

<sup>15</sup> Aristotle, II.9 1109b.

<sup>16</sup> Johnstone, 109.

<sup>17</sup> Aristotle, I.3 1094b.

<sup>18</sup> Aristotle, VII.1 1145a.

the sole exemplars of such behaviour. In one passage the masses are described as slavish because they choose “a life fit only for cattle” but in this Aristotle notes that they mimic the life of Sardanapallus,<sup>19</sup> a mythical King of Assyria known for his life of excess. The slavish life is thus not limited to those of a certain class or race or gender. Aristotle’s criticism is directed towards those who fail to govern their passions by reason. This failure is the focus of Aristotle’s attention and it is this focus, apart from the examples that he uses, that rescues his writing from the criticism of insularity or blind prejudice.

A modern reader can find in Aristotle a rational and non-religious, although at times mystical, account of how to live well. Aristotle himself makes no claims for completeness<sup>20</sup> nor does he pretend to be writing for any other than those living in the small city state of fourth century BC Athens. He has, however, identified a common human goal for human living and on the basis of that goal announced that goodness is to be found in the character of the person and the actions he or she engages in on the basis of character. Aristotle’s ideas continue to yield rewards for the modern scholar as they have proved to be as applicable to the demands of contemporary living as they were to the lives of the ancient Athenians of the fourth century BC.

### 5.1.2

A

#### **Anscombe’s “Modern Moral Philosophy”**

Elizabeth Anscombe has been credited with prompting a renewed interest among western philosophers in the place of virtue in the moral life. Her essay *Modern Moral Philosophy*<sup>21</sup> was first published in 1958. In this essay she reasons that the Kantian and utilitarian ethical traditions are unsustainable and encourages a return to a classical ethic of virtue. She charts the departure from an ethic of virtue as a result of the dominance of institutional Christianity in history in which moral behaviour came to be defined as obedience to the word of a law giving deity. The classical understanding of missing the mark in terms of human behaviour meant that a person had failed to give full expression to his humanity. To put it more positively, “the

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<sup>19</sup> Aristotle, I.5 1095b.

<sup>20</sup> Aristotle, X.8 1178a.

<sup>21</sup> G. E. M. Anscombe, “Modern Moral Philosophy,” Ethics, Religion and Politics: Collected Philosophical Papers, vol. III, Oxford: Basil Blackwell Publisher (1981) 26-42.

flourishing of a man *qua* man consists in his being good”.<sup>22</sup> The emphasis in moral life shifted from an understanding that the virtues were to be cultivated in order to live well to a pre-occupation with the avoidance of sin in order to escape one’s condemnation based on the word of a divine law giver. She believes that this understanding has so “embedded itself in our language”<sup>23</sup> that subsequent ethical deliberations have absorbed this concept but rejected the underpinning belief in a divine law giver, thus rendering their theories fundamentally incoherent.<sup>24</sup> She then points to a classical theory of virtue, most thoroughly articulated by Aristotle, as a way of understanding what it is to be good without resort to a sense of an external divine source that compels humans to be good. She argues that what is needed is a rigorous examination of what it means to be human from which authentic virtues for moral living can be extracted and fully explicated. Her hope is that these will contribute to the development of a coherent ethical framework as an answer to the bankrupt moral framework on which western culture is currently resting.

### 5.1.3

M

#### MacIntyre’s “After Virtue”

Subsequent to Anscombe, MacIntyre wrote *After Virtue* in which he acknowledges the debt owed to her for the renewed interest that virtue ethics now attracts amongst moral philosophers.<sup>25</sup> He argues for a return to the centrality of the virtues in public life and begins with the claim that pluralism has seriously derailed efforts to articulate any kind of universal ethical system and undermined the possibility of articulating a universal *eudaimonia* such as Aristotle described. He writes that the language of morality is in a “state of grave disorder”.<sup>26</sup> After dealing with the failure of “the Enlightenment Project”<sup>27</sup>, his project becomes the reintroduction of Aristotle and virtues theory to the modern reader. MacIntyre achieves his definition of virtue by first advancing the concept of the good end implicit in human life. MacIntyre restates Aristotle’s assertion that to be good is to realise, that is to bring to reality, a person’s “true end”.<sup>28</sup> This true end is an acceptance of the notion that humans have “an essential nature and an essential purpose and function” and that essential nature

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<sup>22</sup> Anscombe, 41.

<sup>23</sup> Anscombe, 30.

<sup>24</sup> Anscombe, 31.

<sup>25</sup> Alasdair MacIntyre, *After Virtue*, 2<sup>nd</sup> ed., (Notre Dame: University of Notre Dame Press, 1984) 53.

<sup>26</sup> MacIntyre, 2.

<sup>27</sup> MacIntyre, 51.

<sup>28</sup> MacIntyre, 54.



and purpose is to live well.<sup>29</sup> This is the *telos* or the true goal of human life. MacIntyre argues that an understanding of the *telos* or goal of human life brings a moral coherency to life. Rules or codes are no longer arbitrary matters; they are referenced to one's *telos*. Perhaps more importantly life gains meaning when people understand their actions in terms of a human goal. There is a point to one's actions. In contrast, life lived independent from a *telos* is a life without meaning. MacIntyre writes:

“When someone complains ... that his or her life is meaningless, he or she is often and perhaps characteristically complaining that the narrative of their life has become unintelligible to them, that it lacks any point, any movement towards a climax or a *telos*. Hence the point of doing any one thing rather than another at crucial junctures in their lives seems to such a person to have been lost.”<sup>30</sup>

Another way of understanding one's life in terms of meaning or having a point is to think of it in terms of narrative. MacIntyre writes that one finds significance and meaning when one's life can be seen as part of a larger narrative. Human beings are not only story tellers, they are also capable of understanding their lives in terms of participation in a narrative. MacIntyre writes that a person can only answer the question “What am I to do?” if the prior question “Of what story or stories do I find myself a part?”<sup>31</sup> has been answered. People find meaning and significance in aligning their lives with the great stories of history such as religion, family, nationality or profession. They learn what role they will play in that greater story through the passing on of stories. MacIntyre observes that people deprived of their stories are left “unscripted, anxious stutterers in their actions as in their words”.<sup>32</sup>

In regard to professional ethics, MacIntyre argues that the professions can be explained in terms of virtue theory because they possess identifiable ends or goals which lend objectivity to determining the necessary qualities of the good practitioner. These qualities are virtues “the possession and exercise of which tends to enable us to achieve those goods which are internal to practices and the lack of which effectively prevents us from achieving such goods”.<sup>33</sup> The virtues can thus be

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<sup>29</sup> MacIntyre, 58.

<sup>30</sup> MacIntyre, 217.

<sup>31</sup> MacIntyre, 216.

<sup>32</sup> MacIntyre, 216.

<sup>33</sup> MacIntyre, 191.

understood in relationship to the *telos* of a profession or the various traditions or practices to which a person is committed.

Identification of the good or the *telos* of a profession has been foundational to subsequent ethicists' articulation of various professions as virtues-based. Some discussion of MacIntyre's understanding of internal and external goods is warranted. MacIntyre makes a distinction between "internal" and "external" or "contingent" goods. Internal goods can, according to MacIntyre, "only be identified and recognised by the experience of participating in the practice in question". Further to that, "those who lack relevant experience are incompetent thereby as judges of internal goods".<sup>34</sup> He also argues that in every good practice, whether it be chess playing or portrait painting, there is some good to be gained from the practice itself and some good to be gained external to the practice. External goods are those that come to the practitioner characteristically in the form of "property or possession"<sup>35</sup> and, in contrast to internal goods, can be obtained by engaging in a range of practices.

MacIntyre acknowledges that external goods will, in the case of the reluctant chess playing child, encourage a child to start to play chess. As the child engages in the practice of chess, he comes to appreciate chess for its own sake. Therefore external rewards such as candy or money have helped the child to move from being motivated by external goods to being motivated by internal ones.<sup>36</sup> If it can be so for the child, it can reasonably be assumed that, for example, a student nurse may be motivated to commence study on the basis of possibility for travel and flexibility in career opportunities and come to appreciate the internal goods of the encounter with the patient that nursing offers.

The distinction between internal and external goods is helpful because consideration of internal goods of a practice defines the *telos* of a practice and provides a contest for virtuous practice. It is also a reminder to consider the *telos* of one's profession as a guide for moral practice. More pragmatically, it identifies core aspects of one's profession or practice which the practitioner will, without doubt, encounter. In identifying the internal goods of a profession, the aspiring practitioner can at least be

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<sup>34</sup> MacIntyre, 188.

<sup>35</sup> MacIntyre, 190.

<sup>36</sup> MacIntyre, 188.

certain that he or she will be engaged in a particular activity and be able to make the evaluation as to whether that activity will be sustaining for his or her future working life. External goods such as opportunities for financial advancement or gains in status are never certainties within any profession. It would be unwise for any person to enter a profession in pursuit of external goods as the practitioner may meet with disappointment. On the other hand, if a person enters a profession for the internal good that that profession offers, then that person will never be disappointed.

MacIntyre also provides a systematic description of the context in which virtues may be practiced by the professional. A practice is characterised by “cooperative human activity” which has as its goal the realisation of some good.<sup>37</sup> Practices require institutions to sustain them. When MacIntyre describes institutions he again relies on the distinctions between internal and external goods. He states that the institution is characteristically concerned with external goods which are, on the one hand, necessary to sustain practice, but are also of a potentially corrupting nature. This makes the practice of the virtues of “justice, courage and truthfulness” by practitioners essential in relation to the institution.<sup>38</sup> MacIntyre’s thinking stands in contrast to prevailing thinking on the nature of institutions. At a time when institutions are criticised seemingly for their very existence MacIntyre helps the practitioner to be alive to the possibility of achieving some good within the body of an institution without being compromised by its demands.

MacIntyre helpfully distinguishes between internal and external goods and describes the goods that can be derived from the professional life. However, in making this distinction, it is important to be alert to the problem of dualism which is to value the unseen or the intangible as implicitly morally superior to the seen. To do this implies that internal goods are morally superior to external goods because they do not attract a material benefit, whereas external goods do. Therefore benefiting from a material reward renders a practice morally compromised. In fact, internal goods may not be sufficient in themselves to sustain a good practice. The practitioner must provide for his or her own physical needs. Further to this, in a complex world, material resources are required to underpin increasingly sophisticated practices. It is reasonable that practitioners have an expectation of reward for the provision of services and there is

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<sup>37</sup> MacIntyre, 187.

<sup>38</sup> MacIntyre, 194.

therefore no conflict with a moral commitment to the person who is receiving the service.

MacIntyre's work extends beyond an interest in restoring a sense of virtue to professional ethics. He concludes with the expressed hope that virtues theory can be a renewed basis for the maintenance of moral communities and that as the "tradition of the virtues was able to survive the horrors of the last dark ages" the virtues will provide a defence against the "barbarians" who have "been governing us for some time".<sup>39</sup> Whilst the prophetic tone may not always be echoed in followers of MacIntyre, there is, nonetheless, both a widespread appreciation of his anxiety about the cost to western culture at the loss of a universally held moral framework and respect for his contribution to a rebuilding of a coherent framework for western morality.

#### 5.1.4

P

#### **Pellegrino and Thomasma's Virtue Theory Applied to Medicine**

Medical ethicists, Thomasma and Pellegrino, have been prolific writers in the area of medical ethics. They acknowledge that they have borrowed heavily on the work of MacIntyre as they have articulated an ethic of medicine that they describe as virtue-based.<sup>40</sup> Their efforts have been concentrated chiefly in three areas. The first is to articulate a *telos* or goal for medicine. The second is to give substance to how the articulation of that goal affects the behaviour and demeanour of physicians in relation to their work and the way they relate to patients and their families. The third is to offer some way physicians may be an influence for good amongst their own colleagues and in the wider community.

Pellegrino states that the clinical encounter between physician and patient is the "central moral defining phenomenon of a clinical philosophy of medicine".<sup>41</sup> Pellegrino and Thomasma emphasise that this is the place on which to ground any ethical framework concerning medicine. It is this quality which is the unchanging feature of the practice of medicine. A sufficient valuing of the therapeutic relationship

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<sup>39</sup> MacIntyre, 263.

<sup>40</sup> Edmund D. Pellegrino, "Toward a virtue-based normative ethics for the health professions," Kennedy Institute of Ethics Journal 5.3 (1995): 269.

<sup>41</sup> Edmund D. Pellegrino, "The internal morality of clinical medicine: A paradigm for the ethics of the helping and healing professions," Journal of Medicine and Philosophy 26.6 (2002): 562.

safeguards the practice of medicine from the “whims of society” and the conflicting and competing influences of a pluralistic society.<sup>42</sup> It is from this encounter that Pellegrino develops his position that the relationship between physician and patient makes of medicine a fundamentally moral practice. The physician is trained as a physical healer and is therefore under a moral obligation to do all he or she can to bring healing to that person. Given the moral underpinnings of the profession of medicine, Pellegrino and Thomasma bring to their philosophy of medicine a vocational understanding of their profession. Pellegrino considers a profession to be a way of life that makes a “declaration” or a promise to those in need that the practitioner who possesses expert knowledge will assist that person in a way that will benefit and not exploit the one in need.<sup>43</sup>

It is on the basis of the articulation of the moral underpinning of medicine that they describe some of the virtues that physicians require in order to be known as good practitioners and to practice well. Firstly, Pellegrino acknowledges that to speak of virtues is ‘to be suspected of sanctimoniousness or hypocrisy’.<sup>44</sup> Undeterred by the unfashionable nature of their position, he proceeds to outline some of the necessary virtues for good practice. He rejects the influence of self-interest in the profession of medicine as a failure of “character and virtue”.<sup>45</sup> He acknowledges that self-interest has a legitimate place in the life of the professional in regard to the provision of a measure of material well-being to the practitioner and the practitioner’s family. The virtuous practitioner acknowledges the need for a level of effacement of self-interest so that consideration of personal safety or material advancement does not dominate the way medicine is practiced.<sup>46</sup>

Pellegrino defines the *telos* of the health professions (and in this category he includes nurses, dentists “and the like”) as “helping and healing”.<sup>47</sup> He describes a virtue as an attribute “that disposes its possessor habitually to excellence of intent and performance with respect to the telos specific to a human activity”.<sup>48</sup> His list of virtues is fidelity to trust and promise, benevolence, compassion and caring,

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<sup>42</sup> Edmund D. Pellegrino & David C. Thomasma, *The Virtues in Medical Practice* (New York: Oxford University Press, 1993) 51.

<sup>43</sup> Edmund D. Pellegrino, “Character, virtue and self-interest in the ethics of the professions,” *The Journal of Contemporary Health Law and Policy*, 5 (1989): 57.

<sup>44</sup> Pellegrino, “Character, virtue and self-interest in the ethics of the professions,” 54.

<sup>45</sup> Pellegrino, “Character, virtue and self-interest in the ethics of the professions,” 55.

<sup>46</sup> Pellegrino, “Character, virtue and self-interest in the ethics of the professions,” 58.

<sup>47</sup> Pellegrino “Toward a virtue-based normative ethics,” 267.

<sup>48</sup> Pellegrino “Toward a virtue-based normative ethics,” 268.

intellectual honesty, justice and prudence<sup>49</sup>. To behave otherwise is to betray the moral underpinning of healthcare and to act in ignorance of its *telos*.

As a correction to a perceived loss of interest in the role of character in the place of the professions, Pellegrino offers an explanation of the erosion of a teleological ethic which is parallel to and indebted to MacIntyre's explanation. It is to be found in the rejection of "the ideas of universals or of essence in the nature of things, thus disarticulating the connections between ends and the good".<sup>50</sup> He then articulates the significance of virtue theory for the practice of healthcare and addresses common misconceptions about virtue ethics. He rejects the claims made by some that virtue ethics means that the physician is bound to do whatever the patient defines as good<sup>51</sup> or that the physician determines the ends of medicine<sup>52</sup> by reminding the reader that there is an objective end for medicine which is revealed in the good practice of medicine. He has demonstrated a commitment to the advancement of a virtue ethics for the practice of medicine that has spanned three decades. His has been a constant and consistent articulation of an ethic of virtue in medicine in both journals and books.

In the matter of teaching and fostering ethical development amongst medical students and in the wider community, he expresses a hope similar to that of MacIntyre when he suggests that an ethic of virtue in the professions might be 'the leaven for raising the standards of conventional morality as well'.<sup>53</sup>

### 5.1.5

O

#### **akley and Cocking's Virtue Theory Applied to the Professions**

In *Virtue Ethics and the Professional Roles*<sup>54</sup> Oakley and Cocking devote a chapter to "A virtue ethics approach to professional roles". In this chapter they build on and echo the work of MacIntyre, Pellegrino and Thomasma as they argue for the

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<sup>49</sup> Pellegrino "Toward a virtue-based normative ethics," 269-270.

<sup>50</sup> Pellegrino, "The internal morality of clinical medicine," 567.

