ETHICS IN NURSING: THE DEVELOPMENT OF AN EDUCATIONAL MODEL FOR PRACTICE

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This thesis is presented in part fulfilment of the degree of Doctor of Philosophy (PhD) in the Department of Educational Studies, University of Surrey, Guildford, England, 1988.
DEDICATION

For Brian Morley Rodmell, C.Eng., FICE, FIHT, MBIPE, MASCE, MILE, - my husband - for sponsoring my academic curiosity, for exemplifying his commitment to education, for encouraging my independence, for accepting my absences, for offering intellectual challenge and constructive criticism, and for surrounding me with the stability, security and protection that afforded me the luxury of pursuing this thesis on a full-time basis.
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STANDARDS/CONVENTIONS

THEMSELVES, THEM, THEY, THEIR

These conventions will be used when the terms individuals, nurses, patients, clients, are referred to and denotes an indefinite expression of gender, or mixed groups (Oxford Miniguide to English Usage 1984: 248-251).

VOCABULARY

Oxford English Dictionary spellings are utilised except when North American terminology is used or authors are quoted.

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MORALS AND ETHICS

In everyday usage the terms 'morals' and 'ethics' are used synonymously and for the purposes of this thesis, moral, from the Latin work 'moralis' meaning custom or manners, is taken to mean something which is right, wrong, good, or bad and refers to standards of behaviour held or followed by individuals or groups (Dictionary of Philosophy 1984: 112). Ethics, from the Greek word 'ethos' meaning character, in this thesis dictates the meaning or use of words or concepts, such as right, wrong, good or bad, and refers to the science or study of morals (Hare 1972: 45-46). As a philosophical term ethics is concerned, therefore, with the "investigation into the fundamental principles and basic concepts that are, or ought to be, found in a given field of human thought and activity" (Dictionary of Philosophy 1984: 112).

Two important distinctions may be made between the meanings of the words ethics and morals. Firstly, ethics are formal, theoretical statements which intellectualise morals and involve professional values, such as those seen in Codes, theories, research or enquiry. Secondly, morals refer to values or principles which are less formal, and more personal or subjective, and to which the individual is committed, that is the individual follows and defends these morals in their daily lives.
(Jameton 1984: 4-5). Thus, morality is concerned with the conduct men ought to follow. Though these two concepts overlap in the language and subject-matter and very broadly are taken to mean philosophical enquiry about norms, values and what ought and ought not to be done (Raphael 1981: 1-8), they are not used interchangeably in this thesis.

PATIENT/CLIENT

The term patient refers mainly to those individuals requiring care in a clinical or hospital setting, and the term client refers to those individuals in the community setting. In some instances patient and client are used equivalently as the discussion may incorporate both settings.

CLINICAL/COMMUNITY

The term clinical in this thesis refers to the delivery of care at the bedside or in the hospital setting, and community refers to the delivery of care in the home.

HEALTH CARE/MULTI-DISCIPLINARY TEAM

Health care team or multi-disciplinary team in this thesis is taken to mean all the members of the nursing, medical and paramedical or allied disciplines who are concerned with the care of the patient/client, such as nurses, doctors, physiotherapists, dieticians, occupational therapists, social workers, community nurses, specialist nurses and chaplains.

NURSING MODEL

A nursing model is a symbolic representation of a perceptual phenomena which is based on a theory and must include the essential physical and philosophical elements of nursing.
This thesis presents an ethical model to guide the nurse in the application of moral standards or principles in the clinical and community setting. The study is concerned with looking at ethics primarily in terms of patients'/clients' rights, not ethics in general. The contribution of contemporary nurse theorists and philosophers in the international arena are considered to see how their contributions relate to the present and future developments and trends in the field of nursing, and how they may be translated into action in the daily care of patients/clients in the clinical and community setting.

The research methods include an historical review of local, national and international nurse educational, philosophical and ethical literature.

The central theme investigates the caring roles of nurses and the commitment to patient/client care which are the basis of the ethical perspective of nursing. The ethical principles inherent in the nursing discipline, such as patients'/clients' rights and autonomy are examined, to see how these principles may be applied at the bedside and in the community.

Validation criteria are adapted and this validation tool, together with the ethical constructs/components, are used as a framework to ensure that an ethical perspective is included and utilised in all nursing models.
As ethics is concerned with human conduct and relationships, the author concludes that an ethical model is vital and may be used with all models which guide nursing practice currently in use and in future developments.

An Ethical Analysis Framework and Model has been developed by the author, to serve as a tool for the inclusion of ethical constructs/components in models which guide the practice of nursing in the clinical and community setting. It also aids in the application of ethical principles. The Ethical Analysis Model will hopefully contribute to the theoretical framework of curriculum development as curriculum is concerned with shaping attitudes towards knowledge and creating a forum for discussion and criticism. Ethical knowledge is part of that subject matter. Through deliberation and judgement the definition and solution of curriculum and ethical problems may be effected as curriculum development, like ethics, is concerned with what is, and what might be. An example is presented of how the Framework and Model can be used, and is strongly recommended for use with any model which guides the practice of nursing.

The findings, their limitations and the relevant discussions and recommendations are highlighted, and areas for further research are identified.
PREFACE

Prior to this study the author presented a Masters Degree (MSc) dissertation (Rodmell 1985) in which the present nurse education syllabus and curriculum were examined, the rationale for ethics education was explored, and the author concluded that ethics education was not explicitly stated (Rodmell 1985: 4). The potential implications and relevance to nurse educators of implementing an ethics education programme were outlined with implementation guidelines as a separate academic discipline (Rodmell 1985: 119-131).

Contained within this separate academic discipline the author presented a module which was subsequently implemented in nursing curriculae in the Commonwealth of the Bahamas, and recommended that nursing students engage in ethical decision-making in the final year of their training (Rodmell 1985: 121, 130-131). The specific objectives presented at this stage were aimed at the application of fundamental moral principles to ethical issues and dilemmas; the assessment of whether the ethical decisions were reached and whether the consequent actions reflected the stated values; a sensitivity to and awareness of the skills required, such as communication and counselling. To this end the author suggested the application of ethical decision-making, to cope with the ethical issues and dilemmas which arise for nurses, firstly using hypothetical critical incident techniques (Rodmell 1985: 114) and then real
life experiences in clinical practice (Rodmell 1985: 125, Stage 3, Level 6). Crisham (1981: 104) has demonstrated that reasoning in real life situations is similar to reasoning in hypothetical situations using critical incident techniques, a method of obtaining data from study participants by in-depth exploration of specific incidents and behaviours related to the matter under investigation (Polit and Hungler 1983: 612). Certain real events were used as a focus of discussion with the participants in the incident, and was designed to stimulate more complex reasoning (Clay et al 1983: 300). Briefly, Crisham (1981: 104) investigated a selection of one-hundred and ninety four (194) nurses of varying grades, and thirty eight (38) non-nurses using an instrument designed to measure their hypothetical responses and compared them with the moral judgements taken in real life nursing dilemmas.

Having ascertained the need for an ethics education programme in the nurse education curriculum, and the need for nurses to engage in ethical decision-making in clinical practice, this study seeks to present an ethical model which will enable the nurse to translate ethical theory into practice, by offering clear guidelines for the application of ethical principles, in addition to those techniques mentioned above. Nursing practice is generally guided by the utilisation of nursing models, so it was decided to commence by examining these nursing models to assess whether the ethical principles or concepts such as
rights and autonomy are explicitly stated. The author examined current nursing models and established that other than the study done by Mooney (1980: 7-9) and the models advocated by Weidenbach (1964: 16), King (1981: 143-144 ; 1986: 102), Levine (1986: 130), and the work done by Wright (1986: 22) there was little explicit mention of ethics in current nursing models.

This thesis then aims to present an ethical model which will include ethical principles with validation criteria which may be applied in the clinical and community setting. This will enable nurses and nurse educators to put into practice the means of coping with conflicting ethical principles, and utilising ethical theories and debate to justify the ethical decisions that have to be made at the bedside and in the community. For example, the rights of the patients/clients and nurse will be one of the foci of discussion, as this will serve to highlight the conflict in principles that may arise and the process of justifying these decisions.
"All that is said and done, will be said and done with a view to what is good for those on whom he practices his art, so every art seeks not its own advantage, but the wellbeing of the subject on whom it is exercised or, put more bluntly or less eloquently; 'that the patient takes no harm', we shall not go far wrong."

Plato,
On the professional man,
427-347 B.C.
CHAPTER ONE

INTRODUCTION

This thesis presents an investigation of the ethical perspectives of nursing practice, with the aim of presenting an ethical model to facilitate the application of ethical principles in the clinical and community setting. It raises questions about the nature, significance and appropriateness of currently used nursing models, on which nursing practice is reputed to be based, as to their ethical content.

The author has examined in depth the scant empirical data, and studies on some nursing models in current use, and on which nursing practice is reputed to be based, appear to demonstrate that ethical principles and guidelines for practice are not explicitly stated. This was demonstrated by nurse theorists such as Weidenbach (1964: 16), King (1981: 143-144; 1986: 102), Levine (1986: 130), and Wright (1986: 22), who all showed a concern for ethical standards in nursing practice. Weidenbach (1964: 16) identifies three essential components of a nursing philosophy which demonstrates some consideration for ethics, however, no guidelines for practice are offered as to how this philosophy may be realised. Weidenbach's (1964: 16) components include a reverence for the gift of life, a respect for the dignity, worth, autonomy and individuality of each human being; and, the resolution to act in relation to one's belief.
King (1981: 143-144; 1986: 102) maintains that individuals have a right to knowledge about themselves; the right to participate in decisions that influence their lives, health and community services; the right to accept or reject health care; and insistence on consideration of the clients' perception of a situation and their participation in goal-setting. Again no guidelines for practice have been generalised.

Levine (1986: 130) also demonstrates a concern for the individual person, reflecting the ethical standards of nursing, evidenced by her belief that "nursing intervention must deal with the rights and privileges of the individual in tangible ways ....... and the recognition of the individual's rights to be assisted in understanding the implications of his disease, his treatment and his care". These beliefs of Levine (1986: 130) are features of a model rather than a model itself. Levine's "model" does not advocate guidelines for practising these ethical standards, nor is it clear whether her concern for the "rights and privileges of the individual" includes the nurse.

A recent British text makes one reference to nursing ethics (Wright 1986: 22) and though it clearly outlines how to build and use a model of nursing, no further mention is made of ethics. It may be that Wright's (1986: 22) reference to "ethics", though explicitly stated, is meant to set the
framework for practice, and it is up to the nurse to explicitly detail the content of the subject, where, how and when it must be incorporated in programme/curriculum development, and so the ethical model to be proposed will provide these guidelines for practice.

CONTEXT OF THE STUDY AND CONTRIBUTION

The author has recently returned from the Commonwealth of the Bahamas where she was employed with the Ministry of Health as a Curriculum Specialist on special projects with the World Health Organisation/Pan American Health Organisation (WHO/PAHO) and World Bank. The author's post was aimed at initiating, developing and maintaining the work of curriculum development within the pre-registration and post-registration nurse education departments. The post also included conducting special projects/workshops such as the implementation of the Nursing Process\textsuperscript{1} and the Role-Based Training Course\textsuperscript{2} for Senior Nurse Managers within the hospital and community setting.

In January 1989 the author hopes to commence a new post with the World Health Organisation and Pan American Health Organisation (WHO/PAHO) as a full-time Nurse Educational Consultant/Advisor based in the Commonwealth of the Bahamas and serving the Americas and Caribbean basin countries. The issues raised from this thesis will hopefully make a contribution to the practice and theory of ethics education in the developed and developing countries, and in particular in the author's country, Jamaica, West Indies, where because of the recent hurricane
disaster all medical and nurse educational facilities require re-building and re-development.

Further to this, the author hopes that the issues raised from the study will be submitted to the appropriate nursing research groups, such as Nursing Research Abstracts (DHSS Index of Nursing Research 1988) from which nurse theorists, educators and ethicists creating nursing models draw some of their data.

The author hopes that the results of this thesis will make an important contribution to the debate about the emerging professional status of nurses. The development of a recognised, effective, operational Code of Practice is one of the established features of a developing profession and though the existing United Kingdom Code of Professional Conduct (Appendix 1) is based on ethical concepts it does not address itself to certain ethical issues and it assumes that nurses are experts in ethical decision-making. It is also hoped that this thesis will help to clarify some of the concepts and terms which people use in this emerging "profession".

The author refers to nursing as an academic discipline as opposed to an academic profession, on the grounds that the author believes that nursing has not yet attained status as a profession, as it does not meet all the criteria afforded the status of a "profession". Two of the main criteria not yet attained is that firstly, nursing practice is rarely based on research; and secondly, "autonomy" is not possible as
nursing is an interdependent and dependent discipline, with no real decision-making powers, as to date, doctors are legally ultimately responsible for patients/clients. However, nurses can assume a professional manner which is an attitudinal attribute and nothing to do with being or not being part of a profession. This professionalism assumes the individual to be an expert in inter-personal situations with the skill and knowledge to undertake the nurses' role with competence. Dingwall (1986:27-28) and Clark (1986:28) suggest that whether nursing is a subordinate, that is to doctors, occupation, or an "autonomous" profession determines the individual's perspective of nursing, and the "interpretation of history and of the changes that have taken place in nursing over the past 25 years" (Clark 1986:28). Earlier to this, Segal (1985:43) had pointed out that the legal system in America does not accept nursing as a profession. This is grounded in the belief that the "educational paths" to being considered a profession are doubtful, nursing being viewed mainly as a training as opposed to an education. The same could be echoed in the English legal system. However, nurses have the same moral responsibilities as every other human being, regardless of whether nursing is a profession or not, as nursing ethics is no different to any other ethical relationship.

IDEA FOR THESIS/RESEARCH

The idea for this thesis was first developed during the last year of the author's post as Curriculum Specialist with the
Government of the Commonwealth of the Bahamas. During the special projects/workshops run by the author and described earlier (page 20) it became increasingly a concern for course participants, and for the author to see how the nursing models being utilised and the ethics education model (Rodmell 1985) being taught as a co-requisite of the courses (page 20) could be effectively incorporated. This was not because there was an inability to see the importance of an ethical framework but rather that there seemed no easy way to incorporate the ethical components/aspects when deciding which particular nursing model was to be used for each area of speciality, especially as no clear guidelines for practice were offered. The difficulty seemed to lie in the translation of ethical principles into practice. These ethical principles include the right to life, individual freedom, respect for persons, truth telling, justice/fairness and beneficence and non-maleficence.

A review of the current literature revealed that there has been an increasing reference to nursing models and theoretical frameworks and an "extensive blanket adoption" of these nursing models in nursing (Hardy 1986: 103). Anecdotal evidence suggests that many Schools of Nursing and hospitals purport to be using a nursing model as a basis for nursing practice. Furthermore, anecdotal evidence by nursing peers suggest that many Schools of Nursing incorporate the use of nursing models within their Curriculum just because it is part of the local School of Nursing policy, not because of the use
that can be made of nursing models and their effectiveness. In addition, readings of certain authors do not clarify the intent of their papers about nursing models. This lack of criticism and comment may be "damning evidence to the true state of nursing" (Hardy 1986: 103) which is reputed to be emerging as a "profession". This is an assumed state as according to Pyne (1981: 4-7) nursing meets all the criteria that he has laid down for a "profession". In spite of the difficulties nurses appear to encounter with the interpretation of models, the author believes that it is the translation of theory to practice which is the difficulty. This may be due to an underlying lack of ethics education, a lack of some validation criteria, a lack of ethical principles in nursing models, compounded by the lack of guidelines for practice. To this end, the author hopes to present an ethical model which may aid the nurse in the application of ethical principles into practice, thus enhancing active participation of patients/clients in health care.

The advantage of the author's model is that it includes specific validation criteria and clear guidelines for practice. The impact of the model will be enhanced by congenial conditions characterised by an appropriate environment and attitudes, though the author is appreciative of the fact that this may be difficult to achieve in light of the problems nurses appear to be having with nursing models.
AIM/PURPOSE OF THE THESIS

The aim of this thesis is to present an ethical model to aid the nurse in the application of ethical principles (page 23) in the clinical and community setting. The author's model may be used independently as an ethics education model, or it may be used in conjunction with other models which guide nursing practice.

This investigation critically examines the use of ethical principles in an effort to draw attention to what could be considered as the ethical aspects of nursing, as distinct from the technical aspects of nursing. It can be argued that nursing is not only concerned with technical, that is, scientific skills, and mechanical skills, but with personal and social relationships and policy. When attempting to make an ethical decision individuals often confuse technical arguments with ethical and/or legal arguments. This would indicate that nurses need to be shown how the arguments differ, and need to be skilled at distinguishing these arguments before they can become competent ethical decision-makers (Rodmell 1985: 120). Clearly, the need to identify the implications that may arise for nursing practitioners, nurse educators and nurse ethicists in curriculum planning or programme development and design is paramount, and thus the target population for this thesis includes these groups specifically.
Levine (1977: 845) suggested that the personal philosophies of individual nurses, combined with religious and cultural expectations, are serving as the foundation of nursing ethics rather than explicit ethical theory as a part of nursing theories. This interpretation by Levine (1977) means that the ethical perspective in nursing practice is derived from individual nurses’ subjective beliefs, the mores of their groups, or the socialising influences. These moral views appear to arise from religious and cultural influences, rather than from an ethical perspective in a theory of nursing, which guides the practice of nursing. Nurses therefore need to be encouraged to understand how their belief systems may be intellectualised, how dilemmas arise, how ethical judgements are arrived at, and how ethical decisions are made. In order to do this then the ethical principles in a theory of nursing, for example, Orem’s (1985) self-care theory which is "the practice of activities that individuals initiate and perform on their own behalf in maintaining life, health and well-being" (Orem 1985:84) need to be examined. So, in order to try and achieve the aims (page 25), the author will examine in more detail the issues which contribute to the ethical model proposed by the author, such as the patients’/clients’ right to participation in and knowledge about their health care.

Finally, the author feels that this investigation is "worthy of urgent pursuit" (Cormack 1984: 7) partly due to the fact that if patients/clients are treated in an ethical
manner, and become active participants in their own care, then it may be that the ethical problems, such as the paternalistic attitudes of staff towards patients/clients, could be effectively reduced. Paternalism is acting in another's interest without consulting them. It may be that greater participation in decision-making may provide a more cost-effective health care system, as in some instances, such as in surgical procedures which enable a quicker recovery from ill-health, reduces the cost to the consumer, and ultimately the costs to the Health Service.

Research studies (Wilson-Barnet et al 1983: 37) already outline an appraisal of what patients/clients can expect. These studies demonstrate that coping strategies are thought to contribute towards more rapid mobilisation, reduction in complications, and early discharge from hospital. The underlying assumption is that patients/clients who can participate actively in their health care should be considered as rational human beings who can share in the responsibility for their own care, or vice versa. This participation, however, does not appear to be the case at the moment in health care. In viewing patients/clients as active participants in their care, according to Willer and Miller (1976: 687-690), nurses would be taking an ethical stance and this may well have some therapeutic benefit for the patient/client. Clearly it is the nurse who is taking the ethical stance, not the patient/client, and in taking this ethical stance the nurse is demonstrating a proper respect for human beings. However, an ethical stance is a requirement
in inter-personal relationships whether or not it has a therapeutic benefit.

In order for the patient/client to be an active participant in health care, it is hoped that an assessment of the patient/client may be made by nurse and patient/client where possible, a nursing model is selected which is understood and appropriate to meet the patient's/client's needs and discussions held to decide whether the patient's/client's goals are realistic and ethical. It is the relationship between carer and care-recipient that needs to be an ethical one. The goal for the care-recipients is a return to being "autonomous"\(^3\), where possible, and a regaining of their self-respect, assuming these characteristics were there originally, and they are able to recall them. If these characteristics are absent then the nurse must still be guided by the principle of "autonomy", and continue to treat the patients/clients according to their needs and potential. The practical problem of guiding the care-recipients toward self-sufficiency and a regaining of self-respect is daunting for individuals who have to cope with being cared for and the difficulty of developing responsibility for their own lives. It may be that some patients/clients actively enjoy being cared for, or may have no choice, as in high dependency units or long-term care institutions. In the case of planning goals if nurses and patients/clients hope to bring about a good, they would need to take steps to bring about good results. To act rationally means not only willing an end but taking the steps to bring about that end.

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RATIONALE

There are five clear reasons for enabling the practice of ethical principles in the clinical and community setting.

Firstly, it is important that the nurse has a good knowledge of ethics, that is, knowledge which may be applied or translated into practice, which could be the result of research/enquiry. Ellis (1983: 211) believes that the knowledge base for nursing practice includes empirical science, and that the purpose of scientific enquiry is to search for "new formulations" (Ellis 1983:212) arising from a need for new knowledge or to clarify the inadequacies in knowledge. As she views philosophic enquiry as clarifying meanings and "articulates the perspectives, beliefs, conceptualisations, and methods that characterise a field" (Ellis 1983: 212), then for Ellis (1983) nursing models would be scientific. Earlier Silva (1977:58-63) had advocated that ultimately all nursing theory and research is derived from, or leads to, philosophy which is in itself a legitimate method of scientific enquiry. Silva (1977) exposed the limitations for nursing of overemphasis on scientific method before a philosophical stance is established, as she believed that "current activity in model building and grand theories of nursing practice are searchings for meanings and philosophic stances". Clearly, Silva (1977) had conflicting views but this is reflective of current publications. Some knowledge of how nurses' perceive health care may be important in ascertaining whether these
perceptions influence, or are influenced by, the environment in which nurses work. An ethical model for practice requires an ethical knowledge base, and so it is paramount to examine the explicit knowledge required to ensure that it is incorporated into the ethical model.

Secondly, it has been proposed that nursing is or should be a scientific research-based profession (McFarlane 1980: 13; Sheehan 1982: 17; Kratz 1982: 128; Hawthorne 1983: 41-43). It may be considered scientific, that is, justified by scientific theory, because of its technological concerns, such as the concept of asepsis. However, it is not a research-based profession, as anecdotal evidence by colleagues suggest, as nurses rarely practice the current research done in clinical areas and continue to practice traditional, or even out-dated methods of care. This may be due to a number of reasons such as not knowing how to do a literature search, failure to understand the research conclusions, a disbelief in the findings of the research, an inability to translate the research into practice, or not being allowed to use the research because of lack of funding or poor attitudes (Hunt 1981: 189-194). For example, research conducted in the use of saline/salt baths in wound healing (Watson 1984:57-59) demonstrates just this, and this may be due to a lack of information and understanding of the research findings, or a lack of time to do a literature search on the research appropriate to that clinical setting. Nursing may also be considered a craft and its practices may be based on
custom, and it could of course be the case that its practices, although purporting to be scientific, are based on out of date scientific theories. The author is concerned with the reliance on the claims made on nursing being a scientific and a research-based profession, and would advocate that nursing may be viewed from differing stances, the ethical stance being complementary, rather than an alternative.