<sup>51</sup> Pellegrino, "The internal morality of clinical medicine," 571.

<sup>52</sup> Edmund D. Pellegrino, "The goals and ends of medicine: How are they to be defined?" *The Goals of Medicine: The Forgotten Issue in Healthcare Reform*, ed. Mark J Hanson & Daniel Callahan (Washington DC: Georgetown University Press, 1999) 63.

<sup>53</sup> Pellegrino, "The goals and ends of medicine," 73.

<sup>54</sup> Justin Oakley & Dean Cocking, *Virtue ethics and professional roles* (Cambridge: Cambridge University Press, 2001).

centrality of the *telos* as a reference point for directing good professional practice. Though they admit that a detailed discussion of the meaning of health is beyond the scope of their own work, they identify the *telos* of medicine as that which serves the human need for health. Beginning with Aristotle's suggestion that when humans are living well they are living according to their true nature, they apply their thinking to medicine, and argue that, since health or physical well being contributes to human flourishing, those who are making a contribution towards the maintenance of human health are engaged in demonstrably good activities.<sup>55</sup> It is from this core of reasoning that they argue that doctors are accountable to an objective sense of what constitutes good practice in the light of which determinations can be made as to the kinds of actions they ought to do in some case and avoid in others in order to be good doctors.

A discussion follows as to what actions constitute good practice. It is characteristic of this discussion that more is said about actions that betray the notion of the *telos* of medicine than those which fulfil it. The point is made that when medicine departs from its *telos*, the practice of medicine deteriorates. Examples of this departure from medicine's *telos* include the human experiments carried out by the Nazi doctors Mengele and Wirths.<sup>56</sup> Practices such as under-treating patients because of a perceived economic loss to the doctor, are examples of actions that are governed by interests that are external to the practice of medicine. These interests may be things such as ideologies or the pressures of defensive practice or meeting the goals of efficiency over health.<sup>57</sup>

Good practice depends on the doctor cultivating the 'appropriate dispositions, emotions and sensitivities'.<sup>58</sup> The virtues Cocking and Oakley identify are beneficence, truthfulness, trustworthiness, courage, humility. Good practice also depends on the doctor allowing the goal of health to determine his or her actions. To express this differently, good practice is dependant on the doctor making his or her practice accountable to the *telos* of medicine. Cocking and Oakley acknowledge that good health intersects with the psychological, behavioural and spiritual dimensions of the person. Where a matter of health is overshadowed by issues not central to health, the doctor is best to modify the level of advice or intervention than might

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<sup>55</sup> Oakley & Dean Cocking, 74.

<sup>56</sup> Oakley & Dean Cocking, 81.

<sup>57</sup> Oakley & Dean Cocking, 82.

<sup>58</sup> Oakley & Dean Cocking, 92.

otherwise be offered. The doctor may discuss and be directive about issues that affect a person's health, but "the closer a patient's problem is to the periphery of what is included in the notion of health, the less directive the doctor *qua doctor* is entitled to be with him".<sup>59</sup> In these matters of judgement about levels of intervention, the good doctor relies on the qualities of character that have been cultivated as much as clinical expertise. They also allow that efficiency of practice or a desire to profit in medical practice are not features that disqualify the practitioner from making the claim to be a good practitioner.<sup>60</sup> Where efficiency and profit making serve the goal of health, the doctor may still claim to be acting as doctor *qua doctor*.

Cocking and Oakley have successfully argued that virtue theory can direct one's actions. They have built further on the thinking of Thomasma and Pellegrino by identifying ways that virtue theory can direct action in practice beyond the identification of the virtues that good practitioners must possess. They have successfully anchored their contribution to the development of virtue theory to the reality of practice by avoiding the other worldly tone that is sometimes detected in the writings of Thomasma and Pellegrino. They acknowledge the real material benefits that sometimes accrue to an excellent practitioner. By articulating the centrality of the *telos* to actions in practice, they helpfully guide practitioners to assess what kinds of goals are guiding their practice, thereby helping them to avoid betrayal of the essential nature of medicine.

### 5.1.6

A

#### **Allmark and Whelton's Application of Aristotelian Concepts to Nursing**

Some nurse philosophers have sought to incorporate the writings of Aristotle and other virtue ethicists in their reflections. Allmark applies Aristotle's distinctions between *phronesis* and *praxis* on the one hand and *sophia* on the other to the problem that the theory-practice gap presents to nursing. Allmark<sup>61</sup> highlights the difficulty that nursing has encountered in marrying theory and practice, a difficulty that the ancient Greeks would not have encountered. For the Greeks, pursuit of theoretical knowledge (*sophia*) was a contemplative activity, engaged in for its own sake. Knowledge that was to be applied to everyday situations was derived from

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<sup>59</sup> Oakley & Dean Cocking, 92.

<sup>60</sup> Oakley & Dean Cocking, 89.

<sup>61</sup> Peter Allmark, "A classical view of the theory-practice gap in nursing," Journal of Advanced Nursing 22.1 (1995): 18-23.



practice. The Greeks would have regarded nursing as a practical activity (*praxis*) which required practical knowledge (*phronesis*) and this is a form of knowledge that enables a person to live well. Classical philosophy made no attempt to marry *sophia* and *praxis* but, as Allmark points out, there are difficulties in keeping the two knowledge traditions distinct. He writes that where knowledge is derived from practice, ritualistic practices abound; where theory attempts to drive practice, barriers of language and institutions (colleges versus hospitals) lead to irrelevance.<sup>62</sup> He suggests that, although the practical and experiential nature of nursing resists its description in totally theoretical terms, nursing theories have effected significant and positive change within nursing even though they will not provide a complete account of nursing<sup>63</sup>. Allmark has thus used these Aristotelian concepts to make helpful distinctions between the kinds of knowledge needed in nursing. Allmark concludes that “perhaps the apprenticeship model of nursing was not so wrong after all” and that perhaps Benner’s remarks on intuitive nursing knowledge provide a theoretical account of this kind of “practical knowledge”.<sup>64</sup>

Whelton uses Aristotle to reflect on the practical nature of nursing. She comments that as nursing “is primarily concerned with doing and being rather than making” the nurse needs wisdom or *phronesis* rather than *techne* or technical knowledge to be a good nurse.<sup>65</sup> Nursing is thus identified as a moral activity which depends on a “stable and universal” knowledge base so that it may achieve its good ends. Allmark and Whelton are two nurse philosophers who have explored the writing of Aristotle and found his work to be applicable and relevant to the articulation of an ethical framework for nursing.

## **5.2** **S** **Some Objections to Virtue Theory**

### **5.2.1** **T** **The Goals of Healthcare Cannot be Found Within its Practice**

Not all are convinced that virtue ethics has a place in healthcare. Robert Veatch, does not accept MacIntyre’s argument that the good ends of a practice “can only be

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<sup>62</sup> Allmark, 18.

<sup>63</sup> Allmark, 22.

<sup>64</sup> Allmark, 23.

<sup>65</sup> Beverly Whelton, “The multi-faceted structure of nursing: an Aristotelian analysis” Nursing Philosophy 3.3 (2002);199.

identified and recognised by the experience of participating in the practice in question".<sup>66</sup> Veatch argues that people turn to their religious belief systems when they are trying to make determinations about what are the proper ends or goals of life. In doing so, they contribute to the development and articulation of cultural beliefs. It is these cultural beliefs which have developed externally to the professional culture which properly determine the ends of the "various professional practices of the culture".<sup>67</sup> On Veatch's account, professional virtues generated on an understanding of that which constitutes an internal goal of the profession is immoral as it bypasses community accountability.

Veatch does, however, offer a subtle appreciation of the meaning of internal goods that, as he points out, is sometimes not appreciated by the advocates of virtue ethics. He warns against the misunderstanding of internal ends which is revealed by some practitioners when they articulate a morality which is unique to the practitioner but not accountable to the identified ends of the profession. Veatch's point is well made that the goal of medicine articulated by a physician need not automatically to be taken as a description of an internal end and, conversely, an end need not necessarily be taken to be an external good.

Veatch takes MacIntyre's account of internal ends where he is referring to professional practice and extends his meaning to "ends of life".<sup>68</sup> It is true at the conclusion of *After Virtue* MacIntyre expresses some hope that virtues theory will provide a framework for the development of a universal ethic for western culture in the face of the increasingly secular nature of western culture in this particular case. However, he is referring to professional practice. He is making a more modest claim for virtue ethics than Veatch is presenting it as.

Veatch argues instead for "a realist metaethic for medicine"<sup>69</sup> that aims to express a universal moral norm for medicine. He acknowledges that such an account will be incomplete and vary from culture to culture but that there will be sufficient 'overlapping consensus' to generate a series of agreed-upon basic moral principles

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<sup>66</sup> MacIntyre, 188.

<sup>67</sup> Robert Veatch, "The impossibility of a morality internal to medicine," Journal of Medicine and Philosophy 26.6 (2001): 623.

<sup>68</sup> Veatch, "The impossibility of a morality internal to medicine," 623.

<sup>69</sup> Veatch, "The impossibility of a morality internal to medicine," 637.

that will provide an external code to which medicine will be accountable. He argues that a distillation of a survey of cultural norms will yield a more coherent morality on which to base the practice of medicine than an examination of the way that medicine is practiced world-wide. The reader is not offered any basis on which to have confidence that the one way is any more coherent than the other. In fact the suspicion is that there may be more commonality in the way that healers practice than the way humanity develops its moral codes.

According to Veatch there is a universal moral viewpoint but that it is unknowable in an identical form in all cultures. He maintains “that all possible human accounts of the moral reality are necessarily social constructs”.<sup>70</sup> By doing so, he avoids the epithet of the cultural relativist and at the same time avoids the task of trying to articulate a universal morality. Aristotle writes more plainly that there are some things that ought not to be done. He makes no accommodation for actions such as “adultery, theft, homicide” because it is wrong “to expect a mean, an excess and a deficiency in committing injustice, being a coward, and being intemperate”.<sup>71</sup> There is no right way to do these things.

## 5.2.2

T

### he Difficulties of Identifying Authentic Virtues

Others too are troubled by the applicability of virtues theory to health care.<sup>72</sup> Loewy considers that virtue ethics has little to offer health care because of the ambiguity of the nature of virtues themselves. Understood as ‘excellences’, they give no guidance as to what qualities of character contribute to good behaviour. He argues that a person can excel at lying or stealing. He also doubts the possibility of reaching agreement on the goals of medicine, based in part in agreement with Veatch<sup>73</sup> that there are so many roles available to the health practitioner but also because of the different roles that physicians have been cast in from entrepreneur to vocational.<sup>74</sup>

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<sup>70</sup> Veatch, “The impossibility of a morality internal to medicine,” 637.

<sup>71</sup> Aristotle, I.1107a.

<sup>72</sup> Erich H. Loewy, “Developing habits and knowing what habits to develop: a look at the role of virtue in ethics,” *Cambridge Quarterly of Healthcare Ethics* 6 (1997): 347-355.

<sup>73</sup> Veatch, 629.

<sup>74</sup> Veatch, 349.

It appears that he has overlooked the importance of a *telos* in the formation of virtue ethics. The *telos* is the good, which is a form of objective standard by which one can measure one's behaviour. Consideration of the *telos* is the means by which patients are both protected from exploitation or negligence by health care workers and a way of ensuring that patients' lives are benefited or enhanced by health care. The good in health care is, as Pellegrino describes it, the health or benefit of the patient. If one has in mind the good of the patient then lying to the patient or stealing from him or her can never be considered a virtue. Correspondingly, consideration of the good for the patient helps health workers to elucidate good qualities such as kindness or honesty that they can bring to their practice.

### 5.2.3

V

#### **irtue Theory does not Guide Action**

Another criticism of virtue ethics is that virtue ethics limits its interest to qualities of character as the determinant of good practice and offers no guidance on action. If this complaint about virtue ethics is true, this is a serious limitation. Rosalind Hursthouse addresses this complaint and applies her thinking to the subject of abortion.

In her article *Virtue and Abortion*<sup>75</sup> she first provides a brief outline on the significant features of deontology, consequentialism and virtue theory. Following that she attends to some of the complaints made about virtue ethics. In the first part of her defence she corrects some misconceptions about virtue ethics. The claim that the concept of *eudaimonia*, for example, is a concept that is "hopelessly obscure" is countered by her answer that the concepts of rationality and happiness in those two theories respectively are equally "rich and difficult concepts".<sup>76</sup> She argues that virtue ethics is not "trivially circular"; it is not only concerned with being but with doing also; it generates moral principles and utilises moral concepts.<sup>77</sup>

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<sup>75</sup> Rosalind Hursthouse, "Virtue theory and abortion," *Virtue Ethics: A Reader*, ed. Daniel Statman (Edinburgh: Edinburgh University Press, 1997): 227-244.

<sup>76</sup> Hursthouse, 229.

<sup>77</sup> Hursthouse, 229.

Hursthouse discusses two limitations for virtue theory but denies that they are problems peculiar to virtue theory.<sup>78</sup> The problem of articulating a rational basis for a universal moral framework is as challenging to the virtue ethicist as it is to the deontologist and the consequentialist. Likewise the difficulty of determining which virtue is required to meet the demands of a particular situation is as real for the rule deontologist as it is for the virtue ethicist. If they are to be considered fatal flaws against virtue theory then they need be considered equally fatal against deontology and consequentialism.

When Hursthouse reminds the reader that “acting rightly is difficult”,<sup>79</sup> she is recalling Aristotle’s words that “it is hard to be good”.<sup>80</sup> There is more to goodness than the development of normative theory. Virtue theory allows that the practice of the virtues is attendant on the development and exercise of wisdom. Such “delicate and sensitive judgement”<sup>81</sup> is a quality that is cultivated over time. Further to this, Hursthouse articulates a *telos* for human life in the manner of all virtue ethicists. She conveys it in terms of understanding what is worthwhile or what matters in human life. Hursthouse thereby provides an underpinning and reference point for virtue theory which elevates virtue theory beyond other frameworks that “any clever adolescent can apply”.<sup>82</sup>

Hursthouse then moves into her discussion of abortion. She argues that the usual means of considering abortion is in terms of women’s rights and the moral status of the foetus reduces abortion to a problem of legality which denies the status of abortion as a “unique moral problem”.<sup>83</sup> She demonstrates the strength of virtue theory by inviting the reader to consider the qualitative differences between the many circumstances that women find themselves in when they are contemplating abortion. These range from a woman having an abortion ‘for shallow reasons in the later stages (of pregnancy)’<sup>84</sup> to the woman with several children who has an abortion because she ‘fears that to have another one will seriously affect her capacity to be a

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<sup>78</sup> Hursthouse, 231.

<sup>79</sup> Hursthouse, 232.

<sup>80</sup> Aristotle., II.9 1106b.

<sup>81</sup> Hursthouse., 232.

<sup>82</sup> Hursthouse, 233.

<sup>83</sup> Hursthouse, 236.

<sup>84</sup> Hursthouse, 237.

good mother to the ones she has'.<sup>85</sup> She reflects on the role that character has to play in each of these instances and the response that that elicits from the observer.

Hursthouse provides a thoughtful discussion on the issue of abortion. Her insights do not descend to the implausible claims that some groups make when they try to convince people that abortion is no different from the "cutting of one's hair".<sup>86</sup> In this she points out the inconsistency of those who articulate this view but who rarely hold the same view when one has a miscarriage at the same early stage of pregnancy. Nor do her claims magnify the loss of a foetus in the early weeks of pregnancy to the same sense of loss which occurs at the demise of a late term pregnancy. Her plea is for realism in this matter.

If readers are seeking simple answers to the issue of abortion, they do not find them in this article. At the beginning of her discussion Hursthouse declares that she has "no single right answer"<sup>87</sup> for the question of abortion. This having been said, Hursthouse does not offer the shallow reassurances of relativism, which is no reassurance at all for those with a well-developed conscience. Nor does she offer the legalistic definitions which fall short of addressing the question of what is the right or the good thing to do. She convinces the reader that abortion is never a trivial matter and provides a way to think about it that is in keeping with the challenges it holds for people who want to be good. In so doing she falls short of sanctioning abortion which is not a sufficiently strong conclusion for those who hold an absolute objection to abortion on religious grounds. However her discussion is "a great advance on the narrow focus of both deontology and utilitarianism [As] it provides a much richer vocabulary and more discriminating parameters for moral assessment".<sup>88</sup>

Hursthouse's approach demonstrates that virtue theory is credible philosophically. This does not mean, however, that virtue theory is limited to the domain of the purely abstract. It can foster an appreciation of the moral significance of serious human dilemmas. If virtue theory is helpful in illuminating issues of such a challenging nature as abortion, there is potential for virtue theory to be integrated into the formulation of professional ethics. Hursthouse does not proceed in that direction in

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<sup>85</sup> Hursthouse, 239.

<sup>86</sup> Hursthouse, 236.

<sup>87</sup> Hursthouse, 233.

<sup>88</sup> Gerald Gleeson, "Renewing the debate over abortion," Bioethics Outlook 3.1 (1992):7.

this article, but her contribution is to make the way clear for others to pursue such an interest.

#### 5.2.4

V

#### **irtue Theory is Circular**

Pellegrino acknowledges that the objection to virtue theory on the basis of its perceived circular nature requires a serious response.<sup>89</sup> The objection is to be found in Aristotle's claim that the good person characteristically judges rightly. Any reader who is uneasy with this assertion becomes more troubled when reading about, for example, the great-souled person who possesses all the qualities of greatness. The great-souled person is concerned only with honour. He accepts honours "in a moderate way... thinking that he is getting what he deserves, or even less than he deserves, because there could be no honour worthy of total virtue". Even Aristotle's contemporaries are not convinced by the virtue of the great-souled man. They sometimes thought of them as "supercilious" and the modern reader would probably agree.

By extension there is a suspicion that by allowing practitioners to be the arbiters of their own standards, they may develop an ethos that is too easily compromised. Pellegrino provides an answer by recalling that internal morality has to do with the essential nature of medicine and the essential nature of medicine is not an arbitrarily determined notion that physicians are free to modify as they see fit. In respect to medicine and nursing he reminds the reader that the proper ends of healthcare emerge from the "universal human experience of illness".<sup>90</sup> It is the external nature of this experience that lends some objectivity to the internal goods of healthcare which is the answer to such complaints about virtue ethics.

Virtue theory overcomes the pitfalls of circularity by employing a matrix of sources for the determination of the idea of the good practitioner. This idea is generated from reflection on the nature of the practice itself, attention to the examples of colleagues

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<sup>89</sup>Edmund D. Pellegrino, "The goals and ends of medicine: how are they to be defined?" The Goals of Medicine: The Forgotten Issue in Healthcare Reform, eds. Mark J, Hanson & Daniel Callahan (Washington DC: Georgetown University Press, 1999) 60.

<sup>90</sup>Pellegrino, "The goals and ends of medicine," 64.

in practice and reflection on the tradition that one's current practice represents in order that the image of the ideal practitioner becomes neither stale nor self-serving.

### 5.3

C

#### **Conceptions of Nursing as a Virtues-Based Activity**

##### 5.3.1

T

#### **The Good Nurse as Obedient, Loyal and Pure**

Nightingale combined her theistic beliefs with her study and admiration for Platonic philosophy to give a Christian account of virtue for nursing. This account claimed that knowledge of God's good character was the objective or external source on which people could aim to shape their own characters, and flourish or live happily in both Godly and humane ways.<sup>91</sup>

She believed that possession of certain virtues was the way to ensure good nursing. This was not meant to exclude scientific knowledge about what a nurse should do but such knowledge was regarded by her as secondary to that which contributed to good nursing. Nightingale was consistent in her beliefs about both the cause of ill-health and the way that ill-health could be addressed. She rejected the germ theory as a cause for disease and believed nurses needed to rely on strategies that would put the patient in the best possible state to allow nature to effect its own healing on the body. Medical modes of treatment were rejected by her because they fought the disease process which she regarded as much a visitation of God as God's provision of a means for the body to heal itself.<sup>92</sup>

Her belief that disease was therefore a moral problem dictated her conviction that nursing was a moral activity. It is therefore unsurprising that she regarded the possession of moral qualities crucial to the practice of good nursing and that moral training was an important focus of the Nightingale style of nurse training.

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<sup>91</sup> Jeanne LeVasseur, "Plato, Nightingale and contemporary nursing," Image – The Journal of Nursing Scholarship 30.3 (1998): 283.

<sup>92</sup> Sam Porter, "Nightingale's realist philosophy of science," Nursing Philosophy 2.1 (2001): 20.



Contradictions emerge in the descriptions of good nursing that are offered by Nightingale of the good nurse and the training regimes described as the “Nightingale method” but which appear to have fostered virtues quite different from those that emerge in her writing. In *Notes on Nursing*<sup>93</sup> Nightingale describes nurses who have cultivated qualities of extreme consideration and care for patients. Nurses must pay attention to the way they walk and dress and the way that they open and close doors. They must learn how to question the patients on their dietary habits or sleeping patterns in order to elicit the most accurate information about their patient’s well being. Nightingale writes at length about the importance of ventilation and emphasises that, although this belief may have been at odds with the views of the physicians or surgeons, the good nurse will do what she must in order to maintain a fresh atmosphere in the wards. These nurses were intelligent, thoughtful, solicitous, courageous and kindly. However, her description of these morally committed nurses bore little resemblance to the nurses who emerged from the “Nightingale” tradition.

Nightingale’s portrayal of nursing convinced hospital administrators that nurses could play a useful role in the hospital system. However, to her dismay, she then witnessed the implementation of a training system which used inexperienced young women as hospital workers, denied them adequate education and, amongst other things, contributed to the formation of character in ways other than she envisaged. Baly writes that the culture which emerged was one that emphasised “obedience and discipline long after the need had gone” and resulted in the formation of nurses who were conforming and unquestioning in nature.<sup>94</sup> Nurses such as these were unwilling to challenge doctors on matters of patient or ward management.

Giarelli notes that the further legacy from Nightingale’s articulation of the virtuous nurse was to also value the qualities of loyalty and purity. Similar to obedience, these qualities did not so much contribute to the practice of nursing but to the perception that nursing was an occupation that was both respectable and acceptable to the medical hierarchy.<sup>95</sup>

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<sup>93</sup> Florence Nightingale, *Notes on Nursing: What it is and What it is Not*, (New York; D.Appleton Company, 1860) 18 May 2004  
<<http://digital.library.upenn.edu/women/nightingale/nursing/nursing.html>>.

<sup>94</sup> Baly, “Florence Nightingale and the establishment of the first school,” 19.

<sup>95</sup> Ellen Giarelli, “Nursing ethics education in Victorian America – 1873-1890,” *Florence Nightingale and Her Era: A Collection of New Scholarship*, eds. Vern L. Bullough, Bonnie Bullough & Marietta P. Stanton (New York: Garland Publishing, 1990) 206-227.

It must be admitted that these virtues did contribute to the advancement of nursing in its initial modern phase and they remain important qualities in the shaping of one's civic and moral persona. Nor are they completely irrelevant to the practice of nursing today. As Chambliss comments in a more modern vernacular, "The job itself seems to call for decency."<sup>96</sup> Is it possible to be a good nurse and to be habitually callous or selfish or untruthful in one's private life? Nightingale and her Victorian peers would say no. MacIntyre argues that the virtues enable a person to achieve a unitary life which resists the modern tendency to partition life into public and private segments.<sup>97</sup> Cocking and Oakley consider that professionals "risk imposing considerable moral costs on their clients and themselves" when they cultivate different attitudes in their public and private lives.<sup>98</sup> These Victorian and Christian virtues do not enjoy modern currency, tainted as they are by associations with the subjugation of women and non-egalitarian attitudes. However, in like manner to Nightingale who was able to articulate a sense of vocation for nursing that was free from sectarian limitations, it is beneficial to devote serious consideration to the connections between private goodness and to the good practice of nursing and to restate them in ways which emphasise the liberating and just nature of personal goodness.

### 5.3.2

T

#### he Good Nurse as "Careful"

Another, seemingly independent, development of nursing as a type of virtues-based activity is that known as "careful nursing". "Careful nursing" was developed by the Irish Sisters of Mercy prior to the influence and formal expression of Florence Nightingale's ideas on nursing.<sup>99</sup> Nightingale encountered the Irish Sisters of Mercy during their time spent nursing the soldiers from the Crimean war and it is known that Nightingale expressed an interest in their "manner of nursing".<sup>100</sup>

"Careful nursing" has been analysed for its similarity with other models of nursing. Meehan finds that it correlates with other models of nursing in that it provides

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<sup>96</sup> Chambliss, 67.

<sup>97</sup> MacIntyre, 204.

<sup>98</sup> Cocking & Oakley, 155.

<sup>99</sup> Therese Connell Meehan, "Careful nursing: a model for contemporary nursing practice," *Journal of Advanced Nursing* 44.1 (2003): 100.

<sup>100</sup> Meehan, 99.

definitions of the four pillars of nursing; person, environment, health and nursing. It differs from contemporary models of nursing in that it describes nursing, at least in part, in terms of the qualities nurses need to possess in order to practice well. The characteristics of good practice in the tradition of careful nursing are: disinterested love; contagious calmness; creation of a restorative environment; 'perfect' skill in fostering safety and comfort; nursing interventions; health education; participatory-authoritative management; trustworthy collaboration; power derived from service and nurse's care for themselves. In summary, the careful nurse expressed "refinement in the attitudes and actions of practice, meticulous attention to details of patient care, expression of great tenderness in all things, and the ability to apply these principles under almost any circumstances".<sup>101</sup>

The careful model of nursing is firmly embedded in a Christian framework. Belief in a benevolent Supreme Being informs the nurse's understanding of the four pillars of nursing and sustains the nurse's commitment to embody the characteristics of good nursing in his or her practice. In Meehan's view, this need not be a reason to limit further exploration of this model for contemporary nursing. She argues that use of the term "Supreme Being" unites nurses of different religious creeds and those who follow no creed yet have a personal belief in a Supreme Loving Being, so that they are able to assimilate this as a universal model for nursing. Whether or not the nurse has a belief in a Supreme Being, Meehan argues, the model allows for nurses to be attentive to the spiritual needs of their patients, if that is the wish of their patients. Use of this model for nursing does not easily allow the nurse to ignore the spiritual aspect of their work or of their own personal life. Despite Meehan's claims for the universal applicability of "careful nursing", it is doubtful that a nurse who professes no belief in a Supreme Being could readily identify with this model as one that could inform his or her practice.

This limitation aside, the "careful" model for nursing is interesting for the role it had to play in a unique time in nursing history and fascinating for the possible cross-pollination it may have had with Nightingale's ideas on nursing. It is also significant in demonstrating that nursing has, at a time and a place independent of Nightingale, been described in terms of the qualities of the practitioner. Whilst this cannot be represented as articulating a true virtues theory, it provides further evidence that there has been an uninterrupted interest in the importance of the virtues to the good

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<sup>101</sup> Meehan, 102.

practice of nursing since the re-formation of modern nursing. This realisation lends substance to the interest in articulating a systematic appropriation of virtues theory to nursing.

### 5.3.3

T

#### **he Good Nurse as Competent**

A contemporary nurse ethicist, Ann Bradshaw, argues that nursing currently confronts a crisis of uncertainty about what constitutes good nursing.<sup>102</sup> This crisis has arisen in part due to the abandonment of objective standards of practice on the one hand and the adoption of values of “autonomy and empowerment” on the other involving the rejection of past nursing values of “submission and obedience” and, paradoxically, has led to a “loss of authority in the present”<sup>103</sup> with a corresponding lack of confidence about occupational identity. Bradshaw attributes this crisis to a departure from the traditional training practices of nursing. These practices were based on the twin emphases of achieving competence in nursing tasks and an articulation and fostering of the kinds of human qualities that there were considered necessary for the good practice of nursing. According to Bradshaw, the recovery of a level of certainty about what constitutes both good nursing practice and what qualities make a good nurse involves a return to a form of nurse training and practice which is underpinned by the Nightingale tradition.

Bradshaw identifies the departure from the practice of systematically and objectively assessing nurse competency as a serious problem, both for nurses and patients. In a survey of nursing theories Bradshaw attributes this to the influence that Heideggerian philosophy has had on nursing practice via writers such as Benner and Wrubel.<sup>104</sup> She criticises the subjective nature of Benner’s recommendation that expert nurses need not consider themselves to be accountable to any objective standards of care. Her twin objections to this claim are that the notion of standard of care is rendered meaningless when each nurse becomes a personal standard and new nurses are ill-equipped to offer competent levels of attention to patients if they are left to themselves to determine standards of practice. She recounts descriptions of nurses

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<sup>102</sup> Ann Bradshaw, “The virtue of nursing: the covenant of care,” *Journal of Medical Ethics* 25 (1999): 478.

<sup>103</sup> Ann Bradshaw, “Has nursing lost its way?: nursing and medicine: cooperation or conflict,” *British Medical Journal* 311.7000 (1995): 304.

<sup>104</sup> Ann Bradshaw, “What are nurses doing to patients? A review of theories of nursing past and present,” *Journal of Clinical Nursing* 4.2 (1995): 84.

who are awkward when handling patients, prefer technical tasks and even then “breach principles of cross-infection”.<sup>105</sup> By contrast, Bradshaw describes the Nightingale form of training where nurses were given specific and detailed instruction in all aspects of nursing activity from the proper way to clean a urinal to intimate aspects of bodily care and which depended on “matrons, tutors and ward sisters (who) constantly reiterated the same message”<sup>106</sup> so that the goal of a standardised approach to all aspects of nursing activity could be achieved. Bradshaw argues that nursing is a practical activity which is “demonstrated”<sup>107</sup> and its continued good practice is dependent on competent practitioners who can demonstrate and give detailed explanations of their actions to new nurses.

Bradshaw’s conception of the competent nurse is described as pivotal to the creation of the ward ethos. Such a nurse can be relied on to be active in scrutinising the level of attention that patients receive in the ward and to supervise the activities of student nurses with a thoroughness and in such a manner that the skills of the nurses will improve without discouraging the student.<sup>108</sup> The competent nurse is similar to Benner’s description of the expert nurse but in fact they differ significantly from each other. They resemble each other in that they both embody the image of the good nurse and they can be regarded as a kind of standard for nursing. Other nurses regard them as mentors or role models. They are points of reference for the practice of other nurses. In this they reflect Aristotle’s ideal of the *good person*. They are, however, unlike in that Benner’s expert nurse practices at an intuitive level which the nurse may or may not be able to give an explanation for. On this account nursing becomes subjective and is more of an experience than a practice. It is ironic that Benner’s theory of nursing, which positions itself as a care theory, focuses more on the experience of the nurse than the experience of the patient.<sup>109</sup> The competent nurse described by Bradshaw is able to give a reasoned account for what is done because nursing has been learnt by reference to objectively derived knowledge and the nurse has continued in the tradition of demonstration and explanation.

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<sup>105</sup> Ann Bradshaw, “Defining competency in nursing (part I): a policy review,” Journal of Clinical Nursing 6.5 (1997): 351. Ann Bradshaw, “Defining competency in nursing (part II): an analytical review,” Journal of Clinical Nursing 7.2. (1998): 103-111.

<sup>106</sup> Bradshaw, “The virtue of nursing,” 478.

<sup>107</sup> Bradshaw, “The virtue of nursing,” 479.

<sup>108</sup> Ann Bradshaw, “Competence and British nursing: a view from history,” Journal of Clinical Nursing 9.3 (2000): 325.

<sup>109</sup> Bradshaw, “What are nurses doing to patients?” 84.

The second aspect of nurse education that Bradshaw identifies as absent from contemporary approaches is the lack of attention that is paid to the importance of character and character development in the practice of good nursing. Bradshaw cites early nursing textbooks which accepted that the good practice of nursing was as dependent on the kindly disposition of the nurse as it was on the nurse's ability to perform tasks competently.<sup>110</sup> It was the role of the ward sister to cultivate moral qualities in her own person and in those nurses whom she supervised.<sup>111</sup> The cultivation of the virtues for professional practice is difficult to achieve and correspondingly difficult to demonstrate. MacIntyre provides some guidance in the matter of the cultivation of the virtues. He argues "it is always within some particular community with its own specific institutional forms that we learn or fail to learn to exercise the virtues."<sup>112</sup> Although Allmark and Bradshaw have not always agreed<sup>113</sup> their writings express a measure of agreement that the formation of desired qualities in the practice of a good profession can be cultivated in the context or the institution where they are practiced. Bradshaw consistently identifies the place where nursing occurs (the hospital) as the crucible for the fusing of theoretical knowledge and practical skills. The hospital is where student nurses become aware that they not only need to know what to do in order to be good nurses, they also need to know how to nurse. To achieve this aim they need to possess moral qualities, and it is in modelling and copying the behaviour of the good nurses they observe around them that they can bring to reality their own ideal of good nursing. In the traditional setting it was the ward sister who knew "how to nurse" and who, by practicing "a code of good manners and kindness, coupled with a quiet professional way"<sup>114</sup> exemplified the virtuous practitioner and acted as an encouragement to student nurses to adopt this manner of behaviour. This process echoes Aristotle who taught that "a virtue of character is a result of habituation ... Virtues, however, we acquire by first exercising them ... for by acting as we do in our dealings with other men, some of us become just, others unjust".<sup>115</sup> Unlike Allmark, Bradshaw does not entertain the idea that nurse training should return to hospitals. Her purpose is to restore the concept of

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<sup>110</sup> Bradshaw, "Competence and British nursing," 323.

<sup>111</sup> Bradshaw, "Competence and British nursing," 325.

<sup>112</sup> MacIntyre, 194.