Ultimately, when nursing defines explicitly its unique or specific body of nursing knowledge, and this knowledge can be contested and corroborated then this unique body of nursing knowledge must be based on scientific principles concerned with the observation and classification of facts and establishing testifiable theories which are well corroborated. However, to know scientifically that asepsis will reduce infection does not necessarily mean that the practice of asepsis will follow; hence the difference between the science of nursing and the practice of nursing based on scientific and researched facts presents the reality gap between what ought to happen and what does happen. Certainly, the body of research in nursing is being treated as "sacrosanct and beyond criticism" (Johnson 1985:42) and the uncritical acceptance by nurse practitioners, on the occasions it is utilised, appears to be the trend. However, if nurses have a good ethical knowledge base then they would be able to critique the research being produced.
At a seminar conducted by Bond (1978) at the Northern Regional Health Authority seminar in relation to developments in nursing, Bond (1978) stated that theorists and academics may conduct research, but the relevance of it to nursing may be lost if those in practice see it as a product of the ivory tower, useless to them in the real world. Thus, if research is to have an impact on nursing, it must be put over in a way the practitioner can understand providing simple, relevant explanations, and not confined to an academic élite. Practitioners need to be involved in negotiating the programme of the research and in the monitoring of that research. Also, there needs to be an active exchange between those generating the research and those using the research, and the author's Model is a clear example of an attempt to bridge this gap, by generating research which will subsequently be utilised by the author. So, if nursing is to become a scientific and research-based profession then nursing research must be assimilated and the ethical aspects of the "profession" need to be included in the research.

Thirdly, nursing as a moral art, that is, the "seeking of a good" (Curtin and Flaherty 1982:86) embodies the principles of ethics, such as patient/client rights, and therefore all curriculum/programme development may require the inclusion of ethical principles to meet the patient’s/client’s needs. Therefore, it is important to ascertain if these ethical principles (page 23) are being practiced in nursing, and to
examine the parameters for that practice. It is the case that ethical principles do change, are not measurable, or are they absolute meaning that one ethical principle may be overridden by another ethical principle (Jameton 1984:139). Ethical principles are difficult to measure because they are relative to a situation and so constantly changing, and the underlying reason for rational behaviour cannot be clarified with assessment techniques. As nursing is a moral art then the practice of acting morally, that is, of doing that which is right, of being good, is not measureable, although the phenomena of morality could be studied scientifically. The most the author can hope for is for individuals to appear to be undertaking an activity which is moral and ethical, especially if the activity seems to be following certain rules of conduct, and individuals are not acting out of self-interest.

Fourthly, in all nurse-patient relationships it is important that certain rights, to be discussed later, of both patient/client and nurse are respected, as individual rights impose an obligation on another individual to recognise and in some cases effect those rights, as in the case of the patients' / clients' right to know. It would depend, however, on the individual's interpretation of rights and an examination of these rights will be detailed later. If these mutual expectations are not met, then there is dissonance between the views of the patient/client and the nurse, and conflict in care will emerge. Thus, it will be important to examine the
potential sources of the conflict when there is dissonance in expectations.

Finally, the Royal College of Nursing (RCN) set up its own Ethics Advisory Committee in 1984, and is a sub-committee of the Professional Services Committee. Much of the work by the Committee has been devoted to the RCN's response to the Warnock Report (1984). The RCN Ethics Advisory Committee was disbanded in July 1986 and reformed in November 1986, and has ad hoc meetings to discuss ethical issues as they arise. In October 1988 the Committee inaugurated a Special Interest Group from the RCN membership, who will then act as a resource to the Ethics Advisory Committee.

More recently, the UKCC (1988a/b: 9) has set up a new Standards and Ethics Group, comprising six Council members to look at quality of care and ethical issues, and their first meeting was held in July 1988 and subsequently in August 1988. At these meetings the Group recommended the formation of a Committee and put forward draft terms of reference for the consideration of the Council. It is hoped that the Committee appointments and the terms of reference will be formalised by November 1988. It could be that an ethical model for practice may contribute to the work being done by these organisations and ultimately contribute to the educational framework in which nurses are trained. It may also contribute to the theoretical framework of curriculum development which is concerned with the shaping of attitudes which aids in guiding nursing practice.
RESEARCH METHODS

The areas for investigation and reference in this thesis are drawn from local, national, regional and international literature. Use has been made of the historical, sociological, anthropological, psychological and health policy research in health care, in the analysis of broad principles in the observation of ethical practice.

Primary sources, capable of transmitting a first hand account of events, and which provides sound evidence of the past in the historical research includes anecdotal or oral testimonies provided by actual participants of events; policy documents; letters and original manuscripts; minutes of meetings; memoranda; official publications; newspapers; professional, general and nurse education journals/periodicals; diagrams; films; recordings; transcriptions and published and unpublished research reports (Cohen and Manion 1982: 39; Madge 1965: 91, 96). These original sources will be used to build up a detailed picture of the factors relating to the ethical concepts and nursing models.

The secondary sources are discussions of events written by individuals who are summarising or interpreting primary source material (Polit and Hungler 1983: 204) and as such are second or third hand accounts of events. The secondary sources will include textbooks in general and nursing education; medical and nursing ethics; philosophy; and research.
The author has limited the use of secondary sources on the grounds that their worth is reduced because of the errors that may result in the transmission and interpretation of information (Cohen and Manion 1982: 39; Madge 1965: 91, 96). Further to this, secondary sources reduces objectivity and may introduce bias, (Polit and Hungler 1983: 83, 204) and though every effort will be made to avoid this, it does make secondary sources less reliable and comprehensive.

**CHAPTER PREVIEWS**

**Chapter Two** explores the issues, such as the ethical knowledge base, which may have to be considered in the development of an ethical model for practice. These issues may serve to influence the application of ethical principles in the clinical and community setting.

**Chapter Three** examines in detail the conflict in ethical principles and the resulting ethical dilemmas that may confront nurses and patients/clients daily. These ethical principles may need to be considered for inclusion in the ethical model.

**Chapter Four** presents an Ethical Analysis Framework and Model which includes curriculum considerations and implementation guidelines. The chapter also examines the national and local implications for research, practice and education.

**Chapter Five** explores the findings and raises discussion and recommendations for the thesis.

The author now considers issues in developing an ethical model.
ENDNOTES (Chapter One)

1 NURSING PROCESS

The Nursing Process workshops involved the author and a team of facilitators running theory and practice orientated, externally based workshops for all nurses at all levels of the Ministry of Health, twice a week for a period of eight months. This was supplemented by in-house, that is, within the hospital setting, workshops. These workshops served to further reinforce the Nursing Process which is a systematic, rational, logical, problem-orientated, dynamic approach to nursing care initiated by Henderson (1980: 905-907) whereby the patient/client is assessed by the nurse, care is planned and implemented, and review and evaluation of the patient and the care delivered is carried out. The Nursing Process further emphasises clearly seven themes viz. the nurse is accountable to individual patients/clients, the public and the discipline, for the care she delivers; the purpose and direction of nursing is decided by the use of a nursing model; the patient is treated as a unique individual; the preventive/health educational, collaborative and curative role is highlighted; emphasis is placed on the problem-orientated approach to care, the nurse being fully cognisant of the fact that not all problems have solutions; the process is practised amicably within a multi-disciplinary team; and the relationship of the nurse and patient is unique by the inter-personal relationships and active partnership that needs to be developed (Open University 1985: 8-26).

2 ROLE-BASED TRAINING COURSE

The Role-Based Training Course for Senior Nurse Managers that is, Ward Sisters and above, is a management course which emphasises on-the-job training, complemented by the relevant theoretical framework within a specified time.

The Role-Based course was run over twenty week periods with units of training and practical application under the supervision of the author as Course Tutor/Speaker, and a team of trained facilitators who worked with the senior nurse managers both in the classroom and clinical setting to ensure correlation or linking of theory and practice.

3 Autonomy in the true sense is a state which cannot be achieved except in a noumenal world or in the world of angels. In this context it is taken to mean taking the responsibility for one's decision, and to a certain extent one's care.
4 Ellis' (1983: 211) view of philosophy is a common and acceptable view, though the author believes that Ellis' (1983) view of philosophy is simplistic as it concerns itself only with the clarifying of concepts and meanings, and is secondary or supportive of science, that is, it is a second order activity. It could be argued that in order to engage in philosophic enquiry the individual is required to go one step further and to examine values and goals which is a traditional view of philosophy, but is coming back into fashion (See for instance, O'Hear 1981).

5 It is the author's view that Silva (1977: 58-63) is suspect in arguing that philosophy is part of the method of science. Science looks at things under the category of quantity and is concerned with prediction, whereas it has been argued already that philosophy is concerned with the clarification of concepts and meanings (# 4). A scientist may, of course, act as a philosopher in preparing the ground for the scientific endeavour. Scientific enquiry requires facts to be collected with reference to some hypothesis.


This study revealed that the only justification for placing salt in the bath of patients/clients with wounds was possibly the psychological benefits, and even this benefit has yet to be proved.

7 Nursing makes use of scientific research, folk memory, personal experiences, but ethics is not a component to be added to this list. Rather it looks at the entire practice from the point of view of ethics and asks whether the relationship between nurse and patient/client is ethically correct.
"Moral positions must be argued for and justified. In any case often we will not know whether we have taken the right decision"

This Chapter will examine further the issues which may be considered in the development of an ethical model for nursing practice.

Based on the author's rationale for undertaking the study (page 29), the issues to be considered in enabling the nurse to apply the ethical principles in the clinical/community setting are centred around a good knowledge base which will enhance active participation for the patient/client in health care. It is arguable that if patients/clients are fully informed then they may participate actively in the planning of their care. This knowledge base is concerned with an understanding of what ethics is and the ethical principles; an understanding of what ethical dilemmas are or the nature of ethical problems and how they arise; how to cope with conflicting ethical principles, and how to justify ethical decisions; and the structure of ethical enquiry. Implementation of an ethical model requires enquiry, principled thinking, strategies for action, and an understanding of the characteristics of nursing. It would also be important to understand how nurses perceive health care as it may be arguable that their difficulty in the application of the ethical principles may be positively influenced by the environment in which they are working, and/or their perceptions of that environment; or, it could conceivably be that the
application of the ethical principles may be hindered by the environment in which they are working, and/or their perceptions of that environment. It may also be the case that their ethical views may influence their perceptions of the environment in which they work.

As nursing is a moral art (page 32), then the main characteristics of caring and commitment are examined to ascertain if these characteristics could affect how nurses apply ethical principles and their ethical decision-making in fulfilling the social contract. Social contract is taken to mean the contribution that nurses make to individuals in society in helping them to maximise their health potential.

The rights of patients/clients and nurses will be examined to see what are the major principles that are applicable to nursing and may need to be included in the ethical model.

For convenience, sub-headings will be used.

1. ISSUES FOR CONSIDERATION

(a) Ethical knowledge base

It is generally acceptable in any field of enquiry that a body of knowledge which serves as the rationale for the discipline may need to be established, and nursing is no exception. This identified body of knowledge serves as form, structure or direction to facilitate understanding for those teaching and learning nursing, in this context.
Carper (1978: 13-14) has identified four perspectives for viewing nursing knowledge, that is, empirics or the science of nursing; aesthetics or the art of nursing; personal knowledge in nursing; and ethical knowledge. It is these last two perspectives with which the author is primarily concerned.

The ethical pattern of nursing knowledge requires an understanding of varying philosophical stances regarding what is good, what is right, what ought to be done or the nature of ethical problems; an understanding of ethical dilemmas and an understanding of the complexity of how ethical judgements are arrived at or justified and the resulting action achieved; and the structure of ethical enquiry.

The Code of Professional Conduct (Appendix 1) which purports to guide the ethical conduct of nurses is based on the primary principle of obligation (Carper 1978: 20) of what ought to be done. This is embodied in the concept of service to human beings and respect for human life. Though the United Kingdom Central Council has recently offered guidelines for practice on the Code (Appendix 1) it does not advocate a knowledge of ethics to complement the Code.

Ethical knowledge will not provide answers to moral questions, or will it avoid having to make ethical choices, but it will at the very least provide the basis for making decisions about ethical problems and engender the individual's interest in the process of justifying ethical actions.

The nature of ethical problems

An ethical problem is to question whether an action is of a type which is governed by an accepted ethical standard. In
order to resolve an ethical problem it requires making an
ethical judgement as to whether a particular action is right or
wrong, and this requires the individual to apply ethical
standards. The acceptance of these standards implies
universality, that is, that an individual "always should
choose to act as all human beings should choose to act in a
similar situation" (Curtin and Flaherty 1982:49). The
standard accepted must apply to all similar cases or all
relevant cases be treated in a similar way. For example, if the
ethical standard is that "killing is wrong" then the course of
action such as one taken in euthanasia is also wrong, as it
falls within the ethical standards set. When there is no
apparent relationship to any ethical standard the question of
rightness or wrongness does not arise.

If an individual is concerned about whether something
is right or wrong then there may be some reason for saying it is
right or wrong and individuals would need to know what this
reason is. Usually when individuals are concerned whether an
action is right or wrong it is because it is of a type which is
allowed or forbidden by their own moral standards. If an
individual has no moral standards then there would be no moral
problems for that individual. For example, an individual who
does not believe that killing is wrong would have no problem in
committing murder or in participating in euthanasia. Thus, there
are no solutions to ethical problems unless there are some
ethical concepts, and no hope of an ethical enquiry, as without
these ethical concepts the facts are meaningless.
The justification of ethical actions

The formal justification of ethical actions requires individuals to follow a certain procedure, and the author proposes using the process adopted by Taylor (1961:68-106; 125-188). Taylor's (1961) four stages include verification, validation, vindication, and rational choice. The author will include one further stage which is called confirmation, on the grounds that it appears that the standards used in Taylor's (1961) process does not include confirming that the appropriate value system is utilised.

These five stages are now detailed.

Stage 1. Verification
Stage 2. Validation
Stage 3. Confirmation
Stage 4. Vindication
Stage 5. Rational choice

An attempt may be made to verify value judgements by showing that they are consistent with the standards adopted by individuals. These standards are validated by showing that they are consistent with higher standards. These standards are confirmed by reference to the value system appropriate to the standards being used. A value system is a "set of standards and rules of a certain kind arranged according to the place they have in the verification and validation of value judgements of that kind"; and a moral value system is a
"set of moral standards and moral rules that are appealed to in verifying moral judgements...... and that are arranged in an order of relative precedence corresponding to the hierarchy implicit in their validation" (Taylor 1961: 107). The value system is then vindicated by showing that it is part of the form/way of life. A form/way of life is an organisation of different sets of standards, rules and the individual’s set of value systems, religious, moral or otherwise, which makes up what that individual is. The final stage in the procedure is to demonstrate that a rational choice has been made between possible alternative forms/ways of life. In practice this would be extremely difficult to do as to some degree there will have been socialising influences which will guide the choice in a certain direction. To the extent that individuals are not able to show that a rational choice has been made, an arbitrary element may be the basis for the justification offered. However, as Aristotle (384-322BC) pointed out individuals cannot be any more accurate than the subject matter allows.

The process of justification is examined in more detail:

1. Verification
The statement and action are given meaning by applying a standard, and fulfills or not the standard applied. Are the beliefs about the action under the appropriate standard?

2. Validation
In this stage the standard is challenged as to whether it is the appropriate one in the circumstances. It must
therefore be relevant, and show that no conflict exists with other standards or rules being applied. One way of doing this is to show the standard used is derived from a higher standard, until the appropriate standard is confirmed.

3. Confirmation

This is a confirmation that the standards used are part of the appropriate value system, and whether the value system is the appropriate one to use in the circumstances. The standard is accepted as correct if it reflects the framework of values that individuals have from a moral point of view.

4. Vindication

This stage asks whether the value system used is appropriate, and provides the right point of view. This is done by looking at the forms/ways of life which contain the set of personal value systems which make up the character of individuals. These value systems reflect the individual’s outlook on life. Ideally, if an individual’s form/way of life is known then individuals would know which value system would take precedence in a conflict. Thus the rule would be derived from the moral nature of the general form/way of life. If the action/event is viewed from a moral point of view then the individual’s moral value system takes precedence over other points of view. This stage also requires individuals to commit themselves to the standard or rules of conduct which make up the value system; to freely choose to adopt the system; and the value system must be experienced by the individual adopting it.
5. Justification of rational choice

This stage is an attempt to show that the form/way of life chosen, which includes ethical and religious value systems, have been rationally chosen out of the alternative sets of value systems. These values have been determined by preference or freely chosen, without coercion, unbiased, objectively and impartially, and after thoughtful consideration of the consequences of each alternative or each form/way of life.

Dworkin (1978: 71-80; 1979: 43-49) argues that there is a distinction between rules and principles. Rules are actions which individuals ought/ought not to do because they are right/wrong and apply in an 'all or nothing' fashion. For example, a rule may state that two witnesses are needed for a will to be valid, and if there is only one witness, the will will not be valid. Principles state social goals such as the respect an individual ought to have for another individual and are taken into account in giving a decision. For example, people should tell the truth.

In choosing an ethical theory to justify ethical action, there is a contrast between ethical theories that emphasise individual rights and "autonomy", and ethical theories that emphasise the total good that might be achieved.

Taylor's (1961) process of moral reasoning by deliberation and justification may be viewed in hierarchical levels (Figure 2a). According to this, judgements about what ought to be done in a particular dilemma are justified or
supported by ethical rules (verification and validation) which in turn are justified by principles (confirmation and vindication), which ultimately are justified by ethical theories (justification of rational choice).
ETHICAL THEORIES
Second order principles
e.g. Utilitarian, Deontology

ETHICAL PRINCIPLES
e.g. Truth telling
Respect for persons

RULES
actions individuals ought/ought not
to do because they are right/wrong
e.g. It is wrong to lie to
a patient/client

JUDGEMENTS AND ACTIONS
judgements are decisions or
conclusions about an action

Figure 2a: Rules and Principles in
the process of ethical
justification
The structure of ethical enquiry

In ethical enquiry the hypothesis is that the course of action under discussion is right or wrong because it is a member of a class of actions governed by an ethical concept. It points to the type of method which is appropriate for conducting ethical arguments, and therefore for testing proposed solutions to ethical problems.

In cases where there is a doubt about the ethical action, three outcomes are possible. The individual may clarify the existing ethical standard, modify the existing ethical standard, or a new ethical standard is created. A legal analogy is utilised to demonstrate these outcomes. In a legal procedure of a murder trial the law is presented and the judge determines what is to count as murder, what evidence is admissible and what facts are relevant. It is the function of the jury to consider the factual evidence, and in the light of judicial interpretation to pronounce the verdict. If a question arises, not about what the facts are, but what the facts amount to, it is referred to the judge for clarification. The facts are examined for relevance and significance, and the sanction sought depends on the place of those facts in relationship to the charge against the accused. For example, if the facts show that a murder was committed, then the verdict would reflect some sanction on the person committing the murder in relation to the circumstances of the case. If the facts of the case are such that the existing law cannot deal with them, then some
modification of the law is required, or a new law may have to be
developed, creating judicial precedence. In the future all like
cases are judged by this "new" law.

In the principle of truth telling, for example, individuals are expected to tell the truth. An individual may
deliberately deceive because of the effect it may have on the
listener, such as the pain or anxiety it may cause. So, the
individual may clarify or justify not telling the truth on the
grounds that it may cause suffering. A modification of this
principle may lead an individual to withhold some information,
or only give some of the information. A new ethical standard
may be created in situations where it becomes acceptable to
deceive, or withhold the truth, provided there is good reason.

(b) Nurses' perceptions of health care or "mind-sets"

The nurses' perceptions of health care, or "mind-sets",
is a useful framework for deciding whether nurses' perceptions
influence, directly or indirectly, the ethical decisions that
nurses make in the clinical and community setting. Aroskar's
(1982: 24-32) theory is presented as it appears to pervade
current nursing literature.

Aroskar (1982: 24-32) identified four mind-sets, or
characteristics, that is the way in which nurses perceive health
care as an activity and its role in society, and how they affect
their ethical views, and vice versa. Aroskar (1982: 24-32) does
not make clear from where these mind-sets are derived, except to
say that they are her views of how nurses perceive health care and are views adapted from an article written by a philosopher (Newton 1979: 7-9). Her statements were based on the belief that nurses react according to their internal environment and the external environment in which they are placed. The internal environment is the nurse’s characterisation or mind-set about the system in which nursing and health care is delivered. The external environment is the larger social system, such as family, or the hierarchical bureaucratic organisation in which care is delivered. How nurses deal with the ethical dimension of practice depends on the interaction between these two environments.

Firstly, health care is viewed as a scientific project in which cure of diseases is the main objective. According to Murphy (1978: 313-320) a study in the 1970's of one unnamed hospital in America on nurses and their supervisors suggested that most of the nurses who were at a conventional level of reasoning, that is individuals who are able to think in concrete ways, and able to reason (Appendix 2), subscribe to this mind-set. Another more recent study done in America in 1981 (Simmons and Rosenthal 1981: 371-375) of twenty-eight (28) nurse practitioner interviews demonstrated that "these professionals tended to defer conventionally to the authority of physicians". The focus in this mind-set is of the nurse following the doctor's orders and feeling that it is inappropriate to question or challenge the doctor, and ethical
practice is equated to following instructions. Though nurse practitioners are legally accountable for their own practice, they do appear to prefer obedience to authority in order to maintain harmonious relationships and avoid blame as exhibited in their statements which reflect following hospital rules or doctor’s orders.

Secondly, according to Aroskar (1982: 25-26) health care is viewed as a commodity, that is, the hospital is seen as selling health care to consumers. This mind-set is often accompanied by a utilitarian perspective, that is, maximising happiness for the greatest number of people, as the nurses tend to defer to the goals of the institution and the administrative hierarchy. This view of health care conflicts with the current patient-centred ethic which commits nurses to meeting individual needs. In this mind-set the nurse may not question what is right or wrong as long as it appears congruent with the institutional goals.

The third mind-set Aroskar (1982: 26) contends is that health care is seen as a patient’s right to relief from pain or from a debilitating condition. The nurses’ primary obligation is to meet needs and wants as identified by patients/clients, and the patients’/clients’ interests are paramount. For example, a patient may identify a preference for a nurse to care for him/her specifically, and the nurse may consider this dependency on a nurse inappropriate, as a higher level of patient independency may be more therapeutic. Because the
patient's interests are paramount, the nurse is overruled. Thus, the identified needs of patients/clients are not congruent with the nurse, there may be a conflict between real wants and expressed wants, the integrity of the nurse becomes questionable, and consumers appear to control the health care system, as the patients' values predominate. Nurses may be viewed as instruments to carry out patients'/clients' wishes and not as advocates. It may of course be argued that a Patients Bill of Rights seems to suggest more consumer control of the health care system.