<sup>113</sup> They debate each other on the understanding of care as a virtue. Allmark argues that "the *telos* of nursing has yet to be adequately addressed" and therefore care cannot be claimed as a virtue within nursing. Peter Allmark, "Is caring a virtue?" *Journal of Advanced Nursing* 28.3 (1998): 466-472. Bradshaw replies that nursing has an objective moral foundation found in its Christian origins which provides a suitably objective account of care. It is only since nursing has separated itself from this tradition that it has been unable to offer a coherent account of a care ethic. Ann Bradshaw, "Yes! There is an ethics of care: an answer for Peter Allmark," *Journal of Medical Ethics* 22.1 (1996): 8-12.

<sup>114</sup> Bradshaw, "Competence and British nursing," 326.

<sup>115</sup> Aristotle, II.1 1103a.

moral training in nursing and to suggest that the hospital, as the place where nurses practice, is the setting where they can experience profound moral growth.

Bradshaw represents the Nightingale model of nursing as the “foundation for quality in the nurse’s care, the warmth of the heart inspired by the moral basis of care”.<sup>116</sup> This is not a position that is uniformly accepted amongst nursing scholars. The Nightingale model was, at times, implemented in ways that were rigid and harsh. It could even be argued that, with its emphasis on hierarchy and order, modelled as it was, at least in part, on a military system, it lent itself to being expressed in de-personalised ways rather than as a way of nursing that contributed to the flourishing of its practitioners. For those who learned to nurse in such an environment, it could be a brutalising and ultimately dehumanising experience.<sup>117</sup> Such experiences contributed to character, but the practitioner could find herself (almost always female in the Nightingale model) shaped in ways that gave rise to the caricature of the cruel, cold nurse. If any criticism is to be made of Bradshaw it would be that, in arguing for a restoration of competence and virtue for good nursing practice, there has been insufficient attention to the connections between “Nightingalism” and the less healthy aspects of nursing culture.

This reservation aside, Bradshaw is convincing in her assessment of the difficulties that contemporary nursing finds itself in and elegantly precise in her description of good nursing as one of “kindness and technical competence”.<sup>118</sup> She emphasises the two features of good nursing practice that constitute the good practitioner. These are a practice based on objective knowledge which is in turn governed by the good character of the nurse. By doing this Bradshaw has cast nursing in such a way that allows it to be best described as a virtues-based activity.

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<sup>116</sup> Ann Bradshaw, “Blurred image” *Nursing Standard* 8.46 (1994) 38.

<sup>117</sup> The training of nurses in Victorian times is described as startlingly intolerant of either physical or moral imperfections amongst its recruits. Nurses were expected to achieve uniformity of both practice and attitude at the expense of independent thought or the expression of individuality. The result was that “under conditions of hard work, long hours and social isolation, the nurse was pushed to the limit of her physical and emotional endurance”. Giarelli, 210, 219.

<sup>118</sup> Bradshaw, “Blurred image,” 38.

## 5.4

E

### Elements of an Account of Nursing as a Virtues-Based Activity

#### 5.4.1

N

#### Nursing as Goal-Oriented

Further evidence that nursing can be understood in terms of virtue theory is the repeated attention that various nursing writers have paid to the description or encapsulation of nursing as a goal-related activity. A clear enunciation of the *telos* of nursing brings nursing into the fold of virtue theory and there have been many attempts to identify a unifying goal for nursing. Nightingale described health as a central goal of nursing.<sup>119</sup> This conviction is echoed by contemporary writers<sup>120</sup> who expand on the meaning of health as “an experience of well-being”<sup>121</sup> which encompasses a person’s total being. Such a conviction is repeated by Hedelin and Jonsson who state that the goal of nursing is “personal development and increased possibilities” which is achieved through “intersubjectivity” or “encountering the other as a person rather than an object”.<sup>122</sup> Nurses achieve the goal of health for patients in a profound way when the support they offer to patients enables the patient to cope with the disruption to their well being that they are experiencing. To restate, the goal is to restore to the person an ability to move from dependency on the nurse to a place of “self-care”.<sup>123</sup> Nursing is thus established in the virtue tradition, not simply because nursing is goal-oriented, but because, as Harbison reminds the reader, nursing seeks to achieve some good or benefit for the patient which renders it a fundamentally “moral enterprise”.<sup>124</sup>

MacIntyre uses the notion of narrative to convey the sense of the *telos* for one’s life. He regards the interpretation of ethics in terms of a story larger than oneself as providing a point to the way people live their lives. Nurses who regard themselves as participating in a tradition of nursing practice that has proceeded them and will continue beyond their participation in nursing avail themselves of a heritage of

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<sup>119</sup> Meleis, 111.

<sup>120</sup> Pamela J. Grace “Professional advocacy: widening the scope of accountability,” Nursing Philosophy 2.2 (2001): 155.

<sup>121</sup> Sue Antrobus, “Developing the nurse as a knowledge in health-learning the artistry of practice,” Journal of Advanced Nursing 25.4 (1997): 830.

<sup>122</sup> B. Hedelin & I. Jonsson, “Mutuality and background music in women’s lived experience of mental health and depression,” Journal of Psychiatric and mental Health Nursing 10.3 (2003): 321.

<sup>123</sup> Yvonne Wengstrom, Caroline Haggmark & Christina Forsberg, “Coping with radiation therapy: effects of a nursing intervention on coping ability on women with breast cancer,” International Journal of Nursing Practice 7.1 (2001): 9.

<sup>124</sup> Jean Harbison, “Clinical decision making in nursing: theoretical perspectives and their relevance to practice,” Journal of Advanced Nursing 35.1 (2001): 127.



practice that guides their actions and that reminds them of the *telos* of their profession. They are also able to avail themselves of stories of particular situations and nurses who can be exemplars for them in difficult or troubling circumstances.

A clear articulation of the goal of nursing clarifies nursing activity and contributes to the maintenance of a sense of priority about their actions. In a brief and very practical article on mathematical skills for nurses Woodrow makes the point that “people do not become nurses to practise maths, but most nurses have to make various calculations each shift”.<sup>125</sup> Nurses do not aim to become excellent mathematicians. They must possess good mathematical skills in order to be good nurses but when nurses find the mathematical or the scientific or the relational aspects of their practice outweighing their interests in achieving the goal of health or well-being for their patients, their practice as nurses has become secondary to some other goal.

#### 5.4.2

T

##### he “Good” Nurse

Aristotle argues that a good person is able to “judge each case rightly” and act as “a sort of standard and measure of what is noble and pleasant”.<sup>126</sup> In order to understand what it is to be practically wise, Aristotle suggests that we consider “the sort of people we describe as practically wise”<sup>127</sup>. He considers that “the good person” or the person of good character is the arbiter or standard of good actions.<sup>128</sup> The concept of the good person as a reference point for one’s actions is criticised as a circular argument as it relies on internal factors for its confirmation and leaves the matter of goodness vulnerable to the subjective standards of every individual.

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<sup>125</sup> Philip Woodrow, “Numeracy skills,” Nursing Standard 12.30 (1998): 48.

<sup>126</sup> Aristotle, III.4 1113a.

<sup>127</sup> Aristotle, VI.5 1140a

<sup>128</sup> This insight is not restricted to virtue theory. It is arguable that it also occupies a legitimate place in Christian ethics. In the Old Testament the Israelites were called to “Be holy because I (the LORD) am holy” (Lev. 11: 45). Jesus is described in the *Gospel of John* as the “word made flesh” (John 1:14). Jesus embodied goodness. People could look to Him and know that if they lived like Jesus and did the things that Jesus did, they would be good. Jesus was that standard or measure of goodness. At the conclusion of the Sermon on the Mount, considered to be the core of his ethical teaching, it is recorded that “the people were astounded at his teaching; unlike their own teachers he taught with a note of authority” (Matt 7:29). There was a seamlessness between the way Jesus lived and the words that he spoke. The Apostle Paul adds to this tradition by encouraging believers to “Imitate me as I imitate Christ” (1 Cor 11:1, 1 Cor 4:16, Eph 5:1). MacIntyre points to the Protestant reformation as a point of departure from this tradition. The Protestant emphasis on the written word introduced a shift from being good because of who God is to being good because of what God says. Although the two are not at odds with each other, the different emphases shape Christian ethics in quite distinctive ways. Alasdair MacIntyre, A Short History of Ethics, (London: Routledge, 2002) 115.

MacIntyre answers the objection to the concept of “the good practitioner” to a certain extent by challenging the notion that “is” does not imply “ought”. He writes that the good practitioner is accountable to and gives full expression to the essence of the practice which is the proper objective marker of the good practitioner.<sup>129</sup> Thus, in the realm of professional life, where objective standards of practice exist and a practitioner can be said to embody those standards, then that practitioner may be considered a kind of standard that other practitioners may aspire to. This argument is further challenge to the complaint that virtue theory is circular or internally accountable.

At a personal level, Raimond Gaita has written a moving account of his father's life. In *Romulus My Father* he testifies to the effect of knowing a good person.

“On many occasions in my life I have had the need to say, and thankfully have been able to say: I know what a good workman is; I know what an honest man is; I know what friendship is; I know because I remember these things in the person of my father, in the person of his friend Hora, and in the example of their friendship.”<sup>130</sup>

The influence of a good role model or mentor is of significant worth for nurses. Bradshaw’s emphasis on the traditional significance of the good nurse has already been discussed. Other writers add to her claim that mentoring and role modelling for student nurses contributes to the cultivation of “the moral sense of practice”.<sup>131</sup> When this moral sense is sufficiently developed it also helps nurses to cope with the reality of negative role models. The Clinical Nurse Specialist (CNS) role has been developed to recognise nurses who have attained an excellent standard of practice. It is expected that the CNS is, in addition to being a “change agent, collaborator, clinical leader, and patient advocate”, a role model.<sup>132</sup> Implicit in this role is the recognition that the good nurse will have a good effect on the practice of others.

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<sup>129</sup> MacIntyre, *After Virtue* 216.

<sup>130</sup> Raimond Gaita, *Romulus, My Father*, (Melbourne: Text Publishing, 1998) 74.

<sup>131</sup> Mei-che Samantha Pang & Kwok-shing Thomas Wong, “Cultivating a moral sense of nursing through model emulation,” *Nursing Ethics: An International Journal for Health Care Professionals* 5.5 (1998): 428.

<sup>132</sup> Sarah E. Ormond-Walsh, “Comparing and contrasting the clinical nurse specialist and the advanced nurse practitioner roles,” *Journal of Nursing Management* 9.4 (2001): 205.

Good nursing continues to be dependent in some way on its role models for the continuation of good practice.

Bradshaw's protests at the development of a mentoring system in the absence of objective standards of practice with the resultant sense of confusion surrounding "the modern nursing identity" have been noted.<sup>133</sup> A study on the benefits of clinical supervision for the development of clinical leadership supports her claim. Nurse managers who find themselves removed from "everyday clinical practice" thereby ceasing to be a role model for direct patient care, experience frustration in their attempts to articulate a vision for the unit that is effective in maintaining consistent standards of care.<sup>134</sup> The nursing units were demoralised and bore the markers of stressed working environments.<sup>135</sup> The participants were troubled by their experiences as they interacted with the supervisors. As nurses were drawn from their core activity they were less able to exercise the kind of moral leadership that would effect the practices on their wards and the wards were denied the presence of their role models.

The researcher admitted that "the research process put pressure on the practitioners to pay attention to their clinical leadership role that they had not previously considered". Furthermore, despite increased commitment levels and time given to supervision for some of the participants, no obvious improvements in leadership skills became evident.<sup>136</sup> Nevertheless, the researcher suggested that what was required was more time given to supervision and that "the sustaining of leadership expertise must become a norm". This comment is made without any evidence that the researcher has considered the means nurses commonly employ to exercise clinical leadership. The possibility that the support of good clinical role models in the ward environment might be a means of sustaining clinical leadership is not entertained. Other researchers are aware of the power of the mentor or the good role model. However, this researcher persisted in recommending strategies for management that resulted in an absence of clinical leaders from the clinical area and were persistently ineffective in achieving improvements in the ward practices. The picture that emerges is one of a philosophy of management that is in disarray. The

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<sup>133</sup> Bradshaw "Competence and British nursing," 328.

<sup>134</sup> Christopher Johns, "Clinical supervision as a model for clinical leadership" Journal of Nursing Management 11.1 (2003): 228.

<sup>135</sup> Johns, 231.

<sup>136</sup> Johns, 232.

confusion of professional identity that Bradshaw points to, can at least in part, be attributable to a failure to foster and value good role models in nursing.

The appreciation of good nursing role models need not be limited to observance of such exemplars as they practice at the ward level. Biographical accounts of nursing heroes also make a significant contribution to the development of a good nursing culture. Pellegrino laments the failure of educational centres to promote the life stories of ethically sensitive professionals. By such neglect, medical students are denied rich and meaningful reference points for their future practices. His concerns are applied equally to nursing. There is evidence that there is some recognition of the importance of good exemplars for the nursing population. Nursing journals profile the stories of nurses who have made honourable contributions through their profession. These may vary from recording the reminiscences of older, retired nurses<sup>137</sup> to profiles of nurses who have had long and significant careers.<sup>138</sup> When this is done to remind nurses that they are participating in a tradition of competency and care, such stories have, as Pellegrino writes “inspirational value”.<sup>139</sup>

Both Pellegrino and Bradshaw advocate for the place of good practitioners as exemplars who have a significant role to play in the influencing of other less experienced or accomplished practitioners and the presence of good practitioners is at least part of the way that people “learn” to be virtuous. This learning is partially embedded in the cultivation of good habits of practice but it is also motivated by the quality of the relationship with the practitioner and the desire to be like him or her.

There are two possible weaknesses in the argument for the elevation of the good nurse as a role model either by living example or as found in written accounts. The first weakness is one raised by Bradshaw which is that, at times, good exemplars are absent from the nurse’s environment. An ethic of nursing that is dependent on good examples is flawed if there are no good examples to follow. A second weakness is that an overly developed dependence on historical accounts of good nursing could contribute to what Ziadam Sardar describes, in his commentary on the contributing

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<sup>137</sup> Leslie Jean Neal, “Elder RNs: learning from their experiences,” *Geriatric Nursing* 23.5 (2002): 244-249.

<sup>138</sup> Steven Black, “The habit of a lifetime,” *Nursing Standard* 13.31 (1999): 16-17.

<sup>139</sup> Pellegrino, “Character, virtue and self-interest in the ethics of medicine,” 71.

factors to fundamentalism in culture, as “ossified interpretations” of past stories.<sup>140</sup> If nursing culture is to avoid being similarly labelled as fundamentalist, it must avoid a rigid attitude to the interpretation of its history lest it become a slave to it. Nursing must adopt a dynamic culture of inquiry in which the past is used to amplify and illuminate present situations and the present can be a commentary on the past.

The idea of the good nurse can be a dynamic, and therefore sustaining, concept as a state of fluidity between observation of the present (those with whom the nurse interacts on a daily basis) and reference to the past is achieved. One may act as a corrective for the potential weakness of the other. If there is an absence of role models for a nurse, then reference to the past is a helpful way to keep the ideal picture of the good nurse alive. Where a nurse is witness to good exemplars in everyday practice the nurse is able to assess past accounts of nursing to decide on those qualities that are of an enduring nature to good nursing and those that can be left in the past. By this means, the practicing nurse avoids both a slavish approach to history on the one hand and being overly reliant on one’s immediate environment for the provision of good exemplars on the other.

## 5.5

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### Some Virtues for Nursing

Without going as far as Smith and Godfrey who comment that “research on the place of virtue ethics in nursing practice is practically nonexistent”,<sup>141</sup> it is true to say that current interest in applying virtues theory to nursing has been limited. It is characteristic of the interest that nursing philosophers have shown in the virtues, that the virtues have largely been examined in a way to claim moral authority for nurses without the accompanying analysis of nursing to determine if nursing can be understood legitimately in terms of virtue theory.

There is no shortage of nursing articles that make a study of a particular quality of character as necessary for good nursing practice. These qualities are recommended

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<sup>140</sup> Angela Bennie, “The scepticism of a believer: Interview Ziadun Sardar,” The Sydney Morning Herald July 26-27 Spectrum 17.