These first three mind-sets make nurses and/or patients/clients primarily the means to the ends of others. In the first mind-set the nurse is used as a means to an end for the doctor in achieving the goals of the doctor, which is to cure the patient/client. The nurse of course has made the choice to be a nurse and has the choice of refusing to follow the doctor's orders. In the second mind-set both the patient/client and nurse are used as means to an end in achieving other peoples' goals. It may also mean that nurses use other individuals and other nurses to their own ends in meeting the institutional goals or patient/client goals. The patient/client is also used as a means to an end to see the doctor's instructions are carried out and to serve the institution. In the third mind-set the nurse is used as a means to the ends of patients/clients as only the patients'/clients' wishes and values are important, and the nurse is an instrument in carrying out the wishes of patients/clients.
These three mind-sets, held consciously or otherwise by nurses, have certain consequences for nurses. They conflict with the Nurses Code of Professional Conduct (Appendix 1) by which the discipline abides, on the grounds that the standards of practice are developed by the nursing community, and not by doctors or institutions to which nurses sometimes defer. Because nurses appear to accept the doctor's authority and/or that of the goals of the institution, they may not always act in the patients'/clients' "best interests", as shown in the example in the third mind-set previously (page 53). Their ethical responsibility is clearly primarily to the patient/client, as expressed in the United Kingdom Central Council Code (Appendix 1), and in the American Code of Ethics (Appendix 3).

The American Code of Ethics (Appendix 3) developed by the American Nurses Association\(^2\) in no way condones ethically passive behaviour, and suggests "the nurse assumes responsibility and accountability for individual nursing judgements and actions" (American Code of Ethics 1976: Item 4). Because these codes have some legal significance the nurses who directly or indirectly subscribe to these mind-sets ought to be questioning the appropriateness of these mind-sets for nurses and nursing. However, both these Codes would first have to accept the legitimacy of Aroskar's (1982) theory of mind-sets.

Both the British and American Codes demand excellence in the craft, or at least its pursuits, and both suggest that "a profession must subject its activities to critical analysis
and modify these activities in the light of analysis" (Rule 1978: 5). This is emphasised by Rule (1978) who believes that:

"All of us, who wish to act rightly, are alarmingly vulnerable unless we give thought to finding out what it is we should be doing and committing ourselves to performing it"

(Rule 1978: 6)

The fourth mind-set according to Aroskar (1982: 24, 28-29) is viewed as the co-operative promotion of well-being. This view asserts that decision-making is interactive and respects the values and incorporates the view of all members of the health care transaction in maximising the individual's optimum health status, rather than the means to the ends of others, as in the first three mind-sets. This mind-set does however raise questions in regard to what constitutes ethical nursing practice. For example, are nurses required to be accountable and responsible for enabling active participation in decisions in their health care? Aroskar (1982) suggests that any or all of the elements of such mind-sets can be found in the process of decision-making for nurses at any time, given the transient or constantly changing nature of their jobs.

The ways nurses identify or not, interpret and judge ethical issues and dilemmas in the clinical and community setting has implications for each of the four mind-sets. In other words, depending on the nurse's view of what ethics is, and how these ethical issues are interpreted may influence their
perceptions or mind-sets of health care. For example, if the nurse's view of ethics equated with a non-paternalistic attitude, that is that the nurse ought not to act on behalf of, or make decisions for patients/clients without consulting them, then an ethical issue such as deciding whether to prolong life may cause the nurse to believe that the fourth mind-set (page 56) is an appropriate perception of health care to have. It is arguable that the first three mind-sets in which nurses defer to the goals of the institution and doctors that they may not be acting ethically, as individuals are used as means to the ends of others.

The claim of nursing as a moral art will now be discussed, and sub-headings will be used for convenience.

(c) The moral art and perspective of Nursing

The main characteristics of the moral art of nursing will be examined more fully to ascertain if these characteristics could effect how ethical principles are applied, and how ethical decisions are made in the clinical and community setting.

The claim has been made by Englehardt and Spicker (1975: 101); Englehardt and Callahan (1976: xiv); and Cassell (1978: 91, 99) that medicine is "inherently a moral profession" on the grounds that the claim to be a profession involves the claim to be the guardian of certain values. Curtin and Flaherty (1982: 86, 95) contend that this claim can be made,
and validly so by nursing, on the grounds that the end or purpose of nursing is the well-being of other people, and this end is a moral one as it involves inter-personal relationships and the seeking of good with other individuals. This definition of a moral art can also apply to other professions such as politics and economics. However, nursing is particularly concerned with the well-being of the individual to do what is technically right and ethically right, and these rights can often conflict. The application of this knowledge and skill comprise the art of nursing. Therefore, nursing is both a moral art and can be viewed from an ethical perspective. In other words, because nursing comprises three essential domains, that is, the cognitive/knowledge domain, the affective/attitudinal domain, and the effective/skills domain (Figure 2b) which are specific to nursing, then nursing can therefore be viewed as a moral art with scientific and technological aspects. This ethical perspective has been emphasised in the English National Board\(^3\) (ENB 1985/19/ERDB) policy document which states explicitly the need for ethics education and practice in the curriculum, and this has been strongly advocated for by the author in an unpublished Masters Degree (MSc) dissertation (Rodmell 1985).
Figure 2b: The essential domains in Nursing,
Adapted from D. Reilly, ed.,
Teaching and evaluating the affective domain in Nursing Programs,
Nursing as a moral art, requires the special skills of caring and commitment for and to other individuals. This moral art claim, raises the question: what does a nurse practitioner have to do to practice this moral art? The answer to the question would entail detailed explanations about the character, behaviour, role, and the promises inherent in this discipline of nursing, and clearly these are essential for an appropriate nursing model.

Nursing as a moral art also embodies the notion that ethical principles of justice, patient/client autonomy, non-maleficence and beneficence are an integral part of the nature and purpose of nursing. As in any art then due attention may be paid to the selection and the arrangement of these principles so that they may be utilised effectively or operationally. These principles will be discussed in detail in Chapter Three.

In addition, an awareness of the goal to be achieved as far as the ethical requirements are concerned is needed by the nurse, and this achievement may require following a Code of Ethics. However, blind obedience to a Code of Ethics is not morally acceptable, at the expense of the moral obligation to the patient/client. An ethical act must be done for its own sake. As a case in point, if the nurse respects the patient's/client's rights, and facilitates these rights, such as in a request from a patient/client to be allowed to die, then the nurse is at risk of violating the Code of Nursing Ethics (ICN 1973). The Code of
Nursing Ethics (ICN 1973)\(^4\) states that nurses "have a fundamental responsibility of promoting health", and on the strength of this the nurse may refuse to comply with the patient's/client's request. Three notions arise out of this conflict for the nurse and the patient/client. Firstly, patient/client "autonomy" is not recognised if the request is refused; secondly, great unhappiness could be created for the patient/client; and thirdly, the patient/client has been treated as a means to an end. However, the nurse has carried out the obligation to the Code, but the obligation to the patient/client may be forgotten. The dilemma for the nurse is two-fold: firstly, non-adherence to the ICN Code (ICN 1973) or the UKCC Code (Appendix 1) could be of legal significance in that nurses who do not adhere may be disciplined; and, secondly, the possible forgotten obligation to the patient/client may challenge the notion of nursing being a moral art as the notion of obligation/duty is implicit in ethical principles. It is also interesting to note that nurses automatically obey the Code of Nursing Ethics, yet do not use nursing models appropriately. This may be due to the fact that disciplinary procedures could result from a violation of the Code.

Another requirement of this moral art is for the nurse to be an expert at casuistry, that is, the application of accepted ethical principles to specific circumstances in which ethical principles conflict (Gillon 1986:19). Casuistry
embodies some ethics education, and would be essential if nurses are to be members of Ethical Committees, and to be as objective in ethical decision-making as the subject matter allows. To date, nurses do not undergo this experience at a clinical level. What effectively demonstrates the ethical conflict that nurses face is that the existence of the Code of Nursing Ethics (ICN 1973) may bring about the recognition that if nurses try to set out a Code of Practice then some of the principles used may sometimes be in conflict. One of the things nurse education is/ought to be concerned with is how to give the nurse the skills to cope with such a situation. The nurse needs to know how to weigh arguments produced in the application of certain principles and how eventually to make a decision between the different principles and arguments. It has been seen (page 60) that it is possible for a Code of Ethics, because of its failure to address certain issues, to lead to a conflict situation. The point is that nurses need to understand that to make an ethical decision requires being responsible for that decision, and not following Codes blindly. An ethical Code should provide a framework for ethical decision-making rather than be a hand-book of rules.

The bases of the ethical perspective of nursing are now examined.
Varying interpretations of caring as a basis of the moral art and perspective of nursing

The concept of caring in nursing emphasises at least two components, those related to medical diagnosis, and not within the scope of this discussion, and those related to meeting the needs of patients/clients as individuals.

The understanding of what it is to care is of importance as it is central to the conduct of the moral lives of individuals. Five main concepts of caring (Figure 2c) emerge when definitions of caring are examined. Firstly, there appears to be an activities aspect (Figure 2c [1]), whereby caring is expressed in terms of assisting, helping, and serving. However, the study done by Morrison (1988: 51) with a sample of twenty-five (25) experienced male and female charge nurses, utilising content analysis of two hundred (200) constructs, demonstrates that caring as an inter-personal process is emphasised, with very few constructs relating to the physical aspects of caring. The sample in this study may be too small to generalise conclusions for practice, but it does give some indication that the concept of caring does appear to contain a physical aspect.

Secondly, there appears to be an ethical base for caring (Figure 2c [2]). Rogers (1982: 39-58) and Mayeroff (1971: 13-28) have outlined some characteristics of a caring relationship such as respect for individuals, knowledge, patience, humility, hope, courage, honesty, freedom, trust and
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Figure 2c : Interpretations of Caring in relation to the essential domains of nursing
compassion and this seems to be the ethical dimension of caring. These are comparable to the Principles of Ethics advocated by Thiroux (1986: 124-137) which embodies the value of life, goodness or rightness, justice or fairness, truth-telling or honesty, and individual freedom. These principles, which will be discussed later in detail, may be applied to the individuals daily life, as they provide direction for what the individual "ought" to do.

Thirdly, caring is interpreted as the attitudes or feelings underlying these activities, expressed as protective, compassionate or empathic (Figure 2c [3a]).

Fourthly, caring may also be viewed (Figure 2c [3b]) as a long term emotional state, as opposed to a temporary state of an emotion, and may afford individuals such as nurses the opportunity of portraying their altruistic qualities. This caring involves a personal commitment by the nurse, which is in addition to the caring requirement demanded in a professional contract. This caring is in response to the bio-psychosocial needs created by the patient/client on the basis that "humanity" (Curtin and Flaherty 1982: 87) is the common factor.

All these caring views appear to complement each other as they all embody knowledge, skills, attitude, and ethics.

If nursing is to emerge as an academic "profession" with scientific, technological and ethical perspectives, then the basis of caring ought to become one of active partnership
This active partnership is demonstrated by nurses who are already using the Nursing Process, in which the health care responsibilities are shared by nurse and patient/client by facilitating decision-making by the patient/client. In order to achieve the potential in this relationship the nurse is required to provide information, and encourage patients/clients to assume the responsibility for their own health status, either by facilitating them to make informed decisions about their health, or, with the aid of their appointed advocate or trustee, to arrive at decisions in their own "best interests". This may be achieved by utilising an ethical model which incorporates ethical principles with guidelines for practice.

Thus caring in this thesis is taken to mean "attributes which embody the characteristics of knowledge, patience, honesty, trust, humility, hope and courage" (Tschudin 1986: 17-18). This caring concept implies that assisting patients/clients in such a manner requires "empathetic, supportive, compassionate, protective, succourant, educational" behavioural attributes (Leininger 1984: 4).

The fifth concept of caring (Figure 2c [3c]) is now examined.

Caring as a value

Ethical dilemmas arise for the nurse when technical developments occur, such as the use of life-support machines,
When the principles of ethics which have to be taken into account when arriving at ethical decisions conflict, or when ethical principles are valued differently by other individuals. Value in this thesis is taken to mean "an affective disposition towards a person, object, or idea and is expressed through behaviours, feelings, imagination, knowledge and actions" (Steele and Harmon 1983:1). This interpretation implies that values are personal beliefs and attitudes which are put into action, and are intrinsically or extrinsically desirable and rated highly or valued by the individual.

Thus, values guide individual action, that is, they deal with modes of conduct, and once externalised or internalised may become a standard or criterion for guiding action. Arguably, the nurse who makes a decision in a particular situation may well apply these values in a different situation which may or may not be appropriate to the new situation.

Caring may be seen as a value (Figure 2c [3c]), based on the definition above, partly based on emotion, and not an instinctive quality, then by its very nature nurses may or may not have chosen the nursing discipline to act out their beliefs about caring. Thus, each nurse will express caring differently, according to, or based on, the moral values and beliefs that are held and therefore the standards which arise are relative in nature. Belief in this thesis is taken to mean "a special kind of attitude which is based more on faith than on fact" (Steele and Harmon 1983:3).
Values are interpreted differently by each person, and though they may be shared by others, individuals may differ in how they apply them. As a case in point, two nurses may both value the sanctity of life, but they may both be in conflict if they were placed in a situation in aiding to make a decision of removing a patient from a life-support machine. It is the case that the facts or knowledge about a particular situation are independent of the values that will be manifested. The nurse cannot derive morals from facts but ethical standards can give certain facts meaning. For example, if a judgement is to be made about a situation then it has to be viewed in a distinct way and then standards are applied to the distinct point of view to give it meaning. As a case in point, a nurse carrying out a procedure/treatment may harm the patient in so doing. Viewed from a technical point of view the skill and expertise with which the procedure/treatment is performed may be considered efficient and the nurse seen as technically proficient. However, viewed from an ethical point of view, the proficiency of the nurse becomes irrelevant, and the harm caused the patient becomes another point of view to which different standards are applied. From an ethical point of view because the nurse failed to follow an appropriate Code of Conduct, the nurse may be seen as acting unethically.

Nurses accept the responsibility of caring and the extent to which they accept this responsibility depends on their philosophy, that is, their personal values, ideals and beliefs.
about the nature of man and nursing. This philosophy will be reflected in the care the nurse delivers.

Thus, it appears that ethical standards may be based on emotion and are relative to the situation. However, a conscious attempt may be made to intellectualise the situation, to move from this emotive stance by not basing actions on emotions but on rational rigorous debate and in universalising standards (page 43). The practical problem in universal standards is that the application of appropriate standards in each situation is difficult.

It is important to substantiate the claim that ethics is not based on emotion. If ethics, as a form of knowledge, comprises personal beliefs and is not based on reasoning, then arguably Ethical Committees are simply making decisions which are prejudicial and not within the "best interests" of the patient/client. However, individuals who do not live/conform to the conventional ethical beliefs are still living according to ethical standards provided they can defend and justify what they do, but a justification must not be in their own self-interest.

The author therefore argues that ethical decision making must be objective and may be reached by critical reflective argument/debate and reason. An attempt must be made to universalise or go beyond personal interests, likes and dislikes (Singer 1982: 10,11).
This does not imply that a particular decision must be applied universally, but that in making decisions in the interests of patient/client, or nurse, that the decision-maker goes beyond their personal beliefs and preferences and assumes the role of impartial spectator. The ethical nurse is really making the claim that in the present circumstances the action taken is the right one. This is making a universal claim, but this claim is open to criticism and argument. The claim is put into the public arena and in that sense objectivity may be achieved as it opens the claim to assessment and judgement by others.

If ethics education is to take place, and to be included in nursing curriculae, then individuals are required to recognise basic rules and practices, and that these, in principle, should be universally recognised. Otherwise, education becomes the inculcation of prejudices and therefore indoctrination.

A number of modern philosophers (Ayer 1949; Stevenson 1937), argue that moral statements such as "killing is wrong", are expressions of the individuals feelings or attitudes towards that activity. Moral statements merely refer to emotions and feelings and are not in the domain of rational argument. However, it is also true that moral statements often do refer to feelings, and in this sense morality can only be relative.
The author wishes to argue that there is a distinction between morality and ethics. Ethical statements evaluate, instruct, recommend, prescribe and advise, but in doing this a claim is also being made that they are rationally justified or justifiable, which expressions of emotion cannot be. The question arises as to how they can be justifiable.

In making ethical statements individuals are attempting to ensure that the same conclusions will be reached by other individuals, if viewed from an ethical point of view. For example, "I believe killing is wrong because......" Thus, reactions and reasons are placed in the public arena, and claiming that others should agree with the claim. Therefore a universal claim is being made which must be examined and criticised by other people. It is here the autonomy of the moral agent is seen, as the moral agent has to assume the ethical point of view and agree with others who do the same, whilst retaining individual judgement. Thus, individuals are acting on principle and are willing to universalise their principles. In so doing individuals are considering the good of everyone and acting objectively.

(ii) Commitment as a basis of the moral art and perspective of nursing

One of the most distinctive characteristics of the nursing discipline is the commitment to the bio-psychosocial concerns of patients/clients, and this requires a service orientation, the principles of which are embodied in the Code of
Professional Conduct (Appendix 1) for the discipline. However, commitment does not necessarily create a good nurse, it may only create a passionate one. The philosophy of care in nursing incorporates a set of ideals, such as active participation of patients/clients in their health care, and nurses may, or may not, have expectations to exemplify these ideals dependent on their degree of commitment. Arguably, this commitment may not necessarily reduce disease or prevent dying, but it will go some way to affecting the quality of life for the patient/client.

Downie and Calman (1987: 190) believe that the concept of the quality of life changes with time and is related to all aspects of life, and they see the process of achieving a good quality of life as "narrowing the gap between hopes and reality". This implies that personal growth is vital to achieve a good quality of life.

Conversely, the philosophy of the discipline is not followed if there is the lack of moral commitment as the declared promises, that is, the "performative declarations" (Curtin and Flaherty 1982: 98) inherent in a Code of Ethics is not fulfilled, and thus the discipline may be discredited. The licence to practice presupposes an obligation to practice well (Curtin and Flaherty 1982: 99) and to practice or nurse well requires commitment, though commitment does not guarantee good nursing. This obligation to practice or nurse well is based on a commitment to nursing as a discipline, to certain ethical standards, and to acting in an ethical way. Conceivably, they may all conflict.
Thus, nurses are required to develop a pro-active, rather than a reactive, approach to ethics, and this logically entails a commitment to the declared promises professed by nurses, the criteria of which are based on humanitarian grounds, and the fidelity to keep those promises. Without fidelity there is no trust and without trust the nurse cannot practice this moral art.

Clearly then, the ethical principles which are subsumed in the nursing discipline and implicit in a Code of Ethics are based on the concept of human rights and the duties applicable to those rights; on the nurses' obligation to promote public welfare, that is, the responsibility for the service rendered to the public; and to promote excellence amongst colleagues. If nurses make this moral commitment then according to Levine (1977):

"The quality of the moral commitment is a measure of the nurses' excellence"

(Levine 1977: 845)

Just how Levine (1977: 845) proposes to measure the nurses' commitment and the resulting excellence is problematical, and as mentioned previously (page 72), the nurse could be completely committed and perform poorly as a nurse.

Ethical behaviour is not a display of behaviour in times of crisis, such as life or death, but a daily expression of the nurses' commitment to caring for patients/clients and
respecting their rights. It is to these rights the author now turns.

(d) **Human rights**

The claim has already been made (page 33) that there are certain rights which may be respected by nurses and patients/clients. Rights are moral claims which entitles individuals to be treated in a certain way, and may or may not be protected by law. That is, they may be ethical and/or legal. They may be viewed as positive rights or negative rights, and may or may not require action from others.

The author wishes to examine the notions of moral rights, and more specifically fundamental/basic rights, or general/universal rights.

Fundamental human rights are rights which individuals claim from a moral point of view. They are moral precepts, and in claiming them individuals are arguing that even if actual states do not legislate them into effect then they ought to, or at least they should not contravene them. This is therefore tantamount to a hope that civilised societies will recognise such rights, and in declaring this hope, it is argued that these rights are not just subjective beliefs or prejudices, but are objective and claim universal validity.

Fundamental human rights arise from essential human needs and the ability to perceive these needs, though not all human needs translate into human rights. Fundamental rights are
not dependent on some other moral right, that is, they are intrinsic entitlements.

These fundamental human rights need to be recognised and taken into account in nursing practice. The existence of these human rights cannot be realised simply by examining legislation and universal declarations, as such investigations will only reveal the positive rights particular individuals have in a specified state. **Positive rights** are those rights which are given to people by the law, and which are positively enacted by the legitimate authority.

General or universal rights which is often used interchangeably in the literature with fundamental rights, are those rights such as the right to life or liberty which are unconditional, may or may not be restricted in scope and based simply on the individual being a person. They are unconditional in that they are attributable or apply to everyone, and may or may not impose obligation or duties between the individual who has the right and those who have the corresponding obligation to respect that right (Benjamin and Curtis 1986: 158; Gillon 1986: 56). Gillon (1986) argues that though it is clear that general/universal rights may impose a moral obligation on everyone to refrain from certain acts, it is debatable whether they impose moral obligations on everyone to act, and is not persuaded that these rights require anyone to act. As a case in point, an individual's right to life may impose a duty on one individual not to kill another individual, but not necessarily to save them.
Because some individuals have a special relationship, further rights may emerge and these may be considered as special or reciprocal rights as is inherent in the special relationship between nurse and patient/client. It may be argued that the relation between society and nursing is such that a duty of indebtedness does occur. In other words, as nursing is in concept a social contract (page 41), and patients/clients are "party" to that contract, then duty is part of that social contract, and nursing care is part of that duty. Society has a right to nursing care, or at the very least society may claim a right to that care on the grounds that nurses have an obligation to fulfil that care as part of their duty. However, this is not always so. Formalising rights in order to protect individuals is an attempt to make a claim or demand on other individuals which may then be enforced by law. But moral rights do not become law unless the legitimate authority enacts them.

Special moral or reciprocal rights are conditional, limited in scope and grounded in special relationships, such as the right to the repayment of a debt, or the keeping of a promise, or those rights arising from social relationships, as in the rights of children to be cared for by their parents. These rights are conditional in that they are limited to the individuals concerned, and they depend on the nature of the special relationship between the individuals concerned (Benjamin and Curtis 1986: 158; Gillon 1986: 57). It has been argued by Hart (1970: 61-75) that the whole network of our sociopolitical
relationships is a source of special rights of which legal and institutional rights are examples. Both of these examples refer to rights that may be created and abolished by decisions made by the appropriate people such as parliament (Gillon 1985a: 1890) or the legitimate authority (Dworkin 1979: 40 citing Hart).

Utilitarians or consequentialists view the concept of rights as a "convenient fiction, general acceptance of which will tend to maximise welfare and is therefore morally justified" (Gillon 1985a: 1890; Gillon 1986: 56). Arguably, how can utilitarians justify rights when they are a "convenient fiction" and so do not exist. Non-utilitarian opponents of rights such as non-consequentialists however, tend to accept the moral obligations that human rights entail, but deny the need to debate them, on the grounds that the "duties are sufficient on their own....." and that "emphasis on rights tends to encourage people to pursue moral demands on their own behalf at the cost of neglecting their moral duties" (Gillon 1985a: 1890; 1986: 56). Conceivably, if an individual does not have a right, then they cannot have a duty.

SUMMARY

This Chapter sought to examine some of the issues which may be considered in enabling the application of ethical principles and which may have to be included when developing an ethical model for nursing practice.
It demonstrated that nursing knowledge involves ethical knowledge as it facilitates nursing as a moral art, but it is difficult to establish the parameters for practice. The nurses' perceptions of health care varies according to the context in which nursing is being practised, and as nursing practice clearly has a ethical perspective may incorporate ethical principles such as rights, and these rights were examined.

In the next chapter the ethical principles which may be relevant to nursing practice will be examined to highlight the dilemmas which present for nurse and patient/client alike.
The United Kingdom Central Council (UKCC) for Nursing, Midwifery and Health Visiting was set up in 1980 as a result of the passing of the Nurses, Midwives and Health Visitors Act of 1979. The principle function of the UKCC is to establish and improve standards of training and professional conduct for nurses, midwives and health visitors. The UKCC comprises forty-five (45) members including the chair-person. Twenty eight (28) members are nominated by the National Boards of England, Scotland, Wales and Northern Ireland; and seventeen (17) members are appointed by the Secretary of State, Department of Health and Social Security (DHSS).

The American Nurses' Association (ANA) based in Missouri, is the professional association for registered nurses in the United States. Organized in 1896 as the Nurses' Association Alumnae of the United States, ANA is a federation of constituent nurses' associations in each of the 50 states and in the District of Columbia, Guam, and the Virgin Islands. Membership in constituent state nurses' associations is open to any individual licensed to practice as a registered nurse, unrestricted by consideration of nationality, race, creed, lifestyle, colour, sex or age.

The purposes of ANA are to work for the improvement of health standards and the availability of health care services for all people, to foster high standards of nursing, and to stimulate and promote the professional development of nurses and advance their economic and general welfare.

ANA establishes a code of ethics for nurses and speaks for nursing with other health care organizations, governmental bodies, and the public. ANA also represents American nurses in international nursing matters as the U.S. member of the International Council of Nurses.

The governing body of ANA is the House of Delegates, which is composed of representatives of each of the constituent state nurses' associations. The House of Delegates meets annually. In the intervals between meetings of the house, the association is governed by the Board of Directors, the corporate body, composed of officers and directors elected by the House of Delegates. Accountable to the Board are cabinets and councils. The association is administered by an executive director and a professional staff, which manages and executes association programs and operations.

The English National Board (ENB) is one of four National Boards, one for each nation in the United Kingdom which was established under the United Kingdom Central Council (UKCC) as a result of the Nurses, Midwives and Health Visitors Act (1979). The forty-five members of the ENB hold executive
functions in transmitting the UKCC policies into action. Twenty (20) of these ENB officers are nurses, five (5) midwives and five (5) health visitors, partially elected by Registered Nurses in England and fifteen (15) are Ministerial appointments. Eventually all English officers will be appointed by election by all Registered Nurses, such as Nurses, Midwives and Health Visitors of England.

4. The International Council of Nurses (ICN), founded in 1899, is a federation of national nurses associations which includes Britain, with a current membership of over eighty-seven countries in 1988 representing close to a million nurses. The organisation provides a medium through which members can share their common interests in nursing; serves as the authoritative voice in that it acts as a pressure group for nurses and nursing internationally; and has consultative and official relationships with organisations such as World Health Organisation (WHO); the Economic and Social Council which liaises with the United Nations; the International Labour Organisation (ILO); the International Hospital Federation; the Council of Europe; the Red Cross; United Nations International Children's Emergency Fund (UNICEF); and the United Nations Educational, Scientific and Cultural Organisations (UNESCO).
CHAPTER THREE

"To enjoy yourself and make others enjoy themselves, without harming yourself or any other; that, to my mind, is the whole of ethics"

Chamfort, Maximes et pensées, 1805.
CHAPTER THREE

INTRODUCTION

Ethical principles and rules are applicable to all nurses and the activity of nursing, as nursing is, in part, concerned with relationships between people. From an ethical point of view questions about "autonomy", liberty of individuals, honesty, justice and equality arise, and are part of the concern of nurses as facilitators of "autonomy" and acting as advocates or trustees for patients/clients and their rights.

This chapter will examine the ethical principles concerned with the rights of patients/clients and nurses and present some examples of the ethical dilemmas which arise, in order to see what specific ethical principles inherent in these dilemmas need to be taken into account for the development of an ethical model for nursing practice. The notion of paternalism related to nursing practice will also be discussed, as how nurses apply ethical principles may be influenced by the attitudes of nurses to patients/clients.

In this thesis dilemma is taken to mean a "situation requiring a choice between what seem to be equally desirable or undesirable alternatives" (Benjamin and Curtis 1986:4). Not every ethical problem is a dilemma. If the choice is between what the individual "ought" to do, and what the
individual wants, then this constitutes a problem for which an answer exists. However, in a dilemma any action taken may result in an unfavourable outcome and/or may constitute a breach of an individual’s duty to another.

The author now examines some of the conflicts which arise when ethical principles are applied, and the resulting ethical dilemmas that confront nurses and patients/clients in the clinical and community setting.
CONFLICTING ETHICAL PRINCIPLES AND THE RESULTING ETHICAL DILEMMAS FACED BY NURSES.

(a) The Principle of the value of, or right to life (the Sanctity of Life)

The ethical dilemma that arises for the nurse and patient/client alike is what ethical principles are acceptable, and how they may be applied, when issues of the sanctity of life arise.

Most known systems of morality such as Judeo-Christian ethics, Buddhism, Hinduism and Islam, profess to have a doctrine against killing, or a doctrine for preserving life, or valuing life, or a right to life and this is deemed the most important principle on the grounds that if there is no life then there is no morality or ethics.

The principle seems relevant when the dilemmas of abortion, euthanasia, and suicide are examined, and such dilemmas are also a main concern for nurses.

There are clearly two arguments which may be advanced for according this significance to human life. Firstly, according to Downie and Telfer (1980: 42) the individual wants to stay alive, even if their lives are not threatened, as in order to pursue their ideals, life is a necessary condition.

This first argument in the sanctity of life debate is based on the presumed or actual wish for life, and permits euthanasia and abortion of those who "have or will have a life
so wretched that they want to end it, and of those who are unable and will never be able to have any wants constituting desire for or enjoyment of life" (Downie and Telfer 1980: 48). It may be argued that to justify euthanasia on these grounds is difficult though some doctors do support euthanasia on the grounds of omission, that is, letting die or letting events take their course. This is evidenced by the many cases where doctors and nurses omit to resuscitate or treat the elderly, in inoperable diseased patients, or patients/clients with malignant disease. However, to support or practice euthanasia or abortion, does not necessarily mean that it is condoned or always permissible, or is it moral, or ethical, so to do. Though the motive and the results are the same in omission and commission, to be discussed later, the decisions are not necessarily premeditated. The question arises as to whether these decisions should be premeditated. The moral distinction or difference seems to be that intervention does not appear to be wrong if intervention is beneficial to the family, but which criterion to adopt for act or omission must be left to individual moral judgement, and in this case for the health care team to decide in a rational way.

The second reason, according to Downie and Telfer (1980: 46) for an individual's right to life is the special worth or value in human life\(^2\) that is, its intrinsic value, which is independent of the possessor wanting it. The obligation thus rests on the possessor to cherish this right, and other
individuals may not take this life, even if the possessor wishes it.

The second argument, based on the intrinsic value of human life, would permit euthanasia or abortion but only of sub-human, however that is defined, and a respect for human life generally might modify this practice. Clearly there are difficulties in deciding who defines sub-human life, and who falls within the sub-human category.

Those who argue against killing would assert that the principle of respecting people's desires to live must take into consideration their expected future wants, and desires. This would mean that the lives of those "special" people, such as physically handicapped babies, ought to be respected as they will in the future, it may be assumed, develop the normal desire to live with the capacity to want and form desires. It would be impossible to judge, therefore, whether these individuals, were they to survive their illness or handicap, would have any regret about being alive, and so their right to life must be given every consideration, as all individuals belong to the same species of homo sapiens and so must be given equal consideration.

Clearly, just as those "special" individuals then have a right to life, then other individuals have an obligation to give that desire "paramount importance" (Downie and Telfer 1980: 45).
However, the sanctity of life principle is not incompatible with the quality of life, and equal consideration in both principles are paramount in ethical dilemmas as these concepts are not independent of each other. For example, prolongation of a patient’s/client’s life without due consideration for the quality of that life might "violate the integrity of the person and the sanctity of life principle" (Roach 1982: 31). For example, if a patient/client wishes to terminate their life ideally the health professional in respecting their "autonomy" appears to be duty bound to facilitate this wish. However, the health professional is also bound by the moral imperative not to kill, and recognises the need for increased care in these circumstances especially in cases such as the terminally ill or handicapped neonates who are unable to give their consent. It is up to each nurse in the exercise of being accountable (UKCC 1984: 2) to have an understanding of the reverence of life and the acceptance of death. It does not mean that no individual may ever be killed, or that life must be preserved at any cost, or that an individual may never be allowed to die, commit suicide or have an abortion. It is the decision that is made on balance when all the facts have been weighed in a rational manner in rigorous debate, as all professed "doctrines" (page 84) allow killing under certain circumstances, though there are strong convictions held against killing in general.
What the nurse and health care team must justify is why the life will be terminated and whether on balance it is wrong to take that life without consent of the individuals concerned. Also consideration must be given to whether the nurse has the right to interfere with their death or their wish to die. Plainly, if nurses accept occasions when killing is the "right" thing to do, such as balancing good against harm in cases of facilitating death in emergency resuscitation, or untreated pneumonia in the terminally ill or severely handicapped, then this may undermine the ethical principles which protect the right to life. In rigorous discussion the nurse may need to question the difference between killing deliberately, that is active euthanasia, and letting death take its course, that is passive euthanasia.

From the type of arguments presented it would seem that in preserving life there is a full range of options. These range from preserving life at all costs regardless of the quality of that life; preserving life at all costs, though it may be at the expense of another's life, as in abortion; to preserving life but only if the individual wants that life, and how is the nurse to know the seriousness of that wish especially if the patient/client is not rational due to illness.

It is hard to see how these options may be translated into practice for the nurse at the bedside or in the community, as the ethical dilemma for the nurse is that in following the Code of Nursing Ethics (ICN 1973) to preserve life, could result
in acting unethically, as in cases of not performing an abortion. Whilst following the Code (ICN 1973) and preserving the life of the unborn child pain and suffering could be caused to the mother. Thus, violation of the Code (ICN 1973) may/may not result in unethical behaviour and this has already been addressed (page 61).

What is significant for the nurse in the practical setting is that in decisions which concern the preservation of life principle there is not always the time to debate the issues at length. By the very nature of the situation, such as an unborn child and an ill mother, it would appear to depend on when a decision is made.

In summary, the ethical dilemmas appear to be what criteria ought to exist for omission and commission which would justify active and passive euthanasia; who is responsible for exercising rights in those "special" people, such as babies or the handicapped, especially as there still remains the differences in definition. In addition, the nurse is faced with weighing the potential harm against the benefits in cases of the prolongation of life over the preservation of life, as both need to be given equal consideration.

If, however, ethical dilemmas are intellectualised and universalised (page 69), then the most the author may hope for is that a reasoned judgement will be made, which can be justified in light of all the facts and argument, as the Code provides moral guidelines and is not law.
The Principle of the right to Liberty or individual freedom

"Human freedom at its most radical means that I am free to die for what I value more highly than my own life, or free to continue living under execrable circumstances for something I value more highly than my own suffering"

(Curtin and Flaherty 1982: 8)

This quotation implies that the concept of human freedom embodies the concept of human values, as individuals make choices based on their values. However, in the nursing context these values require intellectualising and universalising so that reasoned judgements may be made. This quotation also implies that there are some values that can be valued more importantly than life, which is a denial of some doctrines. If there is such a thing as human freedom then it must include an option, a choice to exercise rights or will, or to refrain from exercising them and an individual is only free if there are no constraints on that freedom.

For nurses the ethical dilemma is how far that freedom should be allowed to extend, as human freedom is not an absolute right as it may conflict with the choice of another individual, even if the individual is willing to "pay the price" for the action taken.

However, individuals are not free to choose for other
individuals as echoed by Curtin and Flaherty (1982: 11):

"Although we are free to abrogate our own rights, we are not free to negate the rights of others"

(Curtin and Flaherty 1982:11)

Freedom, though an essential aspect of the exercise of rights, cannot be a precondition to the existence of rights, as some individuals may not be able to exercise their freedom. In other words, children, mentally ill, senile elderly people, and others, do not lose their rights because they cannot exercise them and these rights may be respected and clearly, special care must be taken to protect these people. If an individual has a right there is no need to insist on it for it would be recognised.

The freedom to choose what is believed to be wrong or right needs to be considered in the framework of ethical judgements, which must be used conscientiously to choose the right thing to do. To use freedom rightly is to "use it for good, to promote justice and truth" (Tschudin 1986: 41). By this Tschudin (1986) means the freedom and individual has to promote good, such as the promotion of health.

In order to have the capacity for self-determination and for the pursuit of ideals, the individual ought to have the freedom to pursue those ideals without interference, or to be "allowed to act as one chooses", that is, liberty (Downie and Telfer 1980: 51). However, it would depend on what those ideals are, and provided it can be shown that the action chosen will not interfere with the liberty or interests of others.
An individual may defend their liberty by claiming a right. For example, patients/clients may refuse to accept analgesia for pain on the grounds that they have the right to suffer if they choose; or patients may discharge themselves from hospital, provided the consequences for discharge does not involve anyone else.

However, the defence of liberty is not as simple as it appears. Firstly, the proximity to one another in society does in some way encroach on or affect the interests of others, and secondly, freedom is dependent on what is considered to be self-regarding or other regarding acts. As a case in point, if individuals discharge themselves from hospital even with a minor infection, that infection may be passed on to others, and eventually the individuals may get worse from lack of care and require further medical treatment, in addition to those who have contracted the infection, thus putting a further strain on medical resources. The individuals may consider this is a self-regarding act as their freedom to discharge themselves has been exercised, though clearly these individuals have a duty to preserve their good health. More recently some doctors are refusing to treat patients who smoke, despite the legal implications of being sued for non-treatment, on the grounds that it is not cost-effective to treat these patients, as the results of smoking are self-induced.
In order for the nurse and the patient/client to make ethical choices it is of paramount importance that both have the latitude so to do. The nurse may be guided by the Code of Professional Conduct (Appendix 1) which gives theoretical guidelines in these matters, and the nurse in turn would facilitate the ethical choice for the patient/client by giving them the information so to do. However, the nurse must be cognisant of the fact that freedom lies in the possibility of making a choice between the right or wrong decision, as clearly if there is no freedom there is no choice, and questions of morality therefore do not arise.

(c) The Principle of Respect for Persons or Patient Autonomy with notions of Paternalism, Trusteeship and Advocacy

The principle of respect for persons and "autonomy" is widely described as the central principle of the caring discipline, so it is assumed that nurses have some regard for this principle, as it is inherent in the aims of their discipline. It embodies personal liberty of action with agreement or consent of the health care team, independence, freedom of choice and decision-making. The role of the nurse has an ethical perspective which requires something intangible, such as human values, respect, or compassion, to be realised, so the nurse has an obligation on behalf of the patients/clients to facilitate the patients'/clients' self-interest by helping the
patients/clients to return to independence, to reduce or alleviate their suffering and promote respect for others.

"Autonomy" is an assumed concept and refers to a state that no one can achieve. However, according to Downie and Telfer (1980: 38) the characteristics embodied in this principle include a capacity for self-determination and a capacity for forming and pursuing ideal values. By self-determination Downie and Telfer (1980: 38) mean "adopting ends and forming policies of action to bring them about". Inherent in this self-determination is the exercise of reason and the possession of emotions.

These features of self-determination and the pursuit of ideals constitute the unique worth of human beings, or their "distinctive endowment" (Mill 1962: 187), and is central to the theme of individuality, as the capacity for choice and commitment is inherent in this notion. However, it is not just the capacity for choice that is important, but the individual's exercise of it.

The dilemma that may arise is that not all individuals may possess the attributes of self-determination and the ability to form and pursue ideals. This may be in cases when patients/clients refuse treatment and where their capacity or ability to make decisions, or their competency or their ability to perform at some stated level of proficiency, is in question. For example, the subnormal, retarded, senile, mentally ill, infants, or unconscious patients may lack these attributes, by
the very nature of their stage or condition of life. However, the same respect and rights ought to be accorded them, though it may be difficult to accede to the wishes of some of the above categories of people, on the grounds that in acceding to those wishes those categories of people may come to some harm.

The concept of "autonomy" will be discussed briefly to distinguish it from the principle of "autonomy", which is essentially the moral requirement to respect other peoples' "autonomy".

(i) The Concept of Autonomy

Autonomy, taken from the Greek words "autos" and "nemein" meaning "self" and "to take hold of" translates into "self-rule", "self-government" or "making one's own laws".

A range of definitions demonstrate similar meanings and some of these are now presented.

For Miller (1981: 21-28) the word means "moral reflection in its widest sense, though this seems to limit the definition to a cognitive component only". This view was further developed by Jameton (1984: 21, 50) and Beauchamp and Childress (1983: 59) who believed that "autonomy" is concerned with discretion, control and self-government, and they view autonomous action as "one which is carried out because of goals or values which are attached to it" and is supported by Harris (1985: 195) who defined autonomy as "self-government whereby individuals are able to control their
own lives, and to some extent their destiny, by the exercise of their own faculties". Gillon (1986: 61) and Hostler (1986: 1) concede that "autonomy" is the capacity to think, decide and act on the basis of such thought and decision freely and independently and without let or hindrance.

Clearly then these definitions appear to imply a notion of rationality or that reasoning has occurred, by the very nature of the terminology used in the definitions.

There are four notions inherent in the concept of "autonomy". Firstly, that the individual is rational therefore, they are capable of making rational choices and arriving at decisions in their own lives; secondly, that they govern their own lives in accordance with principled reasoning which they accept; thirdly, acknowledging their right to their own views without restraint on their freedom being imposed by others; and fourthly, that "autonomy" is not possible, except for angels in the noumenal world, and the individual is merely seeking "a measure of independence and personal management" (Dearden 1975 : 64).

Thus, an individual who is not "autonomous" is an individual who is non-rational, or not mature, and cannot be viewed as a self-determining moral agent. The author has previously stated (page 21) that nurses do not have "autonomy" in their practice. It does not mean however, that they are not self-determining, rational individuals able to make choices and to arrive at decisions in their personal lives.
Before individuals become patients/clients individuals consider themselves and are considered by the health care team to be "autonomous" people, responsible for their own actions and with a claim to be treated humanly as ends in themselves, not used as means to an end. Those who are not "autonomous", such as the mentally subnormal must be protected. On becoming a patient/client that "autonomy" may be temporarily relinquished because of the very nature of the traditional, bureaucratic institutionalised setting of hospitals, which may lead to loss of dignity. The patient/client needs to be recognised for what he/she hopes to become prior to their hospitalisation, that is a self-determining person, assuming he/she was already such a person. It has already been argued (page 28) that if patients/clients do not have certain attributes, such as not being self-determining individuals, then their needs must still be met and their potential recognised.

The individual needs to recognise the reasons for making the decisions they do, and this is not possible if there is a defect in the individuals reasoning; a defect in the stability of the individuals own desires; a defect in the information available to the individual, upon which choice is based; or, a defect in the individuals' ability to control either their desires or actions or both (Harris 1985: 196), otherwise their "autonomy" is undermined or eroded.

"Perfect autonomy then, decisions taken without any defect at all either of information or reasoning or of control, is, like any ideal, unattainable"

(Harris 1985: 200)
It becomes paramount then that the individual has an advocate or trustee to act in their "best interests". These modes of intervention will be discussed later.

The Principle of Respect for Autonomy

In developing the argument based on the initial assertion or premise that nurses must respect or value the self-determination of patients/clients, it appears that individuals like making their own decisions as it allows them to exercise their faculties as human beings.

Implicit in self-determination is the capacity to reason as self-determination presupposes that the individual is capable of rational deliberation in situations. Mill (1972: 198) argued that the capacity to make decisions, and the right ones, improves not with time but with practice, and that an individual's later decisions only have a chance of being more self-determined than earlier ones if the individual is permitted to make the earlier decisions, and learn from them.

Thus the issue seems to be to achieve the correct balance of "autonomy" for decision-making to occur whilst retaining the ability to function effectively in an interdependent environment (Curtin 1982: 7-14 and Aroskar 1982: 22-32). It would appear that this may be overcome by improving communication skills as advocated by the Royal College of Nursing:
"During episodes of illness the autonomy of patients should be maintained throughout treatment and the active participation of patients in their own treatment should be facilitated by means of open and sensitive communication".

(Royal College of Nursing 1976)

A number of nurse theorists such as Rumbold (1986: 88) have argued that patient "autonomy" is eroded (page 97) when patients are admitted to hospital and the selected review which follows demonstrates this.

Schmieding (1968: 205-212) describes the tyranny of institutionalisation whereby the patient is made to become dependent on others, the "antithesis of the behaviours needed for coping in the outside world, where independence, assertiveness, participation in problem solving and decision-making and a sense of self-esteem are among the requirements for functioning". Alfano (1975: 1090) concurs that "hospitals deprive people of their sense of humaneness [humanness] so that they lose their self image at a time when they most need it - when they are weakened through sickness". Chapman (1976: 114) maintains that it is dependence of the patient which satisfies the nurses psychological needs, that is their need to be depended upon, and if not prevented may increase or prolong patient dependency. In this view it is the nurses who encourage patient dependency to satisfy their own needs and though the nurses' needs are important they cannot outweigh the patients'/clients' needs, and thus:
"The reluctance they show in allowing patients to carry out self-care..... is probably due to the fact that such behaviour deprives the nurse of the satisfaction she gains from patient dependency"

(Chapman 1976: 116)

Faugier (1986: 64) concedes that the door of the hospital ward represents an invisible demarcation line between health and illness, and without feeling any different/difference the individual is expected to assume the "sick person" role on entry to the ward, and become a physically dependent person.

According to Rumbold (1986: 88) patients/clients are denied the opportunity of making basic decisions in and out of hospitals such as when to get up, or go to bed, when it is not particularly necessary or relevant to their treatment or recovery. Chapman (1976: 114) concedes that it is the complaint of many patients in hospital that they are not allowed or given the opportunity to carry out normal physical activities as those mentioned above which are "well within their abilities, and that by both conversation and care they are reduced to the level of children", meaning treated like children. Titmus (1970: 212) called this dependent activity by patients on nurses "creative altruism". By that Titmus (1970) means that if the opportunity is afforded the patient by the nurse then the self is realised with the help of others, which is partly what nurses are supposedly trying to achieve. It is the method of achieving it that is in question. This again does however
demonstrate the forced dependence of patients on nurses in order to meet the nurses' psychological needs (page 99).