<sup>141</sup> Katharine V. Smith & Nelda S. Godfrey, “Being a good nurse and doing the right thing: a qualitative study,” Nursing Ethics: An International Journal 9.3 (2002):301.

as a metaphor or standard from which one's practice is measured. Vulnerability is described as a human characteristic that is necessary for the practice of nursing as it is a means to 'understand the human condition'.<sup>142</sup> Serenity is similarly identified as a quality that is a defining goal for good nursing practice.<sup>143</sup> Open-mindedness is another quality that nurses are said to require, in addition to "courage, truthfulness and justice", which will enable them to more firmly embed their practice in the evidence-based tradition.<sup>144</sup> Other writers compile lists to describe the all-round "great nurse".<sup>145</sup> Nurses themselves recognise that the possession of certain human qualities is central to good nursing practice. When nurses are surveyed they identify "care giving" and "activism" as the two values or qualities that make the profession of nursing distinctive.<sup>146</sup>

Other writers have assembled lists of qualities they think are essential for good nursing. Some have assembled these lists on the basis of their own experience.<sup>147</sup> Other are presented in a more systematic attempt to provide a profile of the qualities that contribute to good nursing practice. It is argued that this will enable the structuring of education and management practices to identify and foster such qualities. Qualities such as interpersonal understanding, commitment, information gathering, thoroughness persuasiveness, compassion, comforting, critical thinking, self-control and responsiveness are identified in one study as those which contribute to 'effective nursing performance'.<sup>148</sup> A study was undertaken to identify those qualities that nurses need to possess to advance the contribution that nurses make to world-wide health strategies at leadership level. Nurse leaders generally agreed that there was a particular profile that nurses who were successful at that level of operating exhibited. These were qualities (such as political astuteness, strategic

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<sup>142</sup> Linda E. Daniel, "Vulnerability as a key to authenticity," Image – The Journal of Nursing Scholarship 30.2 (1998): 191.

<sup>143</sup> Kay T. Roberts & Ann Whall, "Serenity as a goal for nursing practice," Image – The Journal of Nursing Practice, 28.4 (1996): 359.

<sup>144</sup> Derek Sellman, "Open-mindedness: a virtue for professional practice" Nursing Philosophy 4.1 (2003): 20.

<sup>145</sup> Janet Abdenour, "What makes a great nurse," RN, 62.10 (1999): 47-48.

<sup>146</sup> Darlene Weis & Mary Jane Schank, "An instrument to measure professional nursing values," Journal of Nursing Scholarship, 32.2 (2000): 203.

<sup>147</sup> Weis & Schank, 47.

<sup>148</sup> Zhi-xue Zhang, Weety Luk, David Arthur & Thomas Wong, "Nursing competencies: personal characteristics contributing to effective nursing performance," Journal of Advanced Nursing, 33.4 (2001): 467-474.

thinking and innovativeness and others such as integrity and being a good communicator) that are held in common with practicing clinicians.<sup>149</sup>

It is apparent that some writers appreciate the significance of virtue theory in the way that nursing is practiced.<sup>150</sup> De Raeve identifies a shift from a rule-based practice to one that is more identifiably virtues-based. In past years nurses characteristically from a sense of duty but they now appear to be increasingly exercising duties as virtues. Duties of loyalty and obedience need to be tempered by practiced judgment. This shift in practice accommodates considerations of compassion and respect for individuality within the bounds of competent practice and authenticates the nurses' claim of professionalism.<sup>151</sup> Likewise, in Allmark's treatment of the duty of confidentiality, he concludes that confidentiality "has always been a matter of discretion rather than an absolute rule" which makes the keeping of confidences a matter of character rather than a universal duty.<sup>152</sup>

There is, thus, a consensus of sorts in the writings of contemporary nurses that, at its most basic, establishes an interest in the relationship between certain qualities of character and good nursing practice. It is clear that, contra Smith and Godfrey, nurse philosophers have been and remain interested in applying insights from virtue theory to nursing. The writings of Allmark and Bradshaw in particular have made significant contributions in this regard. They have demonstrated that an understanding of nursing as a virtues-based activity has the potential to hold the aspects of character, the objective nature of practice and the role of institutions in one coherent whole.

There is an accepted level of interest amongst nurses in virtue theory and it is worthwhile making a systematic attempt to articulate some human qualities that can be claimed as virtues for nursing. The articulated goal of nursing is to help people to cope or adapt to their experience of illness and the accompanying treatment. By wedding this goal to MacIntyre's definition of virtues which are those characteristics

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<sup>149</sup> Deborah Hennessy & Carolyn Hicks, "The ideal attributes of Chief Nurses in Europe: a Delphi study," Journal of Advanced Nursing 43.5 (2003): 447.

<sup>150</sup> The contributions that writers such as Allmark and Whelton have made in applying the writings of Aristotle to nursing ethics thus linking nursing to the broader virtues theory tradition has been discussed.

<sup>151</sup> Louise de Raeve, "Trust and trustworthiness in nurse-patient relationships," Nursing Philosophy 3.2 (2002): 156.

<sup>152</sup> Peter Allmark, "HIV and the boundaries of confidentiality," Journal of Advanced Nursing 21.1 (1995): 163.

that enable the practitioner “to achieve those goods which are internal to practices”<sup>153</sup> it is possible to identify some virtues for nursing. This is not proposed as an exhaustive list of virtues nor is it suggested that these virtues are exercised in no other profession than nursing. It is proposed, however, that nursing requires virtues of character and intelligence from its practitioners. It will be argued that nurses need to be loving, courageous, conscientious and practically wise or prudent for the good practice of nursing.

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Love – the quality of giving oneself in the service of others - is the virtue that saves nursing from becoming a self-interested profession. It restores the notion of vocation to the profession. When a person responds to the call of a profession for its own sake rather than for the benefits it delivers (what MacIntyre refers to as *external goods*) that is an expression of love. The act of giving oneself to a healthcare profession is to give oneself in the service of others. Pellegrino writes that the “act of profession is an act of implicit promise making that establishes a covenant of trust at the physician’s or nurse’s voluntary instigation”.<sup>154</sup> It is a betrayal of one’s profession to be more devoted to professional advancement than to the interests of those the profession is intended to serve. Nurses can participate in inspiring love for the vulnerable sick (an improvement on the nurse as advocate role) in society and they can express their love for humanity in acts of friendliness and compassion.

#### Nursing that “Inspires Loves”

The moral philosopher, Raimond Gaita comments on the place of love in life and professional ethics. In *A Common Humanity* Gaita describes himself as standing between Plato, who says we become like that which we love, and Kant who denies the possibility of commanding love between people but argues that rationality is the basis for the categorical imperative to treat people as ends and not means.<sup>155</sup> This, in Kant’s view, is not love but reason at work. Gaita writes that to employ reason alone as a means of determining one’s morality leads to the categorical imperative and “love, is the name we give to such behaviour”.<sup>156</sup> However, to love those who have no

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<sup>153</sup> MacIntyre, *After Virtue* 191.

<sup>154</sup> Pellegrino, “Toward a virtue-based normative ethic,” 267.

<sup>155</sup> Raimond Gaita, *A Common Humanity*, (Melbourne: Text Publishing, 1999) 6.

<sup>156</sup> Gaita, *A Common Humanity* 20.



merit seems counter to reason. An account of ethics is, Gaita argues, nevertheless incomplete if derived solely on the basis of rationality.

Despite the difficulties that love presents to rationality, the life of love is to be preferred to a life determined by rationality alone. Gaita captures this truth in his account of the love that a nun demonstrated to some psychiatric patients in an institution where he once worked. Although there were compassionate carers who honoured the notion of human dignity, their care was shallow or condescending when compared to the reality of the love that she shared with the patients. Her commitment to the idea of the innate dignity of the person and the sanctity of the human spirit was intensely real. It had a transformative effect on the inmates so that they were able to reflect the image of human dignity that she projected to them. The manner of her relationship with the inmates possessed an authenticity which made the relationships that the other workers had with the inmates seem like a desperate denial of the grim realities that faced these patients.<sup>157</sup>

Having written about the centrality of love in life, Gaita applies his thinking to the area of professionalism. His remarks are predominantly addressed to the profession of teaching but they may be applied to nursing.<sup>158</sup> According to Gaita, nursing is a vocation that may have “forfeited some of its treasures” for the doubtful benefit of professionalism. He regards “mediocre notions of profession” as a poor substitute for the richer traditions of vocation for “when they are fully lived, vocations inspire loves”.<sup>159</sup> Nursing can be the kind of practice that rewards the practitioner the more the essence of the practice is honoured and allowed to shape the practitioner by its demands. Treasures such as character transformation are the kinds of things that can be lost when the process of professionalisation is limited to the delivery of *external goods* such as higher wages and enhanced status in the community.

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<sup>157</sup> Gaita suggests that love is an action that is beyond reason (and therefore cannot be considered a virtue). He demonstrates some similarity with an ethic of care in his preference for love over reason and extends his insight about love beyond MacIntyre’s description of a virtue. His view, however, need not preclude a discussion of love as a virtue that supports the good practice of nursing. Gaita, *A Common Humanity* 18.

<sup>158</sup> Raimond Gaita, “Three Rs and an L,” *Sydney Morning Herald* 23 June, Spectrum: 2.

<sup>159</sup> Raimond Gaita, “Re-enchantment of learning,” *The Australian’s Review of Books* March, 2000 12.

How can a nurse inspire loves? If teaching can inspire love of learning, what kind of love might nursing inspire? Do nurses inspire love for the sick? In some cases a nurse who is self-sacrificing and particularly gifted in ways of attending to patients might inspire others to become nurses. The kind of love that is inspired from everyday practice occurs when nurses demonstrate to people how the sick and the weak can be loved. Illness and disability can disrupt well-established relationships and people need help in re-establishing ways to express love for each other when changes occur in physical states. In a study on the impact of incontinence on older spousal caregivers, participants stated their ongoing love for their partner in spite of physical changes: "If you love somebody, you really can do it".<sup>160</sup> The nurses' role was in the form of relatively simple interventions such as the provision of equipment or referrals, which enabled the carers to continue to express their love for the patient in practical ways. It can be a frightening experience to touch a sick person. Carers appreciate being taught ways to give physical care to those they love.<sup>161</sup> As death approaches, they value being helped by nurses to be present with those that they love. As the nurse shows them how to be comfortable in silence, to offer gentle touch and to listen to the patient,<sup>162</sup> the nurse is helping the carers love the patient to the end.

Not all nurses are at ease with this way of relating to people .The absence of *love which inspires loves* has a negative impact on therapeutic relationships. A study on the difficulties that mothers experience when their infants are in a Neonatal Unit reveals that some nurses actively impede attempts by the mothers to care for their infants. The mothers describe the presence of nurses who monopolise the babies and try to exclude the mothers from the practical aspects of their babies care. This results in a range of emotional responses from the mothers from anger and bitterness to feelings of anxiety about their ability to mother and foolishness. It also significantly interferes with the bonding process between mother and baby.<sup>163</sup> At other times nurses demonstrate that they are aware of the significance of their role in fostering relationships within family groups but then fail to adequately explore this issue. One study which examines the differing expectations of child health nurses

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<sup>160</sup> Colin Cassells & Elizabeth Watt, "The impact of incontinence on older spousal caregivers," Journal of Advanced Nursing 42.6 (2003): 612.

<sup>161</sup> Elizabeth Ford Pitorak, "Care at the time of death: how nurses can make the last hours of life a richer, more comfortable experience," American Journal of Nursing 103.7 (2003): 47.

<sup>162</sup> Pitorak, 48.

<sup>163</sup> Jennifer Fenwick, Lesley Barclay & Virginia Schmied, "Struggling to mother: a consequence of inhibitive nursing interactions in the neonatal nursery," The Journal of Perinatal and Neonatal Nursing 15.2 (2001): 49-64.

and mothers opens with a statement which affirms that “the attachment between an infant and their parents is of great importance”.<sup>164</sup> The study then focuses on the role of the nurse in the family relationship.<sup>165</sup> Attention is paid to the importance of the relationship between the parents and the nurse but no further mention is made of the bond that the infants form with their parents or what it is that a nurse can do to foster the bond between mother and baby. Nurses deny themselves and their patients a potentially profound way of engaging with those in their care when they do not fully explore ways that they can *inspire loves* in others.

### **Love in Nursing as Friendliness**

Kendrick and Robinson agree that the subject of love is one that has not been well addressed in nursing. They find it puzzling that in spite of the claims of the centrality of care by the care theorists they make little connection between care and love.<sup>166</sup> One explanation is found in the critique of the feminist care ethicists. An ethic of care demands almost complete immersion in the needs of the other. Female nurses are rightly wary of an ethic that demands so much from them. Other issues, such as the possibility of erring into inappropriate relationships with patients, have had the effect of limiting the place for the discussion of love in nursing. On the other hand, if the expression of love is one that will help the practitioner more fully realise the goals of the profession, no practitioner can ignore the place of love in the professional life. Harris makes love a central virtue in management because, as he argues, it is a governing principle by which other virtues may be measured. He distinguishes between amorous or erotic love and the love which is described by Aquinas which has at its centre a wish for the good of others. The latter form of love is the kind that is naturally appropriated for the professional life.<sup>167</sup>

Alistair Campbell uses the language of virtues when he describes love in the professional life as “moderated love”<sup>168</sup>. He reasons that there is no conflict with the Christian concept of “agape” in that to be moderate in love does not imply that love is

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<sup>164</sup> A. Fagerskiold, “Expectations of the child health nurses in Sweden: two perspectives,” International Nursing Review 50.2 (2003): 119.

<sup>165</sup> Fagerskiold, 120.

<sup>166</sup> Kevin David Kendrick & Simon Robinson, “*Tender loving care* as a relational ethic in nursing practice,” Nursing Ethics, 9.3 (2002): 292.

<sup>167</sup> Howard Harris, “Is love a management virtue?” Business and Professional Ethics Journal 21. 3&4 (2002): 173.

<sup>168</sup> Alistair V. Campbell, Moderated Love: A Theology of Professional Care (London: SPCK, 1984).

conditional. Instead, love is limited by the reality of the situation. Thus, a nurse loves moderately when the physical limitations of resources and environment are accepted and love is expressed in an ordered manner. When a practitioner makes the assessment about loving in the right way, at the right time, in the right amount and for the right ends, love is being expressed as a virtue. It is an irony that women have less to fear from love expressed as a virtue, grounded as it is on reason, than from the feminist care ethic which asks so much from women. Those who object to love expressed moderately and therefore as a virtue do so on the basis that love is a feeling that is expressed passionately, freely, in an unlimited manner and therefore it is argued that it cannot be moderated. This quality is not love if it is moderated. To cast love in this way is, however, to forget that even love expressed passionately accepts limits. Such love is kept between the partners. It is not shared indiscriminately and if it is done so it is understood as betrayal.

The relationship between the patient and the nurse is at the heart of nursing activity. Historically, the relationship between the patient and the healer was underpinned by friendship, both as an expression of shared humanity and in recognition of the vulnerability of the patient's position<sup>169</sup>. A certain level of physical intimacy is called for in a healing relationship. Where goodwill is enjoyed between the healer and the patient, such friendship can be said to exist to facilitate the achievement of therapeutic goals and the vulnerable are safeguarded from exploitation.

However, with the increasingly technological nature of therapeutic care, the role of friendship in the therapeutic relationship has been called into question. The place of care moved from home to institution and carers changed from being familiar practitioners to strangers. Can a stranger be a friend? The need for friendliness is also challenged by the necessity for detachment in professional practice. Is there such a thing as detached friendship? It seems that there is a limited place for the experience of friendship in the health care setting but friendliness remains necessary for a good experience for patients.

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<sup>169</sup> Paul J. Wadell, "Friendship," *Encyclopaedia of Bioethics*, ed. Warren T. Reich rev. ed., vol. 2. (New York: Simon & Simon Macmillon, 1995) 889.

Friendliness is characterised by an ability to promote interactions and connection with others and is a quality that is appreciated by patients<sup>170</sup>. Friendliness or connection is also thought of as a way for nurses to provide spiritual care, thereby contributing to holistic practice.<sup>171</sup> Friendliness between healthcare workers contributes to a supportive work environment, which is considered significant, both for what it contributes to workplace satisfaction<sup>172</sup> and the effect this has on staffing stability.<sup>173</sup> Geanellos<sup>174</sup> explores the place of friendliness and friendship in nursing care and its effect on patient outcomes. She makes a distinction between friendliness, which she regards as superficial but effective in terms of improving patient experiences and outcomes, and the deeper quality of friendship. There is agreement that friendliness relieves tension and “offers a sense of belonging, comfort and camaraderie for patients”<sup>175</sup> and that friendliness is an essential feature of nursing care. Geanellos makes the suggestion that such interpersonal skills ought to be taught and assessed in nursing schools.

It is necessary to make a distinction between friendliness as a virtue and friendliness as a goal in nursing. When friendliness is considered as a way of helping a patient achieve a good health outcome, it is a virtue. However, it is almost counter to the goals of nursing to think of friendliness as something that is to be aimed at for its own sake. Walker appears to make this mistake in her discussion of the way that nurses comfort patients. She makes the claim that “comfort is characterised as the goal of therapeutic nursing practice”<sup>176</sup> and then describes comfort in ways that are characteristic of a relationship i.e. “empathy, sympathy and humour”.<sup>177</sup> These statements alone would not be sufficiently convincing that she regards the pursuit of relationships for their own sake as a legitimate goal in nursing except that she then argues that “the dominant issue for informants (in her study) was the affective and

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<sup>170</sup> Debbie Kralik, Tina Koch & Karen Wotton, “Engagement and detachment: understanding patients’ experiences with nursing,” Journal of Advanced Nursing 26 (1997): 402.

<sup>171</sup> Bernice Golberg, “Connection: an exploration off spirituality in nursing care,” Journal of Advanced Nursing 27.4 (1998): 840.