To deny patients/clients the basic opportunities for personal decision-making serves to increase their dependence and decrease "autonomy", so undermining personal dignity. This dignity is further undermined if the patient/client is in a paternalistic (page 27) setting, such as a hospital, but it would of course depend on at what stage the decision-making occurs. This dilemma may be approached by increasing the time frame and allowing the patient/client more time for personal decision-making.

(ii) **Paternalism, Trusteeship and Advocacy**

The concepts of paternalism, trusteeship and advocacy will now be discussed to see if these concepts play a part in the way nurses apply ethical principles, or the way in which ethical decisions are justified.

**Paternalism**

Curtin (1980: 4-5) contended that the experience of illness infringes on three basic human rights, that is, freedom of action, independence, and the ability to choose for oneself. Curtin (1980: 4-5) bases her theory on the notion that disease damages the humanity of the individual. Curtin's (1980 : 4-5) argument is controversial on the grounds that illness does not infringe on the basic human rights, it simply makes it difficult to exercise them. Furthermore, she believed that patient "autonomy" is affected by illness (page 97) and this is
increased by being placed in a paternalistic setting, such as a hospital. Paternalistic is taken to mean "acting upon one's idea of what is "best" for another person without consulting that other person" (Marchewka 1983: 1072). Such an interpretation of paternalism suggests that an individual could be expressing their moral beliefs under the guise of acting in another's interest. It also implicitly assumes that patients/clients are immature and irrational and unable to make decisions because they are ill, and that the care-givers are rational, mature and know what is "best" for the patients/clients. In acting in the patients'/clients' "best interests" does the representative for the patient/client act as the patient/client would have acted, should have acted, in the interests of the patient/client, or in the pursuit of their welfare. How is the nurse or doctor to know especially in cases of mental illness.

It would be reasonable to assume that individuals are responsible for their action, and accept them as rational creatures who ought to act in accordance with certain ethical rules such as telling the truth. If there is doubt as to the patient's/client's ability to understand, and it is known previously that the patient/client with complete understanding would now object to what was being done, then there seems no grounds for paternalistic action.
Benoliel (1983: 212) believes that rights are not absolute, that is, they may be overridden by other rights, and thus a paternalistic health care system may intercede in the patients'/clients' "best interests" thus deprecating the patients'/clients' rights. Benoliel (1983) does not state who is to decide what those "best interests" are, and whom do those "best interests" serve, the patient/client or the health care system.

Gadow's (1980: 1-2,6) philosophy of nursing called "self-care" incorporates self-determination as a central concept. "Self-care" has as its primary ideal active assistance to individuals, families, and communities in the development and exercise of their decision-making skills in health matters, resulting in action in the "best interest" of the patient/client with the patient/client deciding what those "best interests" are. This concept is not new, as it may be argued that if patients/clients are self-determining then they will give consideration as to how to determine their own actions. Although the health care institution is obliged to act in the "best interest" of the patient/client, it is the patient/client, or an appointed advocate, or trustee, such as a lawyer, who decides what those "best interests" are. It is only when individuals are treated as self-determining, rational beings with due regard for their fundamental rights and any special rights (page 76) to which they are entitled that they can be aided in clarifying values and beliefs in order:
"To develop their understanding of self and of the situation, and to make decisions based on their own goals and wishes"

(Benoliel 1983: 213 quoting Gadow 1980)

However, sometimes, patients/clients can be helped in this but only if they choose so to do, as some patients/clients welcome and expect a paternalistic attitude from their care-givers.

It is critically important for nurses to exhibit behaviour which infers they understand the importance of patient/client rights and the role that paternalism and truth telling play. Healey (1983: 114) believes that the claims by patients/clients that they have rights and deserve to be treated as active participants in their care "would appear to be quite removed from nursing's re-examination of its professional identity". The concept of patient/client rights is derived from the experience of illness and disease. Cassell (1978: 24-46) described the destructive impact of illness and disease in terms of four losses experienced by the patient/client: the loss of a sense of connectedness to the world through our senses, attitudes and interests; loss of a sense of indestructibility, omnipotence or body image; loss of a sense of omniscience or failure in understanding and reasoning; and, loss of a general sense of independence and control. Cassell (1978: 41-42) views illness and disease as not being healthy with an associated disturbance of organ function, and so the losses
experienced would depend to a great extent on the nature or degree of the illness and disease. It follows then, that the traditional expectation of paternalistic behaviour ensues with the provider that is, the health care team, in a superior role to the recipient of care, that is, the patient/client, thus encouraging dependence.

It may be argued that patients/clients must assert their rights, as health is a shared responsibility (pages 27,66) of the patient/client and of the provider of health care. This is a desirable shift as nursing is beginning to engage in a re-examination of its identity in becoming a "profession" and moving from the traditional dominant model to one of active partnership, as can be seen by the widespread use of the Nursing Process.

Melia (1987: 46) believes that the infringement on patients/clients liberty is in part due to lack of time for decision-making, resulting in decisions "taken in the patient's best interest in accordance with the nurses duty to care". Tschudin (1986: 67) like Marchewka (1983: 1072) contends that paternalism (pages 27,102) is often not justified and this behaviour is common in nursing. Illness makes the patient/client dependent and vulnerable, which in turn lends credence to the assumption that health care professionals are the final arbiters of a patient’s/client’s welfare. Marchewka (1983) asserts that when a decision is made on behalf of the patient/client then that decision is taken in the belief that
the patient/client requires protection from some harm, and thus this act is justified.

Gert and Culver (1976: 45-57) presented five criteria to enable an evaluation of whether a particular action is said to be paternalistic. A nurse is said to be acting paternalistically if, and only if, the nurse’s behaviour indicates that the nurse believes the following. Firstly, that the action to be taken is for the patient’s/client’s good. Secondly, that the nurse believes they are qualified to act on the patient’s/client’s behalf. Thirdly, that the action to be taken violates an ethical rule or principle, such as lying, breaking a promise, or causing pain. Fourthly, the belief that the action taken on the patient’s/client’s behalf is justifiable, whether or not the patient/client consents. Finally, that the nurse believes that the patient/client understands what is good for them.

A pure utilitarian model would justify most paternalistic acts on the grounds that an action is right, if, on balance it produces more positive than negative outcomes (Beauchamp and Childress 1983: 21), that is, it produces more good than any alternative would. The deontological view rarely justifies paternalism, as deontology is based on a theory of moral obligation in which actions are inherently right or wrong, that is, the rightness or wrongness of the act is determined by whether they are in accordance with the moral rules and
independent of the consequences (Gorovitz 1976: 14). Gert and Culver (1979: 199-200) claim that in justifying paternalistic action involves two steps: firstly, examining the nature of the act, and secondly, evaluating its consequences. In this way, Gert and Culver (1979) draw on principles from both non-consequentialist and consequentialist theories. In assessing the nature of the act the nurse is required to identify the ethical rules and principles being violated and define how the violation may affect the rational desires of the patient/client. In evaluating the consequences the nurse is required to determine whether one would publicly advocate the violation or its universal application under similar circumstances.

Murphy and Hunter (1983: 43) assert that paternalistic acts and attitudes are "those which limit the liberty or rights of individuals in their own interests". This notion implies that in a patient/client's interest the nurse may limit their liberty or rights. Implicit in Murphy and Hunter's (1983: 43) interpretation is the element of coercion, as a patient/client who voluntarily submits to a restriction is in fact exercising their liberty in that choice, so paternalism is more explicitly the "use of coercion to provide a good that is not desired by the one whom it is intended to benefit". Arguably, the underlying assumption appears to be that these individuals do not have the ability to make the decision themselves.
Clearly then, there are two principle elements in paternalism: firstly, the intent, that is obtaining what is in the best interest of the patient/client; and, secondly, the effect, violating the individual's known wishes in the matter, though this may not necessarily occur.

However, paternalism can also be viewed from an ethical egoism stance. This notion is grounded in the belief that patients/clients ought to act in such a way as to promote their own good, and if they are unable to do so, say, due to illness, then the decision should be made by someone capable of knowing what actions are in the patient's/client's interest, until such time as the patient/client can resume their own moral duties. As paternalistic acts are not always altruistic, it could be advanced that under the ethical egoism notion the health care worker would act in the patient's/client's own interests.

It may be argued that this view of paternalism is simplistic as it equates the meaning with that of advocacy, that is acting on behalf of another, so that any paternalistic nurse can also claim to be a patient/client advocate under that guise. However, paternalism may seek to violate the rights of patients/clients and advocacy would seek to act in the patient's/client's "best interests", though Harris (1985: 200) believes that:

"The only thing that makes paternalism morally respectable is its claim to be an essential part of what is to respect persons".

(Harris 1985: 200)
According to Gillon (1986: 63) it is an expressed view of some philosophers such as Mill (1974) that although respect for "autonomy" may be essential, it is often important to do the best for people and reduce the harm they suffer. This may mean overriding their wishes which means treating them as "means to an end", that is a means to their own recovery. For example, this situation may be applicable to patients/clients who refuse to have a blood transfusion 'on religious grounds', but in the health care team over-riding their wishes and treating them may mean the saving of their lives. There are two contentions in this situation. Firstly, how can one individual know what is best for another individual, and secondly, how will the individual prescribing or effecting treatment measure that the harm suffered is reduced.

The notion may be advanced, however, that though the overriding tenet, is to act in the "best interests" of the patient/client, it does not mean to do so by means of paternalism, and to do so is suspect, and according to Kübler-Ross (1970: 32, 149-150) could cause distress for some patients/clients and their family.

Buchanan (1978: 380) contends that to make paternalistic decisions involves making "intra-personal comparisons of harm and benefit of each member of the family if divulging the truth"; then estimate the total net harm to the family, and compare these intra-personal and inter-personal net harm judgments about the results of not divulging the truth,
compare the totals and determine the course of action. The question arises as to how to measure the criteria of harm and benefit, so measurement is a philosophical problem in itself. Buchanan (1978: 383) concludes that following this analysis it is "implausible" to hold that the doctor is in a better position to make them [judgements] than the patient/client or family.

Non-consequentialists, such as Kant (1781), would argue that there are many circumstances in which individuals "autonomy must be respected even to do so will result in an obviously worse decision in terms of the patient, family or society's happiness" (Gillon 1985b: 1972). This conclusion is also supported by many utilitarians (consequentialists) on the grounds that respect for "autonomy" is required if human welfare is to be maximised.

The case reported by Bayliss (1982: 1824-1825) of the Christian Scientist Dallas woman who came to England too late to seek orthodox treatment for thyroid disease, describes a case for paternalism in medicine. She had previously undergone treatment by orthodox measures, rejected treatment, in preference for cult medicine. This failing, she had returned to orthodox measures again. Those for whom respect for "autonomy" is paramount would not deny her the respect of allowing her to choose what she wished even though paternalistic intervention could have saved her life.
Rights are automatically linked with duties (Tschudin 1986: 62) and often one person's rights are another person's duties. To illustrate this point, professional contracts give an employee certain legal rights such as the right to receive a salary, holiday or vacation and sick leave, and in return the individual is obliged or has a duty to carry out the tasks for which they are employed. One of these basic primary duties of nurses is beneficence, or a duty to care, which will be discussed later. The difficulty arises when an individual's rights conflict with the organisations/institutions rights, or when individual and collective duties conflict, and the need for an advocate, or the like, may be required to see that fair play is carried out.

This could be helped by some rules, such as a Bill of Rights, and Britain may be hindered by the absence of a Bill of Rights though this is currently being considered. As a result of the low morale and poor self-esteem, arising from the denial or contravening of what the students consider to be their fundamental rights, the Royal College of Nursing (RCN) Association of Nursing Students (RCN 1988:10) has drafted a ten-point Bill of Rights (Appendix 4) and had expected the initiative to be accepted by the RCN. The Association of Nursing Students (ANS) is a particularly vulnerable group by virtue of its employee status with the National Health Service (NHS), and the fear of further "exploitation and injustices to student nurses" (Seymour 1987: 19), has caused the formation
of this action. Clearly the underlying Bill of Rights (Appendix 4) giving the student "the right to question and the right to be valued" (Mills 1987: 19), is an essential part of patient safety and advocacy and the hope was that the Bill would be adopted in Schools of Nursing and as part of all Health Authority policies in England. Health Authorities who have already adopted the Bill of Rights, such as Sunderland Health Authority, view a Bill of Rights as part of their present philosophy. Arguably the student may not be demanding or claiming rights, but rather believe that justice be exercised.

Earlier, the American Hospital Association (AHA) published their Patients Bill of Rights in 1973 (Appendix 5). According to Davis and Aroskar (1983: 15) and Gaylin (1973: 22) the document was "well intentioned", though "timid", as they believe that most of these rights (Appendix 5) are already fundamental human rights, that is, these rights have already been vested in the patient/client, and so propose that the AHA Bill (1973) be renamed the "Hospitals Bill of Duties". It might be assumed that the Bill (Appendix 5) is necessary as it would cover the rights of children and mentally ill or retarded patients. The Bill (1973) implies that the patient has the final word in their own care "to the extent permitted by law" (Bill of Rights 1973, Item 4) and "thus paternalism in health care is not only unhelpful but positively unethical" (Tschudin 1986: 67). This is an exceptional notion as paternalistic acts in the short term can sometimes be justified
and completely ethical, as in the case of a trustee, or an advocate appointed by a patient.

**Trusteeship**

The notion of trusteeship implies that an individual may act on behalf of another. In this notion the nurse is in the position of trustee, who receives a tacit trust or explicit remit, such as ensuring that the patient/client receives competent care. The patient/client is viewed in the position of trustor, having entrusted to the nurse the special remit of caring competently. So this is a reciprocal relationship, and if the implied or explicit trust is demeaned, then the relationship breaks down.

The patient/client is in a special position of being both trustor and beneficiary, and is able to keep a special check on the trustee or nurse to ensure the trust is being carried out. This relationship is not considered paternalistic, as the patient/client would be capable of rejecting the nurse.

If the patient/client became too ill to continue to assess the nurse's competence or to maintain the trust, then a more paternalistic situation would then arise. Nevertheless the nurse would still be ethically, or even legally, bound by the trust.

Thus, it appears that trust depends on the agreement between trustor and trustee when the reciprocal relationship commences as in the assessment phase of the patient's admission to hospital. This agreement would constitute goals, such as
returning the patient to their maximal health status, and if this were not possible could include a euthanasian clause.

In order to contrast the notion of trusteeship and advocacy, a selection of definitions of advocacy is presented to demonstrate the overlap in ideas and varying interpretations which occur.

Advocacy and the nurse practitioner

Advocacy, according to Murphy and Hunter (1983: 55) is "the participation with the patient in determining the personal meaning which the experience of illness, suffering, or dying is to have for that individual". Curtin (1980: 3) bases a philosophy of nursing on human advocacy and asserts that advocacy is first and foremost a person who can and does enter into a relationship with another person. It is based, thus, on our common humanity, needs and rights. By this Curtin (1980) means that common humanity implies that all individuals are morally equal and bonded together, including patients/clients and nurses and this results in a recognition of the common needs such as protection and a need to express oneself in a climate of justice and truth. Kohnke (1982: 314-318) views advocacy as a way to "inform the client in whatever decision he makes". This definition of Kohnke (1982) seems a simplistic one, on the grounds that this pure or idealistic form of advocacy, given the professional - patient/client relationship, is more likely to provide a benevolent paternalism.
Brower (1982: 141-143) further states an advocate to be "one that defends, pleads the cause of, or promotes rights of or changes in systems on behalf of an individual or group. Advocacy involves activities that are aimed at the redistribution of power and resources to the individual or group that has a demonstrated need". This sentiment is further echoed by Clark (1982: 6) who states that patient advocacy means "informing the patient of his rights in a particular situation, making sure that he has all the necessary information to make an informed decision, supporting him in the decision he makes, and protecting and safeguarding his interests".

For Brown (1985: 26-27) advocacy is "a means of transferring power back to the patient to enable him to control his own affairs", which is not doing something on behalf of the patient but developing and fostering a reciprocal relationship. The reason why nurses advocate on the patient's behalf is fourfold according to Brown (1985) and these correspond to the five principles of ethics viz. the value of life, goodness or rightness, justice or fairness, truth telling or honesty, and freedom. The definitions of advocacy seem to convey certain common notions such as informing, promotion of rights, ensuring the patient/client has information to make decisions, and participation.

However, Abrams (1978: 258-267) had earlier disapproved of nurses undertaking the role of advocate on the grounds that because of the historical role of the nurse which is rooted in
hierarchical bureaucracy and dominated by medicine women are socialised into stereotypes. This stereotype defines women as "emotional" beings and relegates them to the caring aspects unable to competently advocate. This leaves the curing aspects to the "assertive" men who assume the role of doctors (Trandel-Korenchuk et al 1983a/b: 53-59; 37-42), and therefore able to be patient/client advocates.

It would seem therefore that the concept of advocacy represents the identification of a need and an attempt to address the need identified. Advocacy involves the intervention of the nurse, or others such as the family, in situations where the patient/client is vulnerable whether that vulnerability is potential, circumstantial, temporary, episodic, permanent, or inevitable.

Conway - Rutowski (1982: 455-456) states that the nurse must be a "covert and overt advocate for the patient/client and family since their [patient's/client's] lack of knowledge and understanding often places them in a vulnerable position" Those individuals who are vulnerable to advocacy can be viewed on a continuum from the potentially vulnerable to the inevitably vulnerable (Figure 3a on page 119) and these will now be discussed under sub-headings.

a) Potential vulnerability

This area embraces individuals at high risk, such as patients/clients who are genetically predisposed to disease; mentally, physically, or socially deprived individuals such as
the homeless/neglected; and the self-induced high risk individual such as the substance/solvent abuser.

b) Circumstantial vulnerability

These include circumstances involving previously relatively well or coping individuals who by circumstances such as in war, famine, poverty or trauma, that is, physical or emotional upheaval, become vulnerable. These circumstances may serve to threaten an individual's health or welfare and will "hold them captive to circumstances they find hard to understand" (Copp 1986: 257). Often, an attempt to find a solution to one problem will endanger them in other situations. For example, in an attempt to aid illegal immigrants and gain social service benefits for them may well place them in jeopardy of being deported to a place, possibly more traumatic, even politically, than the circumstances in which they are now placed. Some effort could be put toward gaining legal status for them, and considering their mitigating circumstances, could mean that they were not deported. However, this case represents the essence of the ethical dilemma for which there is no easy prescription as there are so many overriding ethical and legal considerations.

c) Temporary vulnerability

Individuals in this category have experiences of a transitory nature, such as depression, disruption in family life such as divorce or physical abuse. This disruptive act has a short time span, but the exposure to the experience has a long
term effect manifesting in psychological problems such as "flash-backs" to the causative agent.

d) **Episodic vulnerability**

This occurs with individuals who have recurrent illnesses and who can predict and are aware of the onset but are unable to control or prevent it.

e) **Permanent vulnerability**

These individuals live with chronic diseases or defects, such as birth/genetic defects, hemiplegias, muscular debilitating diseases, and are permanently vulnerable. In addition to this they may become potentially, circumstantially, temporarily and episodically vulnerable, and so are more susceptible than the average individual. This is further compounded by the inevitable vulnerability of the aging processes and all its ramifications.

f) **Inevitable vulnerability**

This vulnerable situation is one in which all individuals find inescapable such as old age.
Figure 3a: Continuum of Vulnerability, After L.A. Copp, Journal of Advanced Nursing, 11(3), 257, May 1986
Being vulnerable then requires an advocate, or a trustee to act in the "best interests" of the patient/client and as mentioned earlier there are many types of advocates, such as the patient/client advocacy (page 114) system. Other systems include human, individual, animal, political, legislative, spiritual, and moral-ethical advocacy. In a vulnerable situation, the patients/clients may "empower" the nurse to act as their advocate, and this becomes a logical extension of the nurse's skill. This will enable the patient/client to endure a particular situation or circumstance.

The types of advocacy will now be discussed using sub-headings.

i) Human Advocacy system

This is where an individual is employed specifically for the system or organisation, such as an Ombudsman in the National Health Service in England, essentially to react to queries, to initiate advice, and advise patients/clients of the benefits and services.

ii) Individual Advocacy

This is the seeking of help for an individual patient/client, with the result that the advocacy may have an effect on a wider patient/client group than the individual concerned.

iii) Animal Advocacy

This is the concern for humane treatment of animals demonstrated by a decrease in the use of animals for
experimentation and the use of simulation and computer models.

iv) **Political Advocacy**

This involves those decisions which have implications for policy makers and health policy.

v) **Legislative Advocacy**

This involves maintaining excellence in skills and being accountable for ensuring that the patients'/clients' rights are being upheld, and actively ensuring they gain the benefits and services to which the patients/clients and their families are entitled, and who may be uninformed about those rights. It infers an adversary relationship as it may require defending the patients'/clients' legal rights against an institution, doctors, or the family.

vi) **Spiritual Advocacy**

This is respecting the patient's/client's choice in seeking spiritual help, and facilitating access, time, space and privacy to undertake this help; or, conversely, respecting the patient's/client's choice in not seeking spiritual help.

vii) **Moral - ethical Advocacy**

This is a consideration for the ethics involved when faced with complex options and decision-making, such as the appropriateness and intrusiveness of research.

viii) **Patient Advocacy**

Advocacy raises certain considerations for the nurse in the assessment of a situation, such as what type of advocacy is required, when to advocate, how to advocate, the consequences or
implications for nurse and patient/client, and what are the implications if the patient/client does not require an advocate: does this legislate for failure?

The author supports Curtin's (1983: 9-10) view that the nurse cannot perform all these advocacy roles, on the grounds that some of these roles, such as spiritual and legal advocacy, are not within the nurses' remit, and to date there is little evidence to suggest that the education of nurses incorporates this special training.

It may be reasonable to suggest that the advocate takes a great deal of risk in advocating for the patient/client and this necessitates a full knowledge of the patient/client, their background and family, and the consequences of the positive or negative outcomes of advocating on behalf of this patient/client.

The implementation of the Nursing Process (page 37) will go some way towards ensuring that in the assessment phase the patient/client has a choice of who is to act as advocate, if required, and this role is undertaken within the constraints and legalities of the institution/organisation. Until the nurse practitioner is truly an independent "autonomous" agent, which may be achieved with professional status, then acting as an advocate is not an independent role. Pankratz et al (1974: 211-216) has shown in a nursing attitude scale that nurses who had undergone advanced educational courses were more likely than others to support advocacy as a nurse's role. The survey of
seven hundred and two (702) nurses' attitudes towards professional "autonomy", advocacy, patients' rights, and the rejection of traditional role limitations were measured against education, leadership, academic setting, and non-traditional social climate.

The bureaucratic nature of health care systems appears to inhibit any assertive stance by the nurse, and thus it is difficult for the nurse to defend patients/clients. **Assertive** is taken to mean "making one's needs known in a self-confident way and standing firm in support of one's own or others' rights" (Webb 1987: 41). This lack of assertive behaviour by the nurse would seem to be due to the hierarchical nature of health care systems because given the correct training nurses may adopt this stance, which is a requirement if advocacy is to be part of the nurses' role.

If the discipline of nursing is to have a philosophical foundation, that is, to be considered as having an ethical perspective (page 57), then it must be based on a philosophical concept. This is a concept which determines the relationships that are to exist between nurse and patient/client, and the common rights that are to be respected in this relationship so that strategies and processes that influence decision-making are articulated clearly for the patient/client.

It is proposed that the philosophical foundation can be grounded in the concept of advocacy, whose basic premise embraces common humanity, needs and rights, that is human
advocacy. If nurses are to respect the patient/client as an individual, then these needs must be given primacy, if the role of trusteeship and advocacy are the foundation of the nurse-patient relationship.

Patient/client advocacy, however, requires special skills and appears to remain the remit of the most junior nurse, as senior nurses appear not to have the time to pursue patient/client contact. Those nurses who do undertake advocacy roles do so in a climate of extreme pressure by the daily increasing workload, some wary of the advocacy role, as it is rarely included in the training. In addition to including advocacy in the curriculum it would also mean restructuring the patients' day, not only to allow for the effective use of the chosen ethical model for nursing practice, but to incorporate the required advocacy role, if so necessary. Also, it may require a policy decision so that the role is undertaken by senior nurses who have undertaken some training and feel confident in the advocacy role.

Unlike the lawyer advocate, who pleads the clients case, the nurse advocate allows the patient/client to make the final decision, and the nurse then abides by that decision and defends their right to make that decision (Melia 1987: 48), which is in keeping with Clark's (1982: 6) notion of advocacy (page 115).
Thus the arguments to support the advocacy role of the nurse is concerned with rights and obligations (page 74). To realise an individual's rights another individual has a moral obligation to ensure this right is recognised and put into effect, but who is to ensure this, and who is to have the moral uncertainty of the decision made in the "best interests" of the patient/client. As a case in point, a patient/client has a legal right to treatment and a legal right to refuse treatment, and any failure to comply with these legal rights violates the patients'/clients' rights. There are occasions when the patients'/clients' refusal of treatment does become an ethical dilemma especially in the mentally ill where competence, that is, rationality and capability, is in question. And, is it right to treat someone despite their refusal? Legally, the law views an individual as competent or incompetent. However, it does appear that competence may be viewed as a graded or continuous concept (Eastman and Hope 1988:51), that is, on a continuum from fully competent to fully incompetent.

The author does not advocate for a particular ethical position, but rather proposes that it may be possible to compromise or to give consideration on balance to the patient/client who refuses treatment, and the consequences of treating or not treating, by using the relative benefits as the criteria for decision-making. For example, if the relative benefits of treatment are not great then treatment would not be enforced; and, if the relative benefits of treatment are great,
then the treatment might be enforced, which would in essence be
paternalistic behaviour. Thus two ethical elements, the degree
of competence and the consequences are in juxtaposition.

However, nurses have an obligation to provide
treatment especially if disease interferes with the
decision-making ability of the patient/client. But who is the
patient/client advocate in situations where the patient/client
makes an informed decision to refuse treatment, but the family
intervene and subject the patient/client to treatment. Is it
the nurse who refuses to aid in the administration of the
treatment in support of the patient’s/client’s rights, or the
nurse who advises treatment despite the patient’s/client’s
wishes? The latter could be said to be acting
paternalistically, but if it materialises that the
patient/client made the wrong decision and was later grateful
for the treatment, would the nurse respecting the
patient’s/client’s wishes be said to be acting in the "best
interests" of the patient/client, and so justified.

Clearly then, the concept of advocacy is reduced to two
main functions: firstly, fully informing the patient/client, and
secondly, fully supporting the decision taken by them, which
echoes Clark’s (1982: 6) belief (page 115), but with some
exceptions and who is to decide what these exceptions are? The
patient/client is entitled to quality of care, access to care,
to be fully informed about the care to be received which
involves information about reasons, effects and side-effects and
full understanding of them, and finally understand the alternatives to the care proposed. These all relate respectively to the principles of ethics.

Curtin (1980: 7) believes that "so often by trying to do what we think is right by our value system, we trespass upon the authenticity of the person. The individual rather than the professional should make such value decisions". Authentic is taken in this context to mean "a way of reaching decisions which are truly one's own decisions that express all that one believes important about oneself and the world, and the entire complexity of one's values" (Murphy and Hunter 1983: 45). Clearly nurses can only be advocates when the patients' rights and values are defended, and to do this one requires self-awareness and a good knowledge of the facts, which may be verbal or non-verbal.

"One important reason, perhaps, for our failure to realise how much knowing there is in caring is our habit sometimes of restricting knowledge arbitrarily to what can be verbalised"

(Tschudin 1986: 17-18 quoting Mayeroff 1972)
d) The Principle of Truth Telling/ Honesty or Veracity, the patients right to know the truth and notions of informed consent and confidentiality

As ethics is involved in caring and commitment (pages 63-74), and caring and commitment in relationships, then it becomes vital that between individuals honesty in communication is fundamental, as trust and respect is more likely to thrive in an ethical arena, as opposed to a legal one.

The right to know the truth, that is, the access to accurate information (Oxford English Dictionary 1969: 610) involves firstly the right to know the truth about the particular situation in which the patient/client is involved, the future life style, and the diagnosis or prognosis. Secondly, it involves the right to know the truth about the possible risks or dangers and benefits of proposed treatments/procedures, alternative treatments, and the option of no treatment at all, or those problems concerned with blind drug trials. These two areas are primarily concerned with a choice between withholding the truth, deliberate considered deception, and non-deception. In the first category the main issue is to avoid suffering and distress; the second category is one of refusing information so a proper choice cannot be made; and the third category is one of information giving so an informed choice may be made. It is in these areas that ethical dilemmas arise.
Clearly withholding knowledge from patients/clients can lead to the avoidance of suffering and distress for them were they to know the truth. Arguably, this withholding of the truth, or possible overt deception, could actually increase the distress, as they may 'sense' the truth, or pick up the strain from relatives aware of the truth.

Davidson (1957: 109-119) argues that real harm rarely resulted from honesty in response to patients/clients who wanted reliable information about their condition, on the grounds that patients/clients may have vital duties which may be required to be carried out, and this can only be done if they have access to that information. In the long run, withholding the information is a "frequent cause of the greatest distress".

The withholding of truth, or deliberate deception also reduces the patients/clients' chances of settling their affairs, such as making a will, and making informed decisions about their family and home that they would wish to do. It also bears the notion of paternalism, and erosion of the patient's/client's rights. Thus it appears that to withhold the truth from patients/clients is far outweighed by their right to know the truth on the grounds suggested above, but it does not condone overt deception. For example, if a doctor prescribes a placebo for a patient's headache and the nurse administers it, the nurse may be viewed as withholding the truth from the patient, but cannot be accused of lying to the patient.
However, it is important for nurses when weighing the evidence to consider the countervailing considerations in favour of telling the truth, and these include the patient’s/client’s desire to know the truth, which would be discussed in the assessment phase of their care, and based on their defence of their liberty (page 90). Conversely, their desire not to know the truth must be equally respected, on the same grounds.

The second consideration, according to Downie and Telfer (1980: 62) is that doctors have a good history of "optimistic pronouncements", which has led to a lack of confidence, as these well-meant deceptions are often unsuccessful.

The third consideration is the patient’s/client’s right to know the truth, which is different from their wish or desire to know the truth.

In the situation of blind drug trials the issue of deception is paramount to the success of the trial, as the results depend on patients/clients not knowing whether they are receiving the real drug or a placebo. Campbell (1984: 57, 61-62) has outlined the ethics of drug or clinical trials/research when the procedures being tested are not related to the patient’s/client’s illness, and often exposes them to unnecessary treatments. Clear guidelines have been offered by the Declaration of Helsinki (1964) which laid down principles for therapeutic and non-therapeutic research (Appendix 6).
There are special circumstances in research experimentation which may affect human rights. These include those individuals who are mentally ill; those situations in which individuals feel that their refusal will create undesirable consequences, such as in prisoners, members of socio-economic groups in deprived situations, or in families where one member is already undergoing research experimentation; or, in situations where full disclosure would affect the research.

The patient/client has the "right to know the truth which is not absolute, that is, it may be overridden if sufficient benefit can be gained thereby" (Downie and Telfer 1980: 65). The patients/clients must therefore be given such information as the proposed trial of a drug, consent or agreement to participate in the trial, and the personal benefits to be gained by this participation. They must also be told that the knowledge of whether the drug on trial or a placebo is being administered will be withheld, and the reasons for so doing. Furthermore, patients/clients in drug trials ought to have a hope of something, and nothing to risk (Mathe and Dion 1985: 291).

The claim that it is the patients'/clients' right to know has been justified on the grounds suggested. However, there is no obligation on behalf of the nurse to tell the truth, but there is an obligation not to lie. One of the bases of authority is knowledge (Ladd 1980: 160-175) but knowledge does
not give an individual the authority to decide the actions or behaviour of others. According to Webb (1987: 40) "nobody - doctor, senior colleague or administrator - has the authority to instruct another person to lie about a patient’s diagnosis or prognosis. We must all make our own moral decisions". This requires informing the patient/client before a decision is made thus it is important to examine the notion of informed consent.

Informed Consent and representation

Barker (1979: 23-28) defines informed consent as "the right of every human being to determine what shall be done to his/her body". It is vital that the patient/client and/or their representative are cognisant of all the benefits and risks.

The issue of the role of the nurse in informed consent is an emotive one. In England, informing patients/clients of their diagnosis is not a legal right, and it is the treatment and procedures that are consented to that constitute a requirement in law. This consent is designed to protect hospital staff, primarily doctors, and not the patient/client, though arguably that may be implicit. Often the information is denied the patient/client on the grounds that the patient/client does not wish to know, or has not got the ability to understand. The classification of central moral issues, such as the linking of informed consent to autonomy as has been suggested by Moros et al (1987: 239), is a way of thinking theoretically or abstractly about moral issues. It facilitates
the reviewing and revising of actual ethical decision-making, so that all expressed moral beliefs viewed as statements of ethical principles and claims underpin justifiable actions, thus ethical principles can be congruous with ethical action.

Recently the UKCC has supported all nurses in informed consent and this is evident in Clauses 1, 2 and 5 of their document (Appendix 1). A recent television debate (Kilroy-Silk 1988) added another reason for not giving information to the patient/client. This reason is grounded in the belief that the doctor may be unable to pronounce subjective feelings about the patient/client if the details of the diagnosis and treatment are disclosed. It may be said that not divulging information may serve to reinforce negative attitudes about the illness, but this has been refuted by some medical ethicists, such as Gillon (1985d: 1556) on the grounds that patients'/clients' welfare appear to be improved by honesty.

However, several surveys about the wishes of patients/clients, such as McIntosh (1976: 300-305) show clearly that some patients/clients do not want to know their medical situation and may wish to be treated paternalistically, but doing what the patient/client wants is not, by definition, the same as paternalism. A second line of justification of paternalism is that patients/clients are not always capable of making medical, that is, technically correct, decisions either because they are ignorant of the medical facts, or too partial to the knowledge they have. Thus, the "wrong" decision may well be made based on these facts.
Gillon (1985d: 1556) favours not telling the truth and bases his argument on Bok's (1978: 41-42, 78-79, 167, 223) interpretation of lying. Firstly, Gillon (1985d) argues that the Hippocratic Oath (Appendix 7) and its obligation to benefit and not harm patients/clients overrides the requirement of not deceiving. For example, to tell the truth in the case of a seriously ill patient might add to the distress of the patient, and all the consequences of that distress such as the low patient morale which results, does justify deception. But who is to decide, what is the patient/client to be told, and by whom? Yet cannot it be argued that the Hippocratic Oath (Appendix 7) is not sacrosanct, as it makes no mention of truthfulness to patients/clients about their condition, prognosis, or treatment, and leaves the informing of patients/clients to the doctor. And, the Hippocratic Oath does not apply to nurses.

Clearly the principle of beneficence (page 111) and non-maleficence or preventing harm, and to be outlined later, overrides any requirement of not deceiving individuals, as deceiving an individual equates to not being aware of their need for "autonomy", which is the underlying principle of informed consent, unless there is strong reason to believe that in a particular case overall welfare would be maximised by deception. Even though the deception may cause harm the respect the nurse has for the patient/client as a person, who ought to have the character to cope, will lead the nurse to tell the
truth. In addition, welfare may be increased by honesty but again, is the doctor the best judge of deciding whether the truth will or will not improve their welfare. All the doctor is able to do is to make a decision on balance of the facts.

Secondly, Gillon (1985d: 1556) argues that doctors can never be sure of the diagnosis or prognosis, so are not really in a position to communicate the truth either to the nurse or patient/client, and even if they were, adds Gillon (1985d), "the patient may not be in position to understand it". Furthermore, technical words are often misunderstood by patients/clients. Henderson (1935: 819-823) summarised the argument ably by stating:

"It is meaningless to speak of telling the truth, the whole truth and nothing but the truth to a patient. It is meaningless because it is impossible"

(Henderson 1935)

The problem here seems to lie in the doctors intention and arrogance. That is, does the doctor intend to discover what the patient/client would wish and is entitled to know; or does the doctor intend to deceive the patient/client. If the patient/client is a mature, rational "autonomous" agent then the doctor ought to know, and thus the intention ought to be clear.

The third argument Gillon (1985d: 1556) offers is that patients/clients do not wish to be told the truth when they have a particularly dangerous or fatal condition. However, there is evidence in several surveys such as Kelly and Friesen (1950:
Aitken-Swan and Easson (1959: 779-783); Cassem and Stewart (1975: 304); Veatch (1976: 229-238); and McIntosh (1976: 300-303), to suggest that usually over eighty percent (80%) of patients/clients would like to be told the truth. McIntosh (1976: 300-303) in interviews with seventy four (74) patients/clients with diagnosed but undisclosed malignant disease, demonstrated that eighty-eight percent (88%) of them knew their diagnosis but had no desire for extra knowledge as they maintained a hope of cure or a hope that theirs was a wrong diagnosis.

Conversely, Oken (1961: 1120-1128) states that American doctors generally withheld the truth about diagnoses of cancer from their patients/clients, but a survey carried out in 1979 by Novack et al (1979: 897 - 900) suggested that up to ninety-seven percent (97%) of responding doctors preferred to tell patients/clients with cancer their diagnosis.

If the desirability of what the patient/client wants is accepted, then the important issue, according to Gillon (1985d: 1557) is not what the doctor or the patient/client thinks, but what the particular patient/client in a particular circumstance wants, so it is not clear how Gillon (1985d) can justify his three arguments (pages 134-136).

In 1983 the British Medical Association (BMA) campaigned for the rights of every patient/client to "have access to all information which is held about them on their behalf". This is seen as a way of encouraging openness and
improving the quality of record keeping, but coupled with the
demand from doctors to withhold access where they see fit.

This broad support for access to records was followed by the DHSS Consultation Document on health data (DHSS 1985) which offered two options: "free access", or, "modified access" to records, though the latter option is yet to be defined. The Royal College of Nursing (RCN) supports the modified access approach.

By June 1986 the BMA had reversed their policy and voted that there should be no statutory right of access to records, on the grounds that it would not "be in the patients best interests", that "people did not want to know", that it would "inhibit record keeping", that "patients would have little understanding of the records", and that it would "irreparably harm the doctor-patient relationship". It has already been argued (page 134) that doctors who believe that full disclosure is not in the patient/client interest may be said to be acting paternalistically and contravening the patient's/client's right in informed consent. However, there are cases where it may be justifiable to withhold access to records, such as in the patient/client who may possibly suffer harm and distress, or mentally ill patients but there is no evidence, to date, to demonstrate just what this harm might be.

The Access to Medical Records Bill (1988) which would give patients/clients the right to see their medical references sent by General Practitioners to insurance companies or
employers, has received an unopposed Second Reading in the House of Lords in May 1988, and goes forward to the committee stage in June 1988. If it becomes law it will enable people to correct inaccuracies about themselves. This Bill (1988) was in addition to the Access to Personal Files Act (1987) which did not include medical records, as the Government claimed it would be too impracticable and costly to make these records accessible by Statutory right. The Government left the sharing of information with patients/clients as a matter of clinical judgement to the doctor. Therein lies the basis of the current problem whereby nurses subsume a deferent role to the doctor. The Access to Personal Files Act (1987) give doctors primary responsibility to decide whether patients/clients may see their records. Nurses may only be consulted if the doctor responsible for the patient/client is not available.

For the nurse the decision to withhold the truth, or deceive deliberately, or tell the truth, would in the final analysis be a decision to tell the truth unless lying proved to be the lesser of two evils, and would be the result of reasoned rigorous debate. The balance then appears to lie between full disclosure which is the patients'/clients' right, and withholding information in certain circumstances where it appears not to be in the patients'/clients' "best interests", as in fiduciary care or responsibility where the individual is unable to make choices/decisions. The difficulty in acting in the patients'/clients' "best interests" has already been highlighted (page 102).
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<table>
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Figure 3b: Disclosure as viewed from a moral perspective, After D.M. Trandel - Korenchuk, Nursing Administration Quarterly, 11(1). 4, Fall 1986
Confidentiality

Establishing the next-of-kin, or significant others, with whom to share information, and to facilitate the principle of informed consent (page 132), provides an ethical dilemma in itself. Many next-of-kin are designated by law to be the next-of-kin. This is further compounded by the changing structure of the nuclear and extended family, the increase in single parent families, either by choice or divorce, and the numbers of the health care team involved in care all make the possibility of a breach of confidence greater. Often patients/clients will name their next-of-kin as the individual they consider to be their closest friend in their social network, and make no distinction between the social, legal, and ethical implications of this choice. Added to this, talking to the next-of-kin before consulting the patient/client is common practice, and is of course in conflict with the principle of confidentiality. This approach raises a major factor in that when the doctor speaks first to the next-of-kin or family, it may be that both patient/client and family recognise that the doctor has a duty or obligation to the next-of-kin or family as well, and clearly clarification is needed to establish that the patient/client is the doctors' and nurses' prime concern. It in no way demeans the consideration due to the family as a whole.

Confidentiality is the right of every patient/client and not a privilege afforded nurses, as implied in the United
Kingdom Central Council (UKCC) Advisory paper on confidentiality
(UKCC 1987: 5, Section 5). These guidelines on the disclosure
of information further implies that nurses are the final
arbiters, as "each nurse, midwife and health visitor is
accountable for his or her practice......." (UKCC 1984 :
Clause 9), and this is an impractical solution to ethical
dilemmas, as increasingly Ethical Committees and care-givers are
being encouraged to share in the ethical decision-making
responsibility at a clinical level and to date the nurse would
need to have permission so to do. This guideline then is a
contradiction as later in the document (UKCC 1987, Section D,
Item 5) it states "practitioners should always take the
opportunity to discuss the matter fully with other
practitioners...... before making a decision".

Nurses must be careful not to confuse issues of
confidentiality with ethical dilemmas even though sometimes both
may overlap in some way. Some of the examples given by the UKCC
(1987) arise from correspondence from nursing staff in what is
to be considered as issues of confidentiality. It does appear
however that in some of these cases confidentiality is not a
problem. As a case in point, the Nursing Sister who finds a gun
on the person of an unconscious patient in an Accident and
Emergency (Casualty) Department, is not breaching any
confidentiality if the gun is put in a place of safety, until a
balanced decision can be made when the full facts about the gun
are known. This example is really an ethical dilemma as to what
the nurse ought to do with the information about the gun, as clearly no breach of confidentiality has yet occurred, and the facts about the gun would be ascertained first.

The main lawful excuses for breaching confidentiality are either legal compulsion or patient consent. However, if the risk to another individual outweighs the risk of disclosure, then the overwhelming evidence suggests that the confidence be breached, and the relevant action taken, provided it has been substantiated. Thus, the Nursing Sister's example, described earlier (page 142), would clearly fall into this category. Other lawful excuses include evidence of child abuse, and breach of confidentiality is permitted if it is in the "best interests" of the child being abused. The UKCC document (1987: 7, Section B, Item 6) gives examples where "public interest exceptions" as in serious crime, child abuse, and drug trafficking outweighs the general commitment to confidentiality.

Clearly patients/clients have a right to know the standards of confidentiality during the assessment phase of their hospitalisation/treatment, or "at first point of contact", (UKCC 1987: 7, Section B, Item 2), and their right to privacy of thought, opinion, records, and physical presence. If they are not aware of these rights then the nurse needs to ensure that they are made aware and thus guidelines for practice are needed. The author suggests a series of questions may be asked to ensure confidentiality and privacy and to facilitate understanding of informed consent, and these questions give some
structure to the interview to aid decision-making. The answers and outcomes to these questions would be noted on the Nursing Care plan to ensure that some record is kept. For example:

1. (a) Are the patients/clients aware of their rights to confidentiality, and all its ramifications?
   (b) Are the nurses aware of their duty to discuss with patients/clients their rights, and the consequences of doing/not doing so?

2. (a) Is the patient/client aware of and understands the reasons why and when confidentiality may be breached? The overriding reasons for breach of confidentiality are for example:
   i) Auto Immune Deficiency Syndrome
   ii) Child abuse
   iii) Serious crime
   iv) Drug trafficking
   (b) Is the nurse aware of and prepared to manage the possible detrimental effects in the nurse/patient/client relationship when a breach of confidentiality could/has occur/occurred?

3. (a) Has the nurse made the appropriate arrangements to give the information in a confidential private manner (place; time spent; who present;)?
   (b) At the appropriate time, is the information received by the patient/client in a confidential private manner (place; time spent; who present/giving information)?

4. (a) Once the confidentiality information is given, is the nurse prepared to manage the situation if the patient/client waives the confidentiality?
   (b) Once the confidential information is received, will the patient/client waive the confidentiality, if necessary so to do?

   Though this may appear time consuming it is considered as part of the patient's/client's rights, and therefore essential to ethical decision-making.
The patient's/client's right to refuse treatment is based on the right to self-determination which is itself based on the respect that is owed an individual as choosing beings. The concept of rights, such as the right to life, to choose, to the truth, is a concept which is in the moral sense impervious to public power.

To say that an individual patient/client has a right clearly subsumes that other individuals have a responsibility not to interfere with that individual obtaining, possessing, or using that right. In this context the author wishes to stress that it is the moral rights (page 76) not the legal rights, of the individual with which these issues are concerned.