<sup>172</sup> Kangas, Sandra, Carolyn C. Lee & Rebecca McKee-Waddle, “Organisational factors, nurses’ job satisfaction, and patient satisfaction with nursing care,” Journal of Nursing Administration 29.1 (1999): 40.

<sup>173</sup> Ellen Strachota, Pamela Normandin, Nancy O’Brien Mary Clary and Belva Krukow, “Reasons registered nurses leave or change employment status,” Journal of Nursing Administration 33.2 (2003): 114.

<sup>174</sup> Rene Geanellos, “Exploring the therapeutic potential of friendliness and friendship in nurse-client relationships,” Contemporary Nurse 12 (2002): 236.

<sup>175</sup> Geanellos, 242.

<sup>176</sup> Annette Walker, “Safety and comfort work of nurses glimpsed through patient narratives,” International Journal of Nursing Practice 8.1 (2002): 43.

<sup>177</sup> Walker., 46.

interpersonal comfort work of nurses, whether or not they were providing physical care". Such a claim is based on patient comments such as the following:

'An informant in pain following wrist surgery was greatly comforted by frequent visits of the night nurse and the sympathy she conveyed. 'She was 10 out of 10 excellent'; yet it was clear on following up this remark with probe questions that the nurse had not fixed the pillows, elevated the arm and hand or advocated for more appropriate analgesia.'<sup>178</sup>

It is alarming that such a patient response can be taken to justify the refocussing of nursing activity from practical bodily care to affective processes. The point can be made that patients are comforted by a friendly, warm approach to their care, but the virtue of friendliness needs to be realised in such a way which is not at odds with the execution of clinical measures, nor is it something which can take the place of clinical care.

Lumby provides vignettes of Australian community nurses who, although they do not identify themselves as having become friends to those in their communities, do the things for their patients that friends do for each other. These nurses are located in remote regions and have contact with, and responsibility for, the care of various aboriginal communities. Lumby identifies isolated aboriginal communities as the most disadvantaged in Australian society.<sup>179</sup> The nurses tell their own stories. They say "You go to an aboriginal community to see people who are sick but at the same time you say, "Have you got an uncle in your family who is sick?"<sup>180</sup> Another says "I do pub crawls to find my clients because they need an injection ... They know their needle's due but they've got no money to pay for their script so I've bought their script ...Usually they pay the money back."<sup>181</sup>

Thoughts differ on the nature of friendship in healthcare relationships. Geanellos regards friendship as a fuller expression of friendliness because friendship cannot exist without a sense of mutuality, whereas a nurse can be friendly towards a patient without any sign of friendliness in return. She offers examples of nurses who have

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<sup>178</sup> Walker., 46.

<sup>179</sup> Lumby, 75.

<sup>180</sup> Lumby, 106.

<sup>181</sup> Lumby, 114.

been the recipients of friendly acts from patients and the restorative help that nurses experience when patients take the time to be supportive. Such friendships are described as “therapeutic”.<sup>182</sup> Wadell takes a different view of the mutuality inherent in friendly relationships between nurses and patients that is more in keeping with a virtues approach to friendship. The mutuality that Wadell identifies has to do with patients also taking a role in their own recovery. Where patient and physician share the goal of good health for the patient, friendly relationships between them help to achieve this goal. Physicians alone are not able to effect cure without patients who are ‘truthful and communicative, cooperative, trustworthy and just.’<sup>183</sup> On this account the relationship has a friendly quality and this quality facilitates in the achievement of health care goals.

### **Love in Nursing as Compassion**

Compassion has been described as the most readily recognisable aspect of caring in nursing.<sup>184</sup> It contains within it the dual meanings of empathy and sympathy, both of which imply an emotional response to another based on a sharing or involvement, at some level, with another person’s suffering.<sup>185</sup> More than an emotional response to the suffering of another, however, empathy also requires that there is intelligent reflection on that response in order to “interpret the feelings, thoughts or perceptions of another person so as to provide professional care”.<sup>186</sup> Compassion, however, is more than empathy or sympathy as it “also adds the dimension of deliberate action”.<sup>187</sup> Thus it can be seen that compassion can be described as an aspect of the way that nurses express love in their practice. Compassion is therefore, a virtue, combining as it does the elements of emotion, action and rationality.

Pike<sup>188</sup> discusses the pervasiveness of the acceptance amongst nurses of the place of empathy in their practice. She acknowledges that there are differing opinions over whether there is a difference between empathy and compassion, what kinds of acts can be described as compassionate and, given the level of intensity required from involvement to approximate empathy, whether there is a place for empathy in

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<sup>182</sup> Geanellos, 243.

<sup>183</sup> Wadell., 889.

<sup>184</sup> Tschudin, 19.

<sup>185</sup> Erich von Dietze & Angelica Orb, “Compassionate care: a moral dimension of nursing,” *Nursing Inquiry*, 7.3 (2000): 167.

<sup>186</sup> Dietze & Orb, 167.

<sup>187</sup> Dietze & Orb, 168.

<sup>188</sup> Adele W. Pike, “On the nature and place of empathy in clinical nursing practice,” *Journal of Professional Nursing* 6.4 (1990): 235-241.

nursing. Despite the range of opinions discussed, Pike concludes that nurse express their empathy in the way described by Benner and Wrubel which is to deny the cognitive aspects of compassion and emphasis action at the more intuitive level. For example, Pike uses the example of a nurse who notices a ballet charm bracelet worn by an elderly lady about to have a leg amputated. The nurse's comment led the women to tell her about her ballet dancing days which contributed to an enhanced understanding of what this operation meant to the woman and prompted a more meaningful level of support for the upcoming operation. This misses the point that much of nursing action is to provide comfort to people whether there is any certainty about whether such action will affect a health outcome. A nurse can know that it is right to act in a kindly manner towards a patients and to pay attention to personal details of their lives.

There is some uncertainty about the place of empathy amongst nurses which arises from the nurse who takes seriously the demands of empathy which seem, and in fact are, all consuming. The more honest among us know that more often than not what appears to be empathy is simply doing our job. The nurse learns that staying with a person who is afraid helps that person. The nurse learns how to stay with a person and does so.<sup>189</sup> Compassionateness is a virtue that is neither paralysed by the overwhelming nature of suffering nor so committed to action that the suffering human is forgotten.

## 5.5.2

C

### onscientiousness

Conscientiousness - meticulousness or precision of practice - is a quality that is recognised to be a virtue of nursing by various writers. Halford regards conscientiousness as evidence of self-mastery or, in his terms, self-management.<sup>190</sup> Bradshaw lists conscientiousness amongst the traditional virtues that nurses acquired as part of their training process.<sup>191</sup>

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<sup>189</sup> Pike, 239.

<sup>190</sup> Scott G. Halford, "The art of fitting into our lives," *AORN* 72.3 (2000): 489.

<sup>191</sup> Ann Bradshaw, "Teaching spiritual care to nurses: an alternative approach," *International Journal of Palliative Nursing* 3.1 (1997): 56.



Conscientiousness is a virtue in nursing because it enhances the practice of nursing. It is a mean between an excess and a deficiency, both of which are vices that impede one's function in life. An excessively conscientious person can be thought of as fussy to the point of perfectionism. Thus described it is an obsession that is an observable trait in psychiatric conditions such as anorexia nervosa.<sup>192</sup> Psychologists George and Zhou examine conscientiousness and openness to experience for their effects on creative behaviour. They write that although "conscientiousness appears to show the strongest and most consistent relationship with job performance" it can also result in "excessive meticulousness, orderliness, or workaholic tendencies" and in particular "may actually discourage creative behaviour".<sup>193</sup> They identify conscientiousness as a virtue which, when it slips into excessiveness, becomes an attribute that limits or impedes one's development as a flourishing human being. They add that a work environment that is negative and has close monitoring practices is thought to be particularly inhibiting for the creative tendencies of the highly conscientious person.<sup>194</sup>

The vice of inattention is a deficiency of conscientiousness. Jenni outlines the serious implications for one's morality that the vice of inattention invites. Even in its most *innocent* form, which is "not working to know", inattention is a vice that can contribute to the harm of others. The more serious level of inattention is the "working not to know" which involves a systematic practice of self-deception where the practices are more brutal.<sup>195</sup> Jenni connects the "not working to know" with less serious deficiencies of morality such as cruelty to animals and "working not to know" with the efforts required to suppress knowledge of wider societal brutality such as the genocide of the Jews in Nazi Germany.<sup>196</sup> She nevertheless challenges both habits as serious breaches of humanity specifically because the vice of inattention inhibits human autonomy which results in the failure of courage, self-control and compassion which ultimately contributes to a loss of integrity.

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<sup>192</sup> Nalini Srinivasagam, Walter H. Kaye, Katherine Plotnicov, Catherine Greeno, Theodore E, Weltzin and Radhika Rao, "Persistent perfectionism, symmetry and exactness after long-term recovery from anorexia nervosa," The American Journal of Psychiatry 152.11 (1995): 1630.

<sup>193</sup> Jennifer M. George and Jing Zhou, "When openness to experience and conscientiousness are related to creative behaviour: an interactional approach," Journal of Applied Psychology, 86.3 (2001): 515.

<sup>194</sup> George & Zhou, 516.

<sup>195</sup> Kathie Jenni, "The vices of inattention," Journal of Philosophy 20.3 (2003): 282.

<sup>196</sup> Jenni, 283.

The implications for nursing are clear. Nurses deal with a vulnerable community who depend on them for their source of comfort, treatment, food and information.<sup>197</sup> Patients can be reluctant to make their needs known so they rely on nurses to prompt them to give expression to their needs. Nurses can observe a patient's discomfort by the way the patient sits or moves about or by the clues revealed in facial expression or demeanour. A nurse who makes the choice to offer analgesia or some assistance to a patient has "worked to know" what it is that the patient requires. One who pleads ignorance of the patient's needs by claiming that the patient failed to request help has either "not worked to know" or has even "worked not to know" what it is that can be done to help the patient, thereby exhibiting the vice of inattention.

In contrast to these two vices, conscientious nursing is captured by the nurse who brings a sense of "attentiveness" to every aspect of the role. This quality was articulated as "carefulness" by the early religious orders of nursing and finds its echoes in the writings of Nightingale and Bradshaw as a "covenant of care".<sup>198</sup> Early nursing training emphasised a scrupulous attention to detail which was a source of occupational pride for many nurses. However, it also became problematic for nursing culture in that it contributed to a vision of nursing which, at times, found its fullest expression in the achievement of a clean and shiny ward. However there is, and has always been, more to this concept than the cultivation of excellent habits of tidiness and hygiene. While ever the nurse regarded every task to be connected with the care of the patient, a culture of petty fussiness could be held at bay from intruding on the expression of the "covenant of care" for the patient.<sup>199</sup> When the nurse's eye is firmly on the patient, searching for ways to help, the nurse cannot later claim "not to have known" what was needed.

Niven and Scott argue that nurses need to rediscover a sense of attentiveness about their work. They refer to Simone Weil (via Iris Murdoch) who describes the act of attending to another as that of a "just and loving gaze directed upon an individual reality".<sup>200</sup> The practitioner sees the patient without the filters of status or prejudice. This ability to attend to a patient has both clinical and moral implications. Arslanian-

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<sup>197</sup> C. A. Niven & P. A. Scott, "The need for accurate perception and informed judgment in determining the appropriate use of the nursing resource: hearing the patient's voice," *Nursing Philosophy* 4 (2003): 202.

<sup>198</sup> Bradshaw, "The virtue of nursing," 478.

<sup>199</sup> Bradshaw, "The virtue of nursing," 477.

<sup>200</sup> Niven & Scott, 205.

Engoren reports that nurses who are responsible for triaging patients in Casualty Departments have some difficulty “seeing” the patients. They are consistently more likely to give higher priority to male patients who present with symptoms of cardiac arrest than female despite knowing that females characteristically present and describe their symptoms differently from men. Arslanian-Engoren identifies a bias in their decision making process and unearths the troubling finding that young female nurses blind themselves to the possibility that other young females could be experiencing heart disease in order to protect themselves at some level from the reality that they too may be vulnerable to heart disease.<sup>201</sup>

Nurses can also blind themselves to the moral realities of their practice when they fail to see ways that they can fully attend to their patients’ needs. Niven and Scott argue that the “checklist mentality” which flavours some models of nursing such as that of Roper, Logan and Tierney and also that found in the “nursing process” has contributed to this blindness to some extent.<sup>202</sup> These approaches to nursing give the impression that completion of a series of tasks means that a nurse has done all that can be done for a patient. However, there is more to nursing than the completion of a series of tasks. In order to explore the full extent of what can be done for patients “the nurse needs to invest effort and exercise skill in order to see their need or understand their interpretation of their particular illness/disease situation”.<sup>203</sup> Cultivation of an attitude of attentiveness is dependent on the nurse being open to be taught about the patient by the patient.

Arslanian-Engoren uses feminist methodologies to reveal the limitations of traditional medicine which largely examines the experiences of males in ill-health and imposes those experiences normatively on women’s experiences.<sup>204</sup> In the area of cardiac disease women and men experience and describe cardiac pain differently. In order for nurses to be able to attend to their needs properly they need to be aware of these differences. Thus attentiveness is dependent on both knowledge about a condition and the development of an attitude that seeks to unearth the full extent of the presenting problems of the patient. Based on the information presented by Arslanian-

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<sup>201</sup> Cynthia Arslanian-Engoren, “Gender and age bias in triage decisions,” Journal of Emergency Nursing 26.2 (2000): 117-124. Cynthia Arslanian-Engoren, “Gender and age differences in nurses’ triage decisions using vignette patients,” Nursing Research 50.1 (2001): 61-66.

<sup>202</sup> Niven & Scott, 205.

<sup>203</sup> Niven & Scott, 206.

<sup>204</sup> Cynthia Arslanian-Engoren, “Feminist poststructuralism: a methodological paradigm for examining clinical decision-making,” Journal of Advanced Nursing 37.6 (2002): 512-517.

Engoren, this form of “knowing the patient” differs from the Benner explanation of what it is to know the patient. Arslanian-Engoren describes knowing the patient based on gleaning information from the patient and interpreting it in terms of objectively derived knowledge.

Conscientiousness is a virtue that is needed for the good practice of nursing. It is developed by cultivating a habit of attentiveness to the patient. A nurse needs to be aware when conscientiousness slips into excessive forms of meticulousness or fussiness, which can result in a paralysis of worthwhile action despite the appearance of much activity. The good nurse also allows conscientiousness to bring about a thoroughgoing diligence that “works to know” the needs of patients thereby avoiding the vice of inattentiveness.

### 5.5.3

C

#### **courage**

Courage has been recognised as a virtue since classical times. It was one of the qualities necessary for the warrior heroes who peopled the mythical tales that informed ancient Greek culture.<sup>205</sup> Aristotle regarded courage as the mean between fear and rashness or over-confidence. He describes courage as that quality that allows a person to be steadfast for a good cause in the face of danger or difficulty. Although acting rashly or in ignorance can sometimes seem to be courageous, Aristotle discounted such actions as not sufficiently rational to qualify as the virtue of courage<sup>206</sup>.

It has been suggested that the influence of Christianity feminised the understanding of the virtues that were required to live the good (or godly) life. The manly virtues of courage, along with “loyalty, magnanimity and patriotism”, were replaced with qualities such as “love, joy peace, longsuffering, gentleness, goodness faith, meekness, temperance” in other words “the fruit of the spirit”.<sup>207</sup> These virtues were more commonly associated with womanly behaviour. Courage, associated as it was with warlike behaviour, did not seem to fit in the Christian lists of virtues. Yet early

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<sup>205</sup> Gary B. Ferngren and Darrel W. Amundsen, “Virtue and health/medicine in pre-Christian times,” *Virtue and Medicine: Explorations in the Character of Medicine*, ed. Earl E. Shelp Philosophy and Medicine 17 (Dordrecht: D. Reidel Publishing Company, 1985) 4.

<sup>206</sup> Aristotle, III.6-8.

<sup>207</sup> Ferngren and Amundsen, 3.

Christians were exhorted to be steadfast in the face of the intense persecution that believers endured until the time of Constantine and which has continued wherever there has been opposition to Christianity to the present day. Courage was required to live the Christian life.

Similarly in nursing a certain kind of courage is required. The kind of courage shown by nurses that most readily comes to mind is the kind that enables the nurse to face the difficult situations and conditions that people experience when they endure the crises of illness and trauma. Perhaps the most fundamental way that nurses exhibit courage in relation to their patients is their commitment to be at the bedside, with patients when they are experiencing difficulties. It takes a great deal of courage to stay with a person in these circumstances. When nurses stay with patients they are exhibiting that quality of character that is a mean between fear and rashness. The nurse needs to overcome the fear of whatever is occurring to the patient and resist the temptation to invent tasks that will take him or her outside the room: reports needing completion, a consultant needing to be rung, other patients are needing help. The nurse must have confidence that staying with the patient is the most important thing that he or she can do at that time.