Moral rights are grounded in general opinion, good reason, or both (Jameton 1984: 139), and do not necessarily have legal overtones. Clearly there are instances when the patient/client will have a moral right to something, and there should morally be also a legal right to it. Rights are thus contingent on another individual fulfilling the responsibility to meet that right and this reciprocity of action is balanced for example in cases where patients/clients have a right to know the truth about their illness, and the nurse has a responsibility to explain the truth. However, patients/clients also have a duty to tell the truth (or not to lie) to the nurse, just as the nurse has a right to know the truth (or not to be lied to) from patients/clients. Most rights are not considered absolute, that is, they may be overridden by other rights.
(Jameton 1984: 139). As a case in point, if a nurse does not deliver what patients consider to be adequate care, as in the notion of trusteeship (page 113) then patients may refuse this seemingly inadequate care. Thus a patient's refusal of care may override a nurse's right to uphold her professional judgement of adequate care. But, the nurse has a right to refuse to treat or participate in the care of some patients/clients. However, appropriate criteria for a refusal to be justifiable is required and Johnstone (1988: 147-157) has outlined these. For a refusal to be justifiable it requires a respect for individuals as ends in themselves or out of respect for their intrinsic moral worth; upholding the principles of non-maleficence and/or beneficence; the bringing about of equal distribution of harm and benefits; being chosen on the basis of "autonomous" and critically reflective moral thinking; and, the nurse is required to give notice of intention to refuse to care/treat with reasons.

(e) The Principle of Justice or Fairness and notions of Equality/Equity in the allocation of resources

The classical dilemmas, which involve rights and claims, arise in issues of justice or fairness or what is owed an individual by another individual or society, and particularly in the allocation of scarce resources, an "ethical question that intersects all social, political, legal and economic issues facing society and nursing as part of that society" (Aroskar 1979: 35-44). Fromer (1982: 15-21)
challenges the fairest method of determining the receipt of benefits of such scarce resources, such as the use of equipment, costly drugs, and the time of health care professionals. Trying to meet competing needs of patients/clients addresses the notion of the principle of justice. Distributing scarce resources in a fair way involves matching individual needs to the resource. As in all evaluative concepts, there exists the difficulty in obtaining consensus about appropriate criteria by which needs can be ranked relative to one another in a hierarchy. This is further compounded by the varying interpretations of need, and the meanings that recipients place on their plight. Technically, it is possible to identify absolute need - a state in which survival of human organism is not threatened (Jones et al 1983: 26) by itemising the biological requirements as the criteria.

Caplan (1983: 312) noted that when asked by an American hospital to assess an issue of micro-allocation of resources and ethics, found that most philosophers proffered predictable and defensible criteria such as merit, medical need, societal utility or social worth, partiality, arbitrary/lottery or random choice, and maximisation of welfare. Caplan (1983) in investigating the source of the scarcity of the product, discovered that in some cases of efficacious ethical action, his problem solving lay in ameliorating the source of the scarcity, and was not dependent on "analytical rigour or theoretical moral sophistication". According to Caplan (1983) ethical
theory would have been the wrong place to turn for a solution, as:

"Scarce resources do not allow provision of the care which would be in the patients "best interests".

(Melia 1987: 48)

In emergency situations the patient is unable to exercise autonomy for varying reasons (pages 97-99) and the interest of one patient's needs may conflict with another, thus questions of justice and fairness arise.

The concepts of justice and fairness are sometimes used interchangeably, but according to Rawls (1981: 292) they are different concepts, very roughly:

"Justice to a practice in which there is no option whether to engage in it or not, and one must play; fairness to a practice in which there is such an option, and one may decline the invitation"

(Rawls 1981: 292)

Thus justice applies to practices in which there is no choice whether or not to participate, such as with systems of government where the individual has no option but to participate by the nature of the situation they are in. However, fairness applies to practices where individuals are in competition one with another, such as in collective bargaining and games, and by that very nature the individual is allowed a choice as to whether or not to bargain, play, or the like. In this thesis practice is taken to mean "a sort of technical term meaning any form of activity specified by a system of rules
which defines offices and roles, rights and duties, penalties and defences...... and which gives the activity its structure" (Rawls 1981: 293).

For Rawls (1981) though justice and fairness are different concepts they share a fundamental element in common, which he calls the concept of reciprocity. According to Rawls (1981: 308-309) the question of reciprocity arises when two individuals are participating in a joint activity, are sharing in its benefits and its burdens, and need an interest in the outcome of the activity. The principle of reciprocity requires a mutual acceptance of the circumstances and conditions, and the individuals would be seen to conform to this notion if neither individual feels that they are taken advantage of or forced to do things which are not legitimate. So for Rawls (1981):

"It is this requirement of the possibility of mutual acknowledgement of principles by free and equal persons who have not authority over one another which makes the concept of reciprocity fundamental to both justice and fairness".

(Rawls 1981: 309)

Rawls (1981) does not however give consideration to children and mentally subnormal people.

The principle of justice, often referred to as "distributive justice". (Downie and Calman 1987: 55; Frankena 1973: 49) applies to our dealings with individuals or groups and is embodied in the principle of autonomy and
obligation. Distributive justice implies a notion of the comparative treatment of individuals such as "you ought to treat like cases alike", and that any discrimination for or against must be justified.

To illustrate this point two individuals require a renal haemodialysis machine and treatment. The presumption is that both individuals should be treated similarly. However, one will be chosen in preference to the other on justifiable grounds, such as a promise of treatment, or that due to age or prognosis, so one is seen as having more "utility" than the other. Thus, when medical resources are scarce some form of just distribution of these resources must be achieved fairly and efficiently. This principle plainly is concerned with who receives the benefits, and who bears the burden of decision-making in the concept of need, equality of opportunity, equity or desert. In addition, how does the patient/client ensure they are receiving their fair share of the resources.

Ostensibly, there seems to be five main theories of justice which arise for consideration. Firstly, Libertarian theories of justice emphasise that individuals should be accorded maximal respect for their personal liberty. Secondly, Utilitarian theories of justice, such as Hare (1981: 147-168) emphasise that individuals deserve to have their welfare maximised. Thirdly, Marxist theories of justice emphasise that individuals deserve to have their needs met, meaning "to each according to his needs". Fourthly, Rawls'(1976) theory of
Justice is a blend of utilitarian and marxist theories coupled with a respect for autonomy. Rawls' first principle espouses that "people should have the maximal liberty compatible with the same degree of liberty for everyone". Rawls' (1976) second principle asserts that "deliberate inequalities were unjust unless they worked to the advantage of the least well off". Rawls (1976) views the moral personality as the basis of equality which is a mutually contractual agreement. The difficulty with Rawls' (1976) theory is that he assumes that all humans are moral, and he appears to dismiss the varying degrees of morality that exist in humans. Finally, Ross' (1930: 26-27) theory of justice is essentially a matter of reward for individual merit.

The process of nursing clearly involves justice, that is the caring of and caring for patients/clients in a just way. To take care of an individual assumes the notion of verbal and non-verbal communications, and caring for an individual implies a commitment, honesty and empathy. This therefore implies an allocation of benefits in regard to nursing care which is in fact distributive justice. Clearly rights or "justified claims" (Beauchamp and Childress 1983: 50) and duties emerge from the contracts and commitments embodied in nursing, and this involves truth telling.

A number of criteria have been proposed by varying philosophers in deciding what rules of distribution or comparative treatment that individuals are required to act on.
According to Frankena (1973: 49) some of these criteria include meting out justice according to desert or merit; distributing good and evil equally, except in certain cases such as punishment; and treating people according to their needs, abilities or both. Frankena (1962: 19) holds that all men are to be treated as equals on the grounds that they are all humans, with emotions and desires, and who think.

The criterion of desert or merit, advanced by Aristotle (384-322 BC) is based on the notion of proportional equality which implies that justice is distributing the good, such as happiness in accordance with virtue or other criteria. In other words, it means that individuals are given benefits depending on their attributes and which are of particular importance to the community. Aristotle’s (384-322BC) formal principle saw justice as a relative concept in terms of what an individual is owed or entitled and what is deserved. Those who deserved the same were owed the same, so that those who deserved more were owed more, and conversely those who deserved less were owed less. Thus, what individuals are owed is in strict proportion to their deserts, and like cases should be treated alike, echoed by Aristotle (1131) as:

"Equals should be treated equally and unequals unequally in proportion to the relevant inequalities"

(Aristotle 1131: 22-25)
Clearly the distribution of benefits then must be justly determined on the basis of merit or demerit, though there are some instances, such as illness, in which there is no merit.

A generally acceptable substantive position to ensure fair adjudication between competing claims is firstly to distinguish the method for justifying the claims. The preliminary distinctive claims must be presented in an impartial way and justified on ethical grounds. For instance, nursing staff cannot decide that body size is a method for allocation of resources, because this is not a relevant moral characteristic.

What criteria arise for consideration will depend on the efficiency of the ethical argument, however, once they have been established they are rule-bound or bound by laws. In other words these criteria cannot be changed for a long period of time, as it would be clearly unjust if they were changed for each individual. As the criteria chosen are related to the nature of society it is evident that different societies will have differing criteria, that is, they will be culture-bound.

Given the fervent disagreement about which criteria or moral values should take precedent; and given that medical need and medical success are plagued by moral evaluative problems, such as what criteria are appropriate and how is success to be measured, it would be plausible to suggest that the most that any individual can do is to justifiably prioritise, rank or give weighting to the moral value, then justice is done and is seen to be done. The assertion of need however, entails assertion of
implied values, and how are these criteria, such as prolongation of life, or improved quality of life to be ranked. Further to this what definitions are to be accepted by these terms, and how do individuals choose between competing candidates agreed by some criteria to be in medical need.

It would seem plausible to suggest that a mixture of approaches, such as combining the criterion of merit with the criterion of medical need, but there is a considerable amount of historical and sociological evidence to suggest that "the allocation of medical resources on the basis of a patients non-medical merits is widely regarded as repugnant" (Gillon 1986: 97).

In health care the allocation of resources is largely dependent on the medical success of the resource to be distributed. For example, currently research into the Auto Immune Deficiency Syndrome (AIDS) virus is being financed by the Government in an effort to speed up the likelihood of finding a vaccine. Money was also invested in a machine to process cervical smear specimens in the diagnosis of cervical cancer, and its recent medical success demonstrates the priority given to the medical need criteria in deciding resources.

At best any chosen criteria must provide a practical way of resolving the dilemma of allocating scarce medical resources, particularly if the moral values embody the fundamental moral values such as beneficence, non-maleficence, autonomy and patient/client rights. Furthermore, the system
must include Aristotle’s (384-322 BC) formal principle of justice which includes equality, impartiality and fairness. However, treating people equally does not mean treating them identically or justly, it merely implies "making proportionally the same contribution to the goodness of their lives" (Frankena 1973: 51).

It could of course be reasonable to argue that the most egalitarian way would be to conduct a lottery. A lottery at least does not discriminate on merit or ability, age, or race, but it would be difficult to apply, and may conflict with the "do no harm" principle as others may consciously suffer.

Nurses have four obligations under the principle of distributive justice, which gives them the power and responsibility to effect change. These obligations involve the obligation to do all they can to meet the needs of their patients/clients; to be competent whether or not the patients/clients pay for their services; to improve standards and methods of health care by research and design; and to identify if the system of health care is not meeting the fundamental health needs. The dilemma arises as to whether any resources are allocated to a patient/client who wishes to live, but cannot due to some terminal illness, especially when these resources could alternatively be allocated to a patient/client who has a good chance of living/survival.
Justice, however, may also be viewed from a retributive, reparative or corrective standpoint and Frankena (1973: 74) contends that it is just as important to apply sanctions to those who have done wrong, as to those who have done well, though he further concedes a reluctance to do so unless the punitive sanctions are justified.

"It is possible to hold that the function of holding people responsible and applying sanctions is not retribution but education, reformation, prevention and encouragement"

(Frankena 1973: 74)

However, to accept the view that the threat of punishment is a sanction in justice, makes the argument a legal one, and not an ethical one, unless the sanction is limited to blame.

Ostensibly, for justice and fairness to be meted out it requires treating each other in a beneficent and non-maleficent manner, that is, distributing goodness and preventing harm, on the basis of merit or desert; needs, abilities, or both; or what appears to be the most egalitarian is to conduct a lottery whereby all individuals have an equal chance given and an equal chance to acquire.
(f) The Principle of Goodness or Rightness (Beneficence), Non-maleficence, and the concepts of Acts and Omissions, Double effect, Ordinary and Extra-ordinary means

(i) Beneficence and Non-maleficence

These principles imply that individuals such as nurses promote goodness over harm; cause no harm; and prevent harm. **Beneficence** is the active provision or promotion of good, encompassing all direct and indirect action, but not if the provision of that good also produces an equal greater harm. **Non-maleficence** is the obligation not to harm another individual either by deliberate means, or by harm caused by being at risk, or, by harm that occurs during the performance of beneficial action, such as treatment. Clearly the nurse would have to decide what degree of risk is ethically permissible.

In order to respect a person as an "autonomous" being, that is to respect a person as an end, Downie and Calman (1987: 53) believe that the individual has to employ the principles of beneficence that is, benevolence or compassion, and non-maleficence.

Frankena (1973: 45) holds that beneficence underlines the basic premise of utilitarianism as he asserts that in order to do good that is, beneficence, and to prevent or avoid doing harm, that is, non-maleficence, the individual has a duty to try to realise the greatest balance of good over evil. So for
Frankena (1973) the principle of utility presupposes the principle of beneficence, and according to him:

"We have a prima facie obligation to maximise the balance of good over evil only if we have a prior prima facie obligation to do good and prevent harm"

(Frankena 1973: 45)

In everyday discourse 'good' implies commendation or a satisfactory degree of characteristic qualities which are admirable or useful for some purpose (Oxford English Dictionary 1972: 1173); and 'evil' being the antithesis of good, denoting doing or tending to do harm, pain or discomfort (Oxford English Dictionary 1972: 909-910).

Frankena (1973: 79-83, 89) gives a whole range of points of view of good, such as utility values, intrinsic values and final values. He stresses that individuals ought to look for both good and evil values, as some things may be good in one sense and bad in another. However, Frankena (1973) seems to prefer the notions of intrinsic value whereby the good is performed because of their own intrinsic properties, and the utility value whereby things are good because of their usefulness for some purpose.

According to Frankena (1973) individuals do not have a duty or obligation to be beneficent, though praiseworthy and virtuous it may be. If by being beneficent then justice results then that is all that morality demands. Frankena (1973: 45-48) then sees non-maleficence as merely an aspect of beneficence, as
both are weighed together and assessed in the light of respect for autonomy and justice.

Gillon (1985c: 44) outlines Buchanan’s (1982: 33-62) rigorous argument that there is no such moral obligation as doing good for others, and outlines three main constraints to beneficence. Primarily, Gillon (1985c: 44) espouses that the duty of beneficence has to be tempered with the duty of respect for autonomy, on the grounds that consideration must be given to what the patient/client wants depending on whether the patient/client is viewed as an "autonomous" rational agent or as a human being. Secondly, beneficence has to be tempered with the duty of non-maleficence as both good and harm have to be given equal consideration in the assessment, as the benefits and harm to the patient/client that results have to be clearly stated. Thirdly, the duty of beneficence has to be tempered with justice (page 146), on the grounds that cost benefit analysis are considered in terms of distribution of resources, and in order to do good one has to be just or fair in the distribution of goods (Mooney 1980: 177-179). A cost benefit analysis may be a fair way of allocating resources but it is not necessarily justice.

Beneficence implies prevention of harm to the patient/client or removal of harmful conditions. Plainly, the goal is to benefit others, but is it a moral good or a moral duty? For it to be a moral duty then certain criteria must be met. The nurse must be in the position of preventing the harm
or loss and will in fact prevent the harm or loss. At the same time the patient/client must be at risk of harm or loss. The patient/client must be at minimal risk and outweigh any harm to the nurse for any benefit to be gained. If this is so, then nurses clearly have a duty of beneficence. The principle of beneficence does not prescribe how individuals are to distribute goods and evils, it only advocates that individuals produce the one end and prevent the other. When conflict arises it is the principle of justice which is required to enter the interplay.

Non-maleficence implies the non-infliction of harm on other persons, including intentional harm or risk of harm. For example, the nurse who fails to administer a prescribed drug may be causing as much harm by this omission, though it may be unintentional. Were the nurse to administer the prescribed drug, then the administration is intentional as the nurse is in the full knowledge that the patient/client may be at risk from the side effects of that drug. In both cases the patient/client is at risk from harm though the motive seems to be one of intent.

Whilst it seems plausible that we owe non-maleficence to all, it does not follow from the premise that avoidance of non-maleficence takes priority over beneficence, on the grounds that it is impossible to talk of a duty which the individual may not be able to fulfil. Simplistically, the beneficent, non-maleficient principles require an individual to strive to be 'good' human beings, as opposed to bad, thus promoting good over
bad; and to strive to perform the right action, as opposed to the wrong, carefully causing no harm/badness, and preventing harm/badness where it can be foreseen.

(ii) **Acts and Omissions Doctrine**

The second theme concerning intervention into health status is one about killing and letting die or not striving to keep alive, that is, about acts or omission.

"A simple omission to act may bear a different construction than an emphatic neglect of an action"

(Harris 1985: 29)

To illustrate this, a nurse may treat a patient/client, or may fail to omit to treat them. The acts and omissions doctrine implies that "in certain context, failure to perform an act, with certain foreseen bad consequences of that failure, is morally less bad than to perform a different act which has the identical foreseen bad consequences" (Glover 1984: 92). Glover (1984) holds that the varieties of omission range from ignorance that is negligence, to conscious omission due to a variety of motives. For example, sending money to aid famine victims could be conceived as reducing misery for those victims, yet to fail to do so would be an example of the omission part of the act - omission doctrine.

For Foot (1978: 25-27) the acts and omission doctrine is a distinction between what we do and what we allow, and on some occasions both are equally morally wrong. On this basis
she proposes a doctrine of positive and negative duties; positive duties implies helping people, such as acts of charity; whilst negative duties are designed to refrain from injuring or harming people, which are seen as more important than positive duties. Thus, for Foot (1978: 28) it is not permissible to commit a murder or to steal in order to provide food for an individual’s starving children. Arguably, not to provide starving children with food could mean their death, as great a harm as had the individual murdered or stolen in the first instance.

According to Harris (1985: 42) the important difference between positive acts and omissions is that "blame for a positive act seldom depends on how difficult not acting would have been", though according to Harris (1985) this is the exception to the rule. Clearly, some omissions create just as much a probability of death as their corresponding acts. As a case in point, if a doctor and nurse decide to turn off a life support machine it makes death no more certain than having put the patient on it, they fail to turn it on (Glover 1984: 98). From a utilitarian standpoint the individual is required to ensure that "an act and an apparently corresponding omission really do have the same consequences" (Glover 1984: 102). For many individuals there are double standards for in not giving generously and regularly to aid people dying of starvation is tantamount to murder, by virtue of the acts and omissions doctrine.
There is an argument that arises from this doctrine, and that is to put all the arguments before the individual and then let the individual make the choice. However, this would depend on the nature of the present health status of the patient/client, and whether they were competent, that is capable rationally, to make that choice.

(iii) **Double Effect; Ordinary and Extraordinary Means**

There is a clear distinction, however, between using means for the relief of suffering which may shorten life, and actively ending an individual's life and this principle is known as double-effect. This principle or doctrine implies that "it is always wrong intentionally to do a bad act for the sake of good consequences that will ensue, but that it may be permissible to do a good act in the knowledge that bad consequences will ensue" (Glover 1984: 87).

The principle is often closely associated with side-effects as it contends that if an individual consciously administers a treatment, then they are just as responsible for its desired effects as they are for the undesired or unwanted effects. Simply, what is it the individual does, and what was the intended outcome, foreseen or not? As a case in point, a nurse in the administration of care such as relieving pain may cause the death of an individual by virtue of the analgesia or pain-killer prescribed. Thus the death caused by the analgesia, may be a foreseen but unintended consequence, but in both cases the nurse is held responsible.
Clearly there is a problem in deciding what kinds of foreseen but unintended consequences can be justified by the double-effect doctrine; or, where to draw the line between an act and its consequences, that is meaning, where is the distinction between the act from their consequences, or distinguishing intended means from foreseen consequences.

To all appearances it is "sometimes permissible to bring about by oblique intention what one may not directly intend" (Foot 1978: 20), meaning that some actions will bring about that which was intended or aimed at, and an action foreseen but in no way desired. It seems to be a distinction between what individuals do, as the intent is there, and what individuals allow, knowing that an undesirable effect could deliberately occur.

Traditional philosophers, such as Glover (1984: 155), have combined the doctrine of the sanctity of life with the doctrine of double-effect. Infanticide is ruled out as an intended act, as new born babies have no conception of death and so cannot have a preference of life over death, but a course of action resulting in death as a foreseen consequence is acceptable. Yet another modification is the principle of ordinary and extraordinary means. This principle implies that individuals are "obliged to use all ordinary means to save life, but are not obliged to go to exceptional lengths" (Glover 1984: 156). How these exceptional lengths are measured is not quite clear.

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In this context ordinary implies normal medical intervention whereby the health team is not required or obliged to go to exceptional lengths, thus ordinary means of preserving life include "all medicines, treatments and operations which offer a reasonable hope of benefit to the patient, and which can be obtained and used without excessive expense, pain or other means" (Soane 1983: 42). According to Dunstan (1983: 15) ordinary means the doctor is under obligation to offer and the patient/client to accept. Extraordinary is taken to mean "the degree to which they [the means] are expensive, unusual, difficult, painful or dangerous" (Glover 1984: 196); thus extraordinary means of preserving life are "all medicines, treatments and operations which cannot be obtained without excessive expense, pain or other inconvenience, or which, if used, would not offer a reasonable hope of benefit" (Soane 1983: 42). For Dunstan (1983: 15) extraordinary means are thus voluntary or elective in which the patient/client may decline care if it is judged to impose a physical, social or financial burden, more than the patient/client is prepared or willing to bear for the sake of prolonging life.

Glover (1984: 196) debates the inclusion of the word "unusual" in the notion of extraordinary means and argues that if the "unusual" treatment is "cheap, easy, painless and risk free", then who will object to it because of it being unusual.
Harris (1985: 39) further develops the meaning of extraordinary means which he declares is not obligatory, but "involves great cost, pain or inconvenience, or is being a great burden to the patient or others, without a reasonable hope that the treatment will be successful".

How a means is defined in a particular case depends on objective and subjective circumstances such as time, place, age, personal qualities of the patient/client, general health status, and hope of benefit.

The central themes seem to be one of degree in treatment, the extent to which the outcome is satisfactory, and the relevance and worthwhileness of the life. Simply, does the life to be preserved justify the energy that is expended in saving it, and what effects will the preservation have on the patient/client and family? The answers seem to lie in one of priorities.
SUMMARY

This Chapter examined specific conflicts in ethical principles which resulted in the ethical dilemmas faced by nurses, to see whether these conflicts affect the interpretation of ethical practice.

The ethical principles, such as the sanctity of life, liberty, honesty and justice were discussed as a basis and to give meaning to the terminology and concepts in Chapter Four.

The concepts of autonomy, paternalism, advocacy, trusteeship, informed consent, beneficence, non-maleficence, acts and omissions, double-effect, and ordinary and extra-ordinary means were also examined to illustrate that all these notions are inherent in the nurses role. These concepts will be presented in the Model to be proposed by the author in Chapter Four and so will need to be addressed in the selection and utilisation of ethical models on which nursing practice is based.

The commonest recurrent ethical dilemmas seem to be: balancing the rights and interests of the patient/client and the rights and interests of the nurse, family or significant other; decisions between accepting the responsibility for truth-telling and sharing in the resulting consequences; between full disclosure of information and fiduciary care or responsibility; and between what is just and fair in decisions between allocating resources for palliative and therapeutic treatment.
It emerged that the ethical principles discussed in this chapter govern the decision-making that will be used in the clinical and community setting and so will need to be included in the author's proposed ethical model.

The ethical dilemmas which present for both nurses and patients/clients require nurses to examine their own motives, values and beliefs so that in the undertaking of certain ethical actions they may act professionally and as objectively as possible.

The author now wishes to present an ethical model, utilising the issues and ethical principles which have arisen from discussion in Chapter Two and Chapter Three respectively. The author's proposed Framework and Model will be referred to as the Ethical Analysis Framework and Model, so that a clear distinction may be made when referring to nursing models or models of care.
ENDNOTES (Chapter Three)

1. The term right to life is misleading on the grounds that Homo sapiens can only have a right to life if it possesses the concept of self, that is self-consciousness/awareness. It may be argued that things that lack consciousness cannot have rights, as rights are dependent on desires and an understanding of what is desired. For example, if individuals have a right to life and are unable to have a corresponding desire due to disease or illness then until they are able to express desire there is no right to life. The argument seems to lie in one of potentiality. Legally, however, animals have a right not to be ill treated.

Thus the concept of the right to life presupposes that an individual is capable of desires, but if there is no self conscience or there is illness then there is no right to life, and so would be an adequate defence for abortion and euthanasia. The achievement of certain characteristics such as being viable does not give an individual the right to life, as in the case of a foetus' dependence on the mother.

2. Some philosophers such as Brody (1971: 357-358); Wertheimer (1981:69); and Thomson (1986:37) use the expressions human life, human being, and person as interchangeable terms and this gives support to those who are anti-abortion. There are essentially two arguments here:
   1. Foetuses are not considered as human.
   2. What properties does the foetus possess which makes them a person.

3. Thiroux, J. (1986:125) has also argued this view.

4. The Association of Nursing Students (ANS) Bill of Rights (Appendix 4) has met with some resistance from Schools of Nursing who though they agree with the concept in principle disagree with the wording, and have rejected a league table of responses to the Bill. Acceptance or rejection of this Bill is dependent on how these rights are interpreted, the constraints on these rights, that is, the parameters and conditions involved in accepting or denying these rights. If rights are not absolute (page 33) then clarification is required as to what conditions and instances can the rights of nurses override those of their colleagues, and vice versa.

   Currently the Association of Nursing Students (ANS) are enlisting the help of the Royal College of Nursing (RCN) in promoting the Bill.

   A further call for a Bill of Rights for the elderly was endorsed by the Health Visitors Association (HVA) at their annual conference in May 1988.
5. There are, however, a number of assumptions underlying these ethical positions:

(i) that what a person wants can be a reason for it being done

(ii) that the consequences as judged by an outside agent is relevant to deciding what is right

(iii) that the ethical weight given to what the person wants is a function of the persons competence to make a choice

(iv) that the ethical weight given to the consequences is a function of the gravity of those consequences as judged by an outside agent

(v) that the ethical weight given to the persons own wishes and given to the consequences are to be put into the balance at the same time

(Eastman and Hope 1988:53)
"We have, in fact, two kinds of morality side by side; one which we preach but do not practice, and another which we practice but seldom preach"

Bertrand Russell, Sceptical Essays, 1928.
CHAPTER FOUR

INTRODUCTION AND CONSIDERATIONS FOR THE ETHICAL ANALYSIS

FRAMEWORK AND MODEL

In this Chapter the author presents an Ethical Analysis Framework (Figures 4a, 4b) and an Ethical Analysis Model (Figure 4c) for the application of ethical principles in the clinical and community setting. The Ethical Analysis Model is intended for generalisation to all models used internationally in guiding nursing practice. The content for the Ethical Analysis Model and the ethical constructs/components are derived from the issues and ethical principles in Chapter Two and Chapter Three respectively.

It seems evident from the issues in Chapter Two and Chapter Three that consideration be given to nurses and patients/clients to facilitate an understanding of ethics, ethical dilemmas, and the process of making informed decisions. Ideally, the Ethical Analysis Model is building on the work which has already been done in ethics education by nurse theorists/educators and the Statutory bodies (page 34). The author hopes that some degree of ethics education will have occurred prior to the use of the Ethical Analysis Model, and that changes in the training of nurses at all levels, such as advocated by Project 2000, will be taking place concerning the interpretation and application of nursing models in guiding nursing practice.
What emerges for consideration for the Ethical Analysis Model is that there appears to be varying interpretations of the ethical principles, and so clarification of the concepts related to the rights of individuals would need to be included in this Model.

Similarly, specific attention needs to be directed towards identifying the specific ethical principles relevant to nurses and patients/clients, and training in ethics and/or discussion time may need to be arranged prior to the use of the Ethical Analysis Framework and Model.

In addition, some validation criteria would need to be adopted to ascertain whether the rights of patients/clients and nurses are given consideration, and to check to see if the appropriate nursing model is being utilised to reflect ethical practice. Without some validation criteria it may be difficult to translate the ethical principles into practice.

At the outset of this Chapter, the mutual expectations between nurses and patients/clients in nursing are examined to enhance an understanding of active participation (page 28); secondly, the ethical agents who may need to participate, and their effective use in underpinning the Ethical Analysis Framework and Model are identified. Thirdly, the Ethical Analysis Framework and Model are introduced, and the essential elements or the basic assumptions underlying the Ethical Analysis Framework and Model are detailed to ensure the mutual expectations and interaction between nurse and patient/client.
are realised. The five phases of the Ethical Analysis Framework will be presented in diagrammatic form and discussed. The validation criteria, which were adapted from Guion (1977: 1-10), and utilised as a basis for the Ethical Analysis Model are presented, and how these criteria are utilised to assess the proposed nursing model and the ethical constructs/components are detailed. Fourthly, the author examines the curriculum considerations; fifthly, presents the implementation guidelines; and finally presents the implications for research, education and practice.

1. **MUTUAL EXPECTATIONS BETWEEN NURSES AND PATIENTS/Clients**

Ethics is concerned with mutual expectations, of what professionals expect of their patients/clients, and the appropriate expectations of those patients/clients from the professional. The task of educating patients/clients and nurses in expectation, commitment, and co-operation is paramount in the ethical relationship.

This raises many questions as to whether a patient/client ought to act on a nurse’s information, and the freedom that individual has in rejecting that information; or for that matter, what freedom or choice do nurses have in refusing to meet the patient’s/client’s wishes, and protecting their own rights. These are ethical questions and assumptions
which can only be argued on moral philosophical grounds, in rigorous debate in all settings, as then personal and professional beliefs and the convergence and divergence in ethical traditions and religions may emerge.

The knowledge and skill for which nurses are trained invests them with the attributes of medical/nursing knowledge, which in turn gives them "expert" power and authority over patients/clients.

The basic assumption here is that a successful, that is, a mutually rewarding, relationship between patient/client and nurse is conditional on the mutual expectations being met. Thus both patient/client and nurse may need to be aware of the expectations of each other, and what each can provide. Anecdotal evidence suggests that many patients/clients take the nurses advice which is attributed to trust in the nurse, which arises from a tradition of respect for all nurses, rather than any specific attribute of the nurse.

The evidence suggests that an attempt has been made to facilitate these mutual expectations by the development of interactive and inter-personal systems. Kuhn (1974: 81-103), Anderson (1978: 25-26) and Steckel (1980: 1596-1599) have all developed interactive or inter-personal systems whereby the nurse contracts with the patient/client collaboratively desired behaviours. These behaviours may reflect the patient/client priorities and the nurses' specific prescription for accomplishing these desired behaviours. Inherent in this
contractual arrangement are patient/client selected reinforcers for adhering to the contract in order to materialise the desired behaviours. These interactive or inter-personal models provide a framework for communication and negotiation between patient/client and nurse of behavioural outcomes in terms of their values, and establish a plan of care which ideally supports those values and preferences.

Brody (1981: 336-337) describes three models of practice that may have some relevance for how nurses structure their relationships with patients/clients. Firstly, the "engineering model" emphasises the giving of usually only "scientific facts", and allowing the patient/client to decide. An involvement in patient/client values is considered improper in this model, and the evidence suggests that nurses are unaware of how their values influence the situation.

Secondly, Brody (1981: 336-337) outlines the "priestly model" which is paternalistic (page 102) in nature, thus an ultraprotective stance is advocated, the nurse giving directions which the patient/client is clearly expected to follow.

The third model by Brody (1981: 37-39) is the "contractual model" which appears to be the most suitable for the nurse-patient relationship given nursing's primary goals as it advocates "establishing contractual arrangements by mutual consent". It involves the disclosure of values, covert and explicit, and both nurse and patient/client are aware that
interpreted facts and values are brought into their interactions, and compares with Aroskar's (1982: 24, 28-29) fourth mind-set or characteristic (page 56) which favours an interactive process.

These interactive and inter-personal models give some consideration to the personal values of patients/clients, but there is no evidence to suggest that they are put into practice. It has already been seen (page 24) that the author has examined the literature on models and found that models are not used judiciously and that it appears that nurses have difficulty in interpretation and translation.

2. ETHICAL AGENTS

Ethical agents in this thesis are those persons who are involved in the analysis of the proposed nursing Ethical Analysis Framework and Model for use in patient/client care. Those involved may include the patient/client, nurses, the family of the patient/client, and doctors. In many instances, the ethical agent parameters may be extended to include physiotherapists, community nurses, dietitians, social workers, spiritual advisors, and the appointed patient/client advocate or trustee, as some or all of these individuals may be involved at some stage with the patient's/client's care.
3. THE ETHICAL ANALYSIS FRAMEWORK AND MODEL
3. INTRODUCTION TO THE ETHICAL ANALYSIS FRAMEWORK AND MODEL

Ethical frameworks and models which aid in the application of ethical principles, such as the one advocated by the author, are useful tools in analysis as they aid in identifying key factors which are vital for making a decision in clarifying specific principles.

This proposed Ethical Analysis Framework and Model is only one method of guiding the action that may precede the choice of a model of care which guides nursing practice. The Ethical Analysis Framework and Model will hopefully enable ethical principles to be given greater consideration so that they may be included in the context of nursing theories and models of care.

The Ethical Analysis Framework comprises Figures 4a and 4b, and the Ethical Analysis Model is presented in Figure 4c.
1. Initial Overview

2. Preliminary review (Figure 4b) (Assessment)

3. Analysis of proposed nursing model (Planning)

4. Ethical Analysis Model (Figure 4c) explained to patient/client

5. Implementation and Evaluation

Figure 4a: The Ethical Analysis Framework: Used in Assessment phase of Nursing Process
Figure 4b: The Ethical Analysis Framework: Flow Chart demonstrating Preliminary Review outcomes
Prior to the utilisation of the Ethical Analysis Framework and Model there are three significant points it is important that the care-giver utilising the Ethical Analysis Framework and Model understands. An understanding of these points may manifest depending on how effectively the Ethical Analysis Framework and Model are utilised in the practice setting, and also when care is evaluated formatively and summatively. A lack of understanding of these points may jeopardise decisions made in the "best interests" of the patient/client. In addition, the necessary support, such as counselling or the use of the ethical agents (page 178) may be denied the patient/client and/or the nurse.

Firstly, patients/clients may be unable to participate in the realisation of their maximum health potential, because they may not have the capacity or the ability to comprehend information relevant to decisions and to deliberate about choices; or they may not be competent, that is rational and capable, perhaps due to mental illness. In this case, their advocate or trustee, who may or may not have been appointed previously, may need to be fully involved in the discussions and decision-making to effect what is in the "best interests" of the patient/client. In some instances the nurse may have difficulty in interpreting the patients'/clients' true feelings as nurses are guided generally by subjective observations. These subjective observations may overrule the true feelings of the patients/clients, especially if the patients/clients are not
able to articulate their feelings. In this case, nurses may need to intervene and act as/appoint an advocate who can act in the patients'/clients' "best interest". This intervention (page 120), it may be argued, is an integral part of ethical decision-making, at which the nurse will become more skilled, and it has already been seen how difficult acting in the patients'/clients' "best interests" may prove (page 102).

Secondly, the patient/client may choose to consider the nurse as the 'expert' and wish to transfer the decision to the nurse. If the nurse is the patient's/client's appointed advocate then this decision would be undertaken by the nurse, in respecting the patient's/client's needs. If the nurse is not the appointed advocate the patient/client may choose to appoint the nurse at that moment. However, the patient/client may need to be encouraged to share in the responsibility (page 27). Failing this, the nurse accepts the responsibility as the appointed advocate and if there is a conflict of interest, or the nurse refuses to act as advocate then the other ethical agents (page 177) may be involved.

Thirdly, there may be circumstances in which the nurse may not wish to be involved with caring for a particular patient/client, perhaps due to a conflict of interests or a personality difficulty. In this situation the rights of the nurse are respected on the grounds that the nurse's rights are
considered to be equally important and counselling support may be required for the nurse.

The essential elements and aims of the Ethical Analysis Framework and Model are presented first; and the phases of the Ethical Analysis Framework incorporating the Ethical Analysis Model are outlined.
3(i) Essential elements or assumptions and aims of the Ethical Analysis Framework and Model

In addition to the ethical constructs/components and the validation criteria in the Ethical Analysis Model to be proposed by the author there are other essential elements which must be incorporated to facilitate the mutual interaction between patient/client and nurse. In this way paternalistic attitudes from the nurse may be diminished, as the nurse and patient/client, where possible, shares in the responsibility for their care, but the final informed decision is made by the patient/client.

The Ethical Analysis Framework and Model for practice are based on four basic assumptions. Firstly, that the individual patient/client is "autonomous", that is, a self-determining person who has the right and freedom to choose to participate in selecting his/her health care needs, via the nursing model to be selected, or, may have an advocate or trustee acting in his/her "best interests". Secondly, that the nurse - patient/client relationship is one of mutual interaction or reciprocation. Thirdly, that the nursing model chosen will have been validated using the criteria in the Ethical Analysis Model. Fourthly, that the patient/client accepts or shares in the responsibility, where possible, for improving their personal health status.
The Ethical Analysis Framework and Model incorporates the essential domains in nursing, that is, the cognitive, affective and effective elements, and these domains have already been demonstrated in Figure 2a (page 49).

The author hopes that the utilisation of the Ethical Analysis Framework and Model will be evaluated at each phase/stage informally by the nurse and facilitator in the first instance. Later a more formal evaluation, perhaps by action-research, may be conducted. In this way, the nurse will know whether the aims have been achieved.
The three main aims for the nurse and facilitator in the use of the Ethical Analysis Framework and Model are:-

a) To foster understanding in the use of the concepts of the Ethical Analysis Framework and Model.

b) To facilitate increased independence and initiate the transition process from dependence on either educational or clinical facilitators, and/or supervisors, to independent use of the Ethical Analysis Framework and Model thus enabling effective application by the nurse at the bedside, and in the community.

c) To facilitate and undertake an experiential and self-directed approach to learning.
Phases of the Ethical Analysis Framework
incorporating the Ethical Analysis Model

(Figure 4a/4b)

The Ethical Analysis Framework (Figure 4a) consists of five phases, is to be used in conjunction with Figure 4b, and guides the care-giver in the process. The Ethical Analysis Framework and Model will hopefully become an integral part of the assessment phase of the Nursing Process (page 37).

Stage 1: Initial Overview (Cognitive perspective)

This phase/stage is concerned primarily with the educative aspects thus ensuring that the nurse is fully cognisant with the:

a) Assessment of need for the Ethical Analysis Model.

b) Aims for the nurse and facilitator in the use of the Ethical Analysis Framework and Model

c) Content of the Ethical Analysis Framework and Model

d) Use of the Ethical Analysis Framework and Model.

A full understanding of the validation criteria, which will be detailed later, is a primary requirement before assessment of the patient/client can commence. An understanding of the educative aspects in this phase/stage can only be measured when the formative assessments are being done as part of the Nursing Process, and by the effective use of the Ethical Analysis Model.
Stage 2: Preliminary review stage - Assessment Phase
(Figure 4b)

This phase/stage is concerned with establishing a mutual relationship or rapport between the patient/client and nurse in order to gain both subjective and objective information of each other through verbal and non-verbal communication methods. The expectations of both patient/client and nurse are discussed in terms of such things as the general overview of nursing models - their purpose, function/role, advantages and disadvantages; and the beliefs, values and aspirations of the patient/client and nurse. It is at this point that the patient/client may need to understand that a nursing model has to be selected to meet their specific health care needs, and it is up to the nurse to ensure it is valid by using the validation criteria.

At the end of these preliminary discussions with the patient/client three possible outcomes exist. Firstly, the patient/client may be in harmony with the nurse. The rapport established has been congruent, and both are aware that the expectations on either side (page 174) can be met, and both parties wish to proceed with meeting the health care needs of the patient/client (Figure 4b 2 [i]).

Secondly, incongruence exists and the health care needs can only be met by another professional such as a social worker, or clinical nurse specialist such as a stoma therapist, and so the appropriate referral would have to be made in conjunction with the health care team (Figure 4b: 2[ii]).
Thirdly, the patient/client relationships may be incongruent for a number of reasons. The patient/client may quite simply not establish a rapport with the nurse conducting the preliminary review; or, he/she may refuse treatment, or referral; or, his/her expectations cannot be met. The necessary options for coping with this problem are detailed in the flowchart (Figure 4b: 2 [iii]).

As a result of incongruence the patient/client and nurse may need further time for support and counselling. This would be initiated by the member of the health care team to which the patient/client would be referred (Figure 4b: 2 [ii]); or following discussions in health care team meetings, then an appropriate member will be chosen to counsel the patient/client and nurse. In spite of all these options it may still be difficult to know if the decision that the patient/client makes is a rational one. If there is a doubt then intervention seems appropriate and this has already been highlighted (page 182).

Stage 3: Analysis of proposed nursing model - Planning Phase

As argued in Chapter One (page 24) it is hoped that the appropriate environment, a change in attitudes brought about by training (page 172), and the use of validation criteria may overcome the injudicious use of models in general and may enhance the use of the Ethical Analysis Framework and Model. This is paramount as how nurses interpret and analyse nursing models may aid in the utilisation of the author's Model (Figure 4c).
Providing that the patient/client and nurse are congruent/compatible then a more specific analysis (Figure 4a [3]) can occur. The nurse elicits the general theme of nursing model which may most appropriately suit the patient/client in meeting his/her health care needs. For example, a nurse may establish with the patient/client that his/her basic health care needs are educative, such as a diabetic who requires some education about how to self administer a drug such as Insulin, before discharge into the community. They may decide to use a self-care model, such as Orem (1985) on (page 26) and this requires full understanding of this nursing model and how it is used by the nurse and patient/client. If the nursing model selected does not appear to have any ethical principles with guidelines for practice, then the ethical constructs/components and validation criteria in the Ethical Analysis Model may be utilised. It is this validation criteria which will facilitate the effective use of the Ethical Analysis Model.

An assessment of available resources, the environment, and the mutual goal-setting which occurs at this stage is effected. This is done as part of the Nursing Process (page 37) during the assessment phase. However, the author includes these areas here to demonstrate where in the Ethical Analysis Framework (Figure 4a) this assessment of resources occurs and briefly outlines the content of these areas.
a) **Resources**

The resources in terms of time, equipment, personnel/staff input, and finances required and/or anticipated to facilitate meeting the health care needs of the patient/client are assessed. This assessment requires utilising management techniques, such as setting priorities and key task analyses of workloads, and for which the nurse may need some further training. This assessment knowledge is shared with the health care team as every member will need to know their part or role in the care of this patient/client. The health care/multi-disciplinary team meetings may serve as a forum for discussion and decision-making taking all the facts about the patient/client into consideration. For example, the dietitian may need to know the nature and significance of her role in educating the patient/client, in relation to the specific nursing model chosen. Moreover, the health care team may be required to ensure the patient/client receives their share of the scarce allocation of resources.

b) **Environment**

The individuals concerned with meeting the health care needs of this patient/client will need to know the setting(s) in which the care will occur, and generally the expectations of the setting. Again, to use the same illustration, the dietitian will need to share in deciding whether it is more beneficial for the patient/client to be taught about diets in a department, or the patients' home setting, especially if the diabetic is part of a large family and prepares the family meal.
c) **Mutual goal-setting**

Mutual goal-setting highlights the reciprocal relationship of nurse and patient/client. The process involves identifying the behavioural goals, but this would be inherent in the Nursing Process and is not within the scope of this thesis.

What is of importance is that the patients'/clients' beliefs and values are elicited at this stage, as matching or correlation with the chosen nursing model is important. As the nurse will hopefully be utilising the Nursing Process and may possible even be the primary nurse then there may be some first-hand knowledge of the patient/client and their aspirations. For example, in the assessment phase of the Nursing Process (page 37) which may in the future hopefully embody the Ethical Analysis Framework and Model, discussions will take place between nurse and patient/client, and the content of this discussion is already highlighted (page 189). It may also be discussed in an informal way in health care team meetings, or it may even be documented in the Nursing Care plan.

The primary nurse is the named nurse to whom the patient is allocated, and who has twenty four hour responsibility for and accountability to the patient for the whole period in which the patient requires nursing care. The primary nurse is responsible for assessing, planning and evaluating of care with other relevant members of the health care team, and coordinates implementation of care with associate and support nurses. The Nursing Care plan is a legal
record/document of the mutual goals to be achieved by the patient/client and care-giver, and the care delivered. It demonstrates that an effective assessment has occurred, guides the implementation of care and forms the basis of the evaluation.

Stage 4: The Ethical Analysis Model (Figure 4c)

The nursing model selected for use will now be subjected to this analysis, and it is this validation which makes the author's approach to the use of nursing models different. Some of the attitudinal and practical problems of adopting this analysis will be discussed later. If the nursing model fulfils the validation criteria, then the nursing model and the ethical constructs/components are explained to the patient/client. If the nursing model does not fulfil the validation criteria then it may not be an appropriate nursing model to use. Or, it may be that it lacks the ethical constructs/components and so the Ethical Analysis Model's constructs/components may be utilised to complement the nursing model.

This stage is then one of information sharing with the patient/client about the effectiveness of the nursing model as a basis for nursing practice. It is also at this stage that the nurse ensures that the patient/client has a detailed explanation, where possible, of their rights contained within the Ethical Analysis Model, and planning of appropriate strategies in the event of the patient/client taking negative interest in their care (page 183).
Further details of how the validation criteria are utilised will be discussed later.

**Stage 5: Implementation and Evaluation of the Ethical Analysis Model**

At this stage the nursing model has been selected, validated and the ethical constructs/components have been explained to the patient/client.

Throughout the implementation of the selected ethical nursing model continuous/formative or on-going assessment is occurring. These assessment processes are already inherent in the Nursing Process (page 37), but what is of importance is that the nursing