Yet, this does not seem to be the situation most often addressed in the nursing literature. Instead, nursing literature more often describes the courage that nurses exhibit when they are in either dangerous situations or situations of conflict. Courage has been variously described as that quality that terminally ill patients exhibit and nurses observe and support the development of when they are facing the end of their lives.<sup>208</sup> Surprisingly, intensive care nurses identified lack of courage as a problem, not in relation to the difficulty of their role, but in the way that they related to the physicians.<sup>209</sup> Nurses need courage to be innovative and expert clinical practitioners in the face of what Peplau describes as the in-built resistance to change of institutions and as a way to 'beat down tradition'.<sup>210</sup> Some writers comment on the need for nurses to possess courage when the situation itself presents a danger to the

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<sup>208</sup> Donna M, Gauthier, "The meaning of healing near the end of life," Journal of Hospice and Palliative Nursing 4.4 (2002): 225.

<sup>209</sup> Berit Lindahl and Astrid Norberg, "Clinical group supervision in an intensive care unit: a space for relief, and for sharing emotions and experiences of care," Journal of Clinical Nursing 11.6 (2002): 816.

<sup>210</sup> Hildergarde Peplau, "Specialization in professional nursing," Clinical Nurse Specialist 17.1 (2003): 5.

nurse. Nurses who work for relief organisations in war zones,<sup>211</sup> or those who assume leadership roles in disaster response plans need to be courageous.<sup>212</sup> MacIntyre writes generally about the role of virtues in the professions and describes courage as a virtue that protects the practitioner from the corrupting effect of the institution.<sup>213</sup> He also points out that the professional who expresses concern about the wellbeing of others but is not willing to risk harm or danger “puts in question the genuineness of his care and concern”.<sup>214</sup>

MacIntyre’s comments in this regard cannot be taken to recommend habitual abandonment of caution. Instead he recognises that it is not possible totally to quarantine a practitioner from harm where a practice involves some risk to the self. Health care workers routinely take universal precautions to protect themselves against infectious diseases. They know that there is some risk involved in caring for infectious patients and they demonstrate courage when they continue to offer treatment whilst adopting protective practices at the same time. During the recent worldwide outbreak of SARS, despite the obvious risks to their own health and that of their families, many health workers continued to treat people with SARS. They felt threatened by the disease<sup>215</sup> but took proper precautions to protect themselves against infection and continued their practice.<sup>216</sup>

Nurses have exhibited courage at crucial moments in history. Their contributions during times of war and widespread disease are well documented. The influenza pandemic of 1919, coming as it did at the closing of the WWI, offers a glimpse of the way that nurses responded to the hazards of war and disease in a courageous way. *The Close of an Era*,<sup>217</sup> a history of Sydney’s Royal North Shore Hospital (RNSH), tells of Sister Ada Thompson, a graduate of RNSH, who volunteered for war service and left Sydney as the armistice was declared. She returned to Australia via Western Australia and volunteered to care for ‘the victims of a new and virulent pneumonic

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<sup>211</sup> Roberta Gately, “An emergency nurse’s work with refugees in Africa, The Balkans, and Afghanistan,” *Journal of Emergency Nursing* 29.1 (2003): 32.

<sup>212</sup> Joyce Johnson, “Leadership in a time of disaster: being prepared for new age threats,” *Journal of Nursing Administration* 32.9 (2002): 460.

<sup>213</sup> MacIntyre, *After Virtue* 194.

<sup>214</sup> MacIntyre, *After Virtue* 192.

<sup>215</sup> “No obvious end in sight: SARS warning,” *Sydney Morning Herald* 21 April 2003.

<sup>216</sup> Deborah Smith, “Australian on frontline in fight against SARS,” *Sydney Morning Herald* 31 March. 2003.

<sup>217</sup> Margaret Rice, *The Close of an Era* (Sydney: The Royal North Shore Hospital of Sydney Graduate Nurses Association, 1988) 30.

influenza while in Western Australia<sup>218</sup> and died of the disease on 1 January, 1919. Once the disease reached Sydney, the RNSH responded by hurriedly constructing isolation wards. The nurses who cared for the influenza patients were segregated in separate living quarters from other hospital workers until the crisis was over. Of the thirty-four nurses who cared for the influenza victims, twenty contracted the disease.<sup>219</sup> Those nurses accepted the deprivations of their circumstances and the risk that contact with these patients entailed even as they implemented the protective practices of the day. They exemplified the kind of courage that was required to sustain nursing practice in the early 1900s.

Unfortunately nurses need courage for the increasingly common event of being threatened or abused by patients on their care. The recent campaign by the NSW Nurse's Association illustrates the problem this has become for nurses. The courage that is required when facing abuse is the kind that will allow a nurse to remain in practice knowing that some time he or she will experience some level of abuse from a patient. However, when a nurse is in a situation of abuse or threatened violence, the nurse is better served by qualities that enable him or her to make a prudent retreat to safety than those which might encourage an effort at challenge or confrontation.

#### 5.5.4

P

##### **practical Wisdom**

Aristotle describes the practically wise person as one who is "able to deliberate nobly about what is good and beneficial for himself, not in particular respects, such as what conduces to health or strength, but about what conduces to living well as a whole".<sup>220</sup> It is an intellectual virtue that enables the person to reflect on the issues before him or her and to decide about the right course of action. Although practical reasoning guides action, it is more than a skill. Aristotle makes a distinction between scientific knowledge, which is the basis of skills or productive action, and ethical knowledge. Scientific knowledge requires no further deliberation on a matter once a thing is known. However, ethical knowledge requires wisdom in order for the person to be able to think about moral issues well and to make good decisions in concrete situations. As ethics is always directed towards action, it requires practical wisdom. It

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<sup>218</sup> Rice, 30.

<sup>219</sup> Rice, 31.

<sup>220</sup> Aristotle, VI 5. 1140a.

is “applied wisdom”. The point has been made earlier that this kind of knowledge is also distinct from *sophia* which is the kind of knowledge that is pursued for its own sake. It is a contemplative activity.<sup>221</sup> Practical wisdom resists a formulaic approach. Aristotle argues that “it is a mark of an educated man to look in each area for only that degree of accuracy that the nature of the subject permits”.<sup>222</sup> Ethics is not a science. The ethical person relies on more than rules or principles to live and work well. The good person needs to cultivate habits of wisdom in order to understand the demands of each situation and make the right decisions. Aristotle uses the term *eudaimonia* to describe the blessed or happy state in which a person who has cultivated the virtue lives.

Aristotle’s argues that people can only flourish when they are good. If Aristotle’s account is accepted, an application of his precept leads to the assertion that if a nurse to flourish then it is reasonable to expect that a nurse must be a good nurse and requires the virtue of practical wisdom in order to nurse well. The exercise of practical wisdom, even though it leads to goodness in practice, is an exercise in rationality. Good reasoning skills are needed for a nurse to practice well and flourish as a nurse. A good nurse will be emotional as he or she attends to patients but these emotions will be controlled or ordered by the nurse’s mind so that they are expressed in a virtuous way. If emotions are not ordered or controlled by reason they can then be expressed as either an excess or deficiency and they are then vices. Practical reasoning is the way of reflecting on one’s behaviour in order to have emotions such as “fear, confidence anger or pity ... at the right time, about the right things, towards the right people, for the right end, and in the right way” which is “the mean and the best“ and “the business of virtue”.<sup>223</sup>

Practical wisdom (or *prudence*) as described by Pellegrino, is on the one hand a virtue that can stand alone and on the other the virtue that one exercises in the practice of other virtues. He writes that one requires prudence in the “weighing of the alternatives in situations of uncertainty and stress”. Prudence is also practiced when unscrambling apparent conflicts among the virtues or in “understanding their relationships to one another”.<sup>224</sup>

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<sup>221</sup> Aristotle, VI 5.1140a.

<sup>222</sup> Aristotle, I.7 1098a.

<sup>223</sup> Aristotle, II.6 1106b.

<sup>224</sup> Edmund. D. Pellegrino, “Towards a virtue-based normative ethics for the health professions,” Kennedy Institute of Ethics Journal 5.3 (1995): 270.



The term “practical wisdom” has been adopted by some nursing writers to support the description of nursing practice as at times intuitive or as an art rather than a science. Flaming does this when he makes a connection between tacit or personal knowledge, described by Polanyi and Carper respectively, and *phronesis*.<sup>225</sup> Blondeau argues that nursing can be described as a “practical art” because nursing activity requires deliberation about the best way to act in order to achieve the best good for the person.<sup>226</sup> Both writers are making points about nursing in similar vein to Benner (that expert nurses practice intuitively). Like Allmark, they wish to connect Benner’s argument with the teaching of Aristotle. However, they seem to be arguing that the intuitive nature of practice will potentially underpin the place of practical wisdom in nursing, as though it is an alternative to rationality. This is indicated by the suggestion that practical wisdom be considered as an alternative to research-based practice as though they are incompatible with each other. On the contrary, practical wisdom and research based practice complement each other. One is knowledge generated on the basis of reason and the other is a reasoned or well-considered application of such knowledge.

A study of nursing expertise reveals that nurses consider that expertise is demonstrated in two aspects. It is shown by the accuracy of one’s response to the task and also the appropriateness of the way the task is managed.<sup>227</sup> The nurses also valued theoretical knowledge over intuition in their practice (contrary to the expectations of the researchers). Nurses who perform procedures to an objective standard and who can provide a rationale for the different ways that they manage a task are behaving in practically wise ways. The ability to act rightly and make the further kind of ethical deliberations which can guide a practitioner to also do the right thing in the right way is characteristic of the expert practitioner. The possession of this kind of wisdom is dependent on the integration of theoretical and practical knowledge via personal reflection of the practitioner.<sup>228</sup> Its possession is an observable process brought about by the deliberate intent on the part of the nurse to

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<sup>225</sup> Don Flaming, “Using *phronesis* instead of ‘research-based practice’ as the guiding light for nursing practice,” Nursing Philosophy 2.3 (2001): 256.

<sup>226</sup> Danielle Blondeau, “Nursing art as a practical art: the necessary relationship between nursing art and nursing ethics,” Nursing Philosophy 3.3 (2002): 258.

<sup>227</sup> Yoshiko Nojima, Takako Tomikawa, Satsuki Makabe & Mariah Snyder, “Defining characteristics of expertise in Japanese clinical nursing using the Delphi technique,” Nursing and Health Sciences 5.1 (2003): 8.

<sup>228</sup> Gunilla Carlsson, Nancy Drew, Karin Dahlberg & Kim Lutzen, “Uncovering tacit knowledge,” Nursing Philosophy 3.2 (2002:) 146.

learn about the condition of the patient and a willingness to allow that knowledge to affect one's character so that the nurse will be sensitive not just to the practical demands of a situation but also to the moral dimensions that are present in any human encounter.

The possession of practical wisdom is also dependent on the cultivation of an attitude of open-mindedness or tentativeness. Sellman describes open-mindedness as a virtue. Whether or not it is (strictly speaking) a virtue, there is truth to the claim that open-mindedness assists a nurse towards the possession of practical wisdom. When an open-minded person deliberates about how to proceed in a matter there is an acceptance he or she could be wrong.<sup>229</sup> Therefore, the wise person acts tentatively until there is some confirmation that the right decision has been made. Acceptance of the possibility of being mistaken need not undermine confident practice; nor does it mean that one's practice is characterised by uncertainty. A nurse can be confident in the performance of certain tasks and exercises practical wisdom in both the matter and manner of his or her actions. In practical matters there is usually little ambiguity about the right measure of medication or the type of dressing to be performed, although practical wisdom is exercised when making clinical judgements between a number of possible treatment modes. The clinician deliberates and makes a judgement after taking the particularities of the situation into account.

The nurse also exercises practical wisdom in the manner of attending to the patient. Again there need be no uncertainty about some absolutes that underpin good practice. The patient ought not be deceived or treated discourteously. Beyond that the nurse is free to bring whatever can be offered in terms of personality, warmth, humour or level of information that will help the patient. The knowledge about which approach to employ depends at first on a willingness to be tentative (or open-minded) until the nurse learns what the particular patient appreciates. Nurses cannot assume that all people welcome the same level of informality or humour or directness that they themselves would welcome or even that their experience tells them that most people welcome. Nurses who are practically wise value knowledge. They value both knowledge about the condition and knowledge about the particular patient, above what their experience tells them about conditions and patients in general.

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<sup>229</sup> Sellman, 19.

The virtue of practical wisdom has an important place in nursing. However its role in the way that nurses deliberate has not always been well explicated by nursing theorists. The attempt to merge it with intuitiveness equates nursing with other practices of a magical or mysterious nature. This carries with it the implication that only “special nurses” can attain this level of expertise and the process by which nurses achieve this level of practice eludes explanation. Alternatively, a rational account of practical wisdom conveys a sense of achievability to nurses. If practical wisdom can be explained in concrete terms, then nurses can have confidence that they can cultivate this quality in themselves. As they adopt accepted standards of practice and foster habits of tentativeness or open-mindedness in their manner they can expect that their practice will come to be characterised by the virtue of practical wisdom.

## **5.6**

**E**

### **ffects on Nursing Practice**

#### **5.6.1**

**A**

##### **voids Deficiencies of Science and Care**

It has been argued that both the scientific framework and the care ethic have advanced the practice of good nursing to the limits defined by their own frameworks but they have not succeeded in giving a complete account of the work of nursing and what it means to be a nurse. The solution is not to take what appears to be the most workable or applicable aspects of each of the frameworks and blend them into a particular nursing pastiche of professional ethics. The two frameworks are fundamentally incompatible and the attempt to do so has, in large part, contributed to the crisis of nursing ethics and identity that is confronting nurses today. When nurses try to follow two competing ethical guides they fulfill the ideals of neither well and this contributes to the levels of self-doubt and uncertainty that have become characteristic of nursing today.

Virtue theory is a means to describe the rational and objective aspects of nursing practice and the emotional qualities, both of which are essential for the good practice of nursing. This has been discussed in the preceding presentation of some virtues for nursing. Virtue theory can also be a means to articulate a professional identity that sacrifices none of the nursing tradition that nursing relies on so strongly for an

articulation of its moral authority to practice but also sits comfortably with a modern scientific account of the demands of contemporary practice.

## 5.6.2

A

### **acknowledges a Place for Luck in Nursing Practice**

Aristotle argues that one's moral character and inclinations are one's own responsibility. He describes the formation of character as the result of good upbringing and the habit of rational restraint on the spirit and appetites of the body. In other words, good character is dependent on one's good choices. He is not blind however, to the events of fate that make a person's life "blessed" or "cursed". He presents circumstances where it may be understandable if people behave in ways that are not courageous or just, for example when a sea captain jettisons cargo in a storm.<sup>230</sup> However he does not find this sufficient excuse to eliminate one's responsibility for one's actions. He understands an action such as this to be voluntary, in that such an action was taken in order to ensure survival of the boat and passengers. That having been achieved, some action must be decided on by the legislators for taking an action that is counter to the performance of what a sea captain ought to do, which is to deliver the cargo to the agreed port. If the legislators decide to forgive the action (and this is not part of the Aristotelian scheme), that is another issue, but the action still needs to be named for what it is. Aristotle writes "it is ridiculous to blame external circumstances and not oneself for being an easy prey to such things".<sup>231</sup> He therefore does not regard the occurrence of bad luck in one's life a sufficient excuse for bad behaviour.

He does, however, appreciate that good luck or favourable circumstances affect the course of one's life in ways that assist character development.

"Many things, however, both large and small, happen by chance, ... great events, if they are good, will make a life more blessed, since they will themselves naturally embellish it ... but if they turn out the other way, they will oppress and spoil what is blessed, since they bring distress with them and hinder many activities. Nevertheless, even in their midst what is noble shines

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<sup>230</sup> Aristotle, III.1110a.

<sup>231</sup> Aristotle, III.1 1110b.

through, when a person calmly bears many great misfortunes, not through insensibility, but by being well bred and great-souled.”<sup>232</sup>

John Quilter makes such connections with the health care setting. He notes that traditionally, morality is thought to be one aspect of life where one's efforts can determine outcome. There is the hope that “over our performance in that sphere of life we have control”.<sup>233</sup> Quilter then outlines a case where, despite the best and most conscientious efforts of a doctor, the worst happens and a patient falls prey to bad luck. She is the rare person who reacts badly to a new drug. This demonstrates that despite the most conscientious of efforts luck can effect outcomes and have implications for the assessment of one's professional practice. Can this doctor be described as good or bad based on the outcome experienced by the patient? An Aristotelian account suggests that the doctor cannot be extracted from the role that he or she played in the effects on the patient but a realistic assessment of the situation cannot ignore an element of luck or chance involved in this and many experiences the people have in healthcare situations.

Shearer and Davidhizar<sup>234</sup> acknowledge that there is an element of luck involved in the practice of nursing and identify what health care workers may properly call luck in their professional life. They recognise that amongst nurses there is a habit of attributing to luck that which might more properly be attributed to intuition or good habit or thorough training. Therefore an understanding of luck is limited to events that cannot be explained by anything other than chance which reduces the occurrences of luck-related incidents in any nurse's practice. Further to this, they recommend that nurses aim to assert as much control as possible over events in their practice in order to reduce the practitioner's vulnerability to luck, whether it be of the good or bad kind.

Finally, Slote<sup>235</sup> argues against the place of luck in the moral life because he thinks it invites an inconsistency into moral thinking. He argues that a person cannot be

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<sup>232</sup> Aristotle, I.10 1100b.

<sup>233</sup> John Quilter, “Morality: Life's meaning and human equality,” Bioethics Outlook 1.7 (1996): 2.

<sup>234</sup> Ruth Shearer & Ruth Davidhizar, “Luck: What the nurse should know about it and how it affects nursing situations,” International Journal of Nursing Practice 6.1 (2000): 2-6.

<sup>235</sup> Michael Slote, “Virtue ethics,” The Blackwell Guide to Ethical Theory, ed. Hugh LaFollette (Malden, Massachusetts: Blackwell Publishers, 2000) 336.

thought of as not blameworthy for doing a particular activity carelessly if nothing goes wrong and blamed for the same careless action if there is a bad outcome. In order to achieve consistency, particularly in Virtue Ethics theory where one's character or inclination is at the heart of the theory, then an action that is done with little attention to excellence attracts a level of 'blame' regardless of the outcome.

Practitioners in health care recognise the element of luck or chance that can, at any time, contribute to a good or bad outcome for patients. At the very least, the recognition of the role of luck in one's practice may soften judgements about fellow workers. It might also provide some limits to self appraisals with the knowledge that, occasionally, outcomes may have more to do with luck than excellent or poor practice.

### 5.6.3

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#### **rovides a Coherent and Sustainable Identity**

Nursing is at this present time beset with problems of professional identity. The profession is fragmented by its indebtedness to the Nightingale model of nursing for its moral authority and rejection of the Nightingale ideal in its pursuit of professionalisation. The scientific model for nursing at first appeared to advance nursing practice but also had the effect of undermining its moral underpinning because scientific nursing and the accompanying professional status of nursing is dependent on a detached and disinterested approach to nursing activity. The ethic of care, which sought to give a modern expression to Nightingale's morality and provide a basis for claims for professionalism in nursing rather than scientific terms, has been found to be wanting in terms of its ability to sustain complex practice. New nurses entering the profession are hard pressed to know if they will be ministering angels, weavers of magical caring or budding scientists.<sup>236</sup> Stevens and Crouch make the point that the pursuit of professional status by adopting an increasingly biomedical image for nursing, to the exclusion of the low technology, body-centred aspects of nursing activity, has contributed to a serious distortion of the current nursing identity.<sup>237</sup> They liken the current nursing identity to Frankenstein who possessed the mechanics of a body but was without a soul and was, therefore, monstrous.

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<sup>236</sup> Kitson., 117.

<sup>237</sup> John Stevens & Mira Crouch, "Frankenstein's nurse! What are schools of nursing creating?" Collegian 5.1 (1998): 15.

It is important for any profession to have a clearly articulated identity or understanding of the role that is being adopted by joining a profession. A distinctive professional identity has a twofold benefit. The first is that the practitioner has a clear understanding of the demands of the role. Role ambiguity, which is “the lack of clear consistent information about the behaviour expected in a role”,<sup>238</sup> is a significant contributor to role stress experienced by new nursing graduates. When nurses are stressed they report reduced work satisfaction, they have increased absenteeism rates and the organisation experiences this in low retention rates of staff.<sup>239</sup> The culture of change within health care institutions also contributes to confusion about nursing roles and presents a challenge to the maintenance of a sustaining nursing identity. This is particularly so when the nursing identity is confined to the identity of the institution.<sup>240</sup> However, when nurses are given the opportunity to articulate the things that are important to their identity in a creative way, change may be a means to help nurses to “reconnect with their values to maintain a caring environment for patients, families, colleagues and themselves”.<sup>241</sup>

The second benefit of a clearly articulated professional identity is the achievement of a healthy integration between one’s professional and personal life. A study investigating the process of “bonding into nursing” provides examples of nurses who have experienced the kinds of changes that have contributed to the shaping of their identities as nurses. One nurse stated “I taught something to patients, but I was saved by them. I realised that I was healed by patients, so I cannot leave bedside nursing anymore.” Another describes a high level of personal integration with her role as nurse.

“It is not a nurse and I. A nurse is in myself and I was woven into a nurse. It is like braids. I am this way by weaving a nurse and myself together round and round. So I cannot think and I do not try to think separately from being a nurse and me. I as a nurse and I by nature are woven... When they are

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<sup>238</sup> Esther Chang & Karen Hancock, “Role stress and role ambiguity in new nursing graduates,” *Nursing and Health Sciences* 5.2 (2003): 155-163.

<sup>239</sup> Chang & Karen Hancock, 155.

<sup>240</sup> Ann Ewens, “Changes in nursing identities: supporting a successful transition,” *Journal of Nursing Management* 11.4 (2003): 224-228.

<sup>241</sup> Karen Boardman, Maureen Kelpie, Dawn Straub & Rita VanFleet, “Shining through a merger,” *Nursing Management* 34.5 (2003): 45-48.

woven, it becomes as if I am one piece of yarn. If I were not working as a nurse, I would be a different person. I would not be like I am."<sup>242</sup>

Some of the problems of identity have their origins in the infancy of modern nursing. At a time when public health systems were at their most rudimentary, nurse reformers recognised that improvements in standards and practices could not be achieved while ever nurse remained untrained. In order to attract trainee nurses, the moral significance of nursing was emphasised. Nurses were typically represented as female and committed to the setting aside of their own desires for those of others, these two attributes being perceived as inseparable. It was by this means that nurses attained moral authority within their communities. The Victorian notion of altruism excluded the possibility that nurses, in the course of their work, might have a care for themselves.<sup>243</sup> Despite the obvious perils this approach presented to nurses, advancement of the status of nursing was dependent on a thoroughgoing identification of nurses with this model.

As a result of this culture nurses are identified as "good" if they are female and habitually self-denying. The perception persists that nursing is an occupation best suited for females. This has the effect of limiting both the numbers of males who are prepared to consider nursing as an occupation<sup>244</sup> and the options that nurses pursue within the profession.<sup>245</sup> In everyday clinical practice Kneasfey notes the reluctance of nurses to implement easier and safer manual handling practices. She attributes this reluctance to the profound effect of socialisation on nurses that creates a culture where back injury is almost "an expected and accepted part of nursing".<sup>246</sup>

Nursing has therefore, inherited a fragile, some might even suggest pathological, identity. If this is the identity that it is meant to sustain nursing, then it is too easily threatened either by the presence of male practitioners or by nurses who engage in

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<sup>242</sup> Misuzu Gregg & Joan Magilvy, "Professional identity of Japanese Nurses: bonding into nursing," *Nursing and Health Sciences* 3.1, (2001): 47-55.

<sup>243</sup> Rosie Kneasfey, "The effect of occupational socialization on nurses' patient handling practices," *Journal of Clinical Nursing* 9.4 (2000): 588.

<sup>244</sup> Margaret Whittock & Laurence Leonard "Stepping outside the stereotype. A pilot study of the motivations and experiences of males in the nursing profession," *Journal of Nursing Management* 11.4 (2003): 242-249.

<sup>245</sup> Orla T. Muldoon & Jacqueline Reilly, "Career choice in nursing students: gendered constructs as psychological barriers," *Journal of Advanced Nursing* 43.1 (2003): 93-100.

<sup>246</sup> Kneasfey, 588.



activities that demand some benefit for themselves or even when they do so on the behalf of others if that action is perceived to be in any other than a “ladylike” manner. It is dehumanising to base one’s identity on external factors<sup>247</sup> and an account of nursing based on gender and gendered characteristics, diminishes and limits the practice of nursing. Nursing needs to articulate an identity that depends on a true account of itself from which the ideals of good practice can be drawn and the practice of which nurtures the desired attributes of the good practitioner. An identity that is shaped on this basis confers on the practitioner, a resilience which is in contrast to the fragile identity of a practice based on factors that are not central to the practice. Virtues theory illuminates nursing in such a way that a sustaining identity can be elicited. When nurses are known both by their competence and good character they assume an identity that enhances the practice of nursing and contributes to the flourishing of the nurse.

#### **5.6.4 Fosters a Healthy Nursing Culture**

If it is agreed that an ethic of virtue is something to be aimed for in nursing the question arises as to how best to achieve such a goal. Gauthier believes that the virtues can be taught. She refers to Aristotle’s description of practical wisdom as an intellectual virtue which is “developed by teaching”.<sup>248</sup> Alternatively, the practical virtues of character that are necessary for the good practice of nursing are best developed by engaging in the activity of nursing. Nursing research suggests that the experience of engaging in that practice of nursing is the one that most strongly confers the sense of being a nurse on its new practitioners.<sup>249</sup> Bradshaw has consistently argued that it is involvement in the well established and traditional methods of nursing that best prepares nurses for the demands of their profession. Both teaching and practice, in formal and clinical settings are, therefore, necessary for the cultivation of the qualities of character that will ultimately support good nursing.

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<sup>247</sup> Martin Luther King Jr. understood the dehumanising effect of basing identity on external qualities. He said, in his famous speech delivered on the steps at the Lincoln Memorial in Washington D.C. on August 28, 1963, “I have a dream that my four children will one day live in a nation where they will not be judged by the colour of their skin but by the content of their character.” Martin Luther King, Jr. The Peaceful Warrior (New York: Pocket Books, 1968), 8 June 2004 <<http://www.mecca.org/~crights/dream.html>>.

<sup>248</sup> Candace C. Gauthier, “Teaching the virtues: justifications and recommendations,” Cambridge Quarterly of Healthcare Ethics 6.3 (1997): 341.

<sup>249</sup> J. White, “The impact of clinical experiences during preregistration diploma in nursing courses on initial career choice,” Journal of Nursing Management 7.3 (1999): 157-165.

The maintenance of a sustainable nursing identity is dependent on good education. It is equally, if not more so, dependent on the creation of an environment that is conducive to the cultivation of the virtues. As has been mentioned earlier, not all nurses experienced hospital-based training as uniformly beneficial. Some hospitals developed traditions of staff discipline that were harsh and punitive and many nurses suffered and abandoned nursing in the process. Sanctions or penalties are used to punish those who err from an agreed code of conduct or law. They are applied when people steal or lie or kill. They do not lead to the cultivation of the virtues. They are not appropriate for someone who is, for example, trying to be conscientious but does this in such an excessive way that the person is more correctly characterised as being fussy. To apply a sanction to a vice, which is in essence the right thing done either to excess or deficiently is to both exaggerate the seriousness of the vice and to trivialise the seriousness of a wrong. Hospitals in this case were, therefore, not establishing traditions that contributed to the acquisition of the virtues.

If punishments and penalties are rejected as a means to cultivate virtues for nursing practice what strategies are available for institutions such as hospitals to become places where the practice of the virtues can flourish? Aristotle writes that: “We deliberate not about ends, but about things that are conducive to ends”. In other words nurses are not free to choose the goals they are seeking to achieve for their patients. They are established by the practice itself. Good nurses then will deliberate “about how and by what means”<sup>250</sup> these goals are to be achieved. Hospitals need to be places where habits of rational deliberation are encouraged. Habits of reflective practice described in some nursing literature approach Aristotle’s description of rational deliberation. These habits of reflections are “cognitive acts such as thinking, contemplation, meditation and any other form of attentive consideration, in order to make sense of ... and to make contextually appropriate changes, if they are required”.<sup>251</sup> Suggested strategies to cultivate these habits depart somewhat from Aristotle’s recommendations. Aristotle directs us to “drag ourselves in the opposite direction” of our “natural tendencies” in order to “hit the mean” suggesting that the experience of pleasure compromises our sense of impartiality and makes it less likely that our actions will be virtuous.<sup>252</sup> Alternatively, Taylor suggests creative activities from journal writing to painting to quilting as the means to become a more reflective

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<sup>250</sup> Aristotle, III.3 1112b.

<sup>251</sup> Beverly J. Taylor, Reflective Practice: A Guide for Nurses and Midwives (Sydney: Allen & Unwin, 2000) 17.

<sup>252</sup> Aristotle, II.9 1109b.

person.<sup>253</sup> Both approaches are more compatible than they at first appear. As a starting point to the reflective process, a creative activity invites the participant into a deeper understanding of the self and the situation. It can lead the person to make “contextually appropriate changes”. These changes may be just the kind of difficult personal changes that Aristotle identifies as being essential to the development of a virtuous character.

Clearly, hospitals that run pottery classes are not guaranteeing the establishment of centres of excellent nursing practice. However, institutions that employ strategies that foster and value thoughtful practices and in turn integrate them into the mainstream character of the hospital will be places that are good for both patients and nurses. They will attract nurses of both exemplary practice and character who will in turn act as models of good practice to new nurses.

## **5.7 Conclusion**

Virtue theory is a means to sustain good nursing practice. It articulates what it is to be a good nurse, accommodates both scientific and humane practices in a coherent way and contributes to the formation of a sustainable identity. It is not without its detractors of whom it can be said that their proffered ethical frameworks are also not without their weaknesses and their critics. This alone is not sufficient to recommend serious consideration of virtue theory for nursing. The most compelling recommendation for virtue theory is that it invites the practitioner to examine situations in their complexity, to apply objective means to determine what good can be done in this situation and then to act on the basis of knowledge of both the situation and the human being(s) involved in the situation. Nursing is an activity that involves the application of both objectively and humanly derived knowledge and nursing can best be described when done so in terms of virtue theory.

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<sup>253</sup> Taylor, 57-77.

## 6. Conclusion

It has been argued that nursing is an activity that has moral implications both for nurses themselves and for the people whose needs they attend. Good nursing practice demands from the practitioner the ability to meet the physical needs of the patient both by assisting them in their daily everyday needs and in the delivery of, at times, highly complicated treatment regimes. An accompaniment to the biophysical and biomedical attention is the emotional support that people need when they are facing difficult challenges to their physical well being.

Previously held notions of nursing ethic found in a vocational identity, the scientific framework or the articulation of a care ethic have all in their various ways contributed to certain aspects of nursing practice but have been insufficient of themselves to sustain and inform modern nursing practice. These frameworks have also been responsible for competing for nursing loyalties in a way in which was counterproductive to the formation of a healthy and confident nursing culture.

By contrast, nurses finds in virtue theory a framework that enables them to hold together concerns about excellence in technical practice with the more humane concerns about bodily care and the nurse patient relationship. Virtue theory, concerned as it is with an ordering of the emotions, illuminates nursing practice in such a way that nurses are encouraged to develop habits of rational reflection that assist them to implement nursing interventions in both a technically competent and humane way. Whereas the nurse who focuses on the scientific aspects of care may be content to interpret this as fulfilling the obligations of humane care and the nurse who makes the emotional aspects of nursing the benchmark for good nursing may treat as secondary to the more technically demanding aspects of nursing activity, the virtuous nurse practices in such a way that the possession of technical knowledge and of personal traits combine to deliver the complete or holistic care to which so many nurses aspire.

Virtue theory also underpins the fostering of a healthy professional identity and culture deriving as it derives the articulation of its goals and excellences of practice from the activity of nursing itself. It is to be hoped that there is an increasing interest

amongst nurses in virtue theory and what it has to offer in conveying a richer sense of what it means to be a nurse.

## **Appendix 1**

The Code of Ethics begins with a background statement as to the historical development of the code and some introductory notes that outline the traditional ideal of nursing and the centrality of the relationship between nurse and patient for the implementation of therapeutic processes. There are six value statements which are accompanied by explanatory notes. The aim is to provide a guide for nurses to reflect on the tone of their practice. They are that nurses:

1. respect the cultural values and practices of their patients;
2. they accept the rights of patients to make informed choices about their care;
3. they are committed to ongoing professional development to maintain their levels of care at a high level;
4. nurses will hold in confidence information given them and only divulge it for the patient's good;
5. accept a level of accountability and responsibility in their roles;
6. Take into account the significance of the social and ecological environment for the promotion of ethical practice.

## **Appendix 2**

The Code of Conduct aims to provide the professional and the community with a set of minimum standards for practice by which the nurse's practice can be assessed. The Code of Conduct differs from the Code of Ethics in that it seeks to direct actions rather than attitudes. Each statement has explanatory notes which make more explicit the demands of the code. The code requires that the nurse will:

1. Provide safe and competent care;
2. Uphold the agreed standards of the profession;
3. Practice lawfully;
4. Be respectful of cultural aspects of the patient and the family in care;
5. Promote health by providing information and educating the patient about health measures;
6. Act in ways that honour the implicit trust that is necessary between a nurse and a patient;
7. Treat person information confidentially;
8. Refrain from any activity that exploits the patient.

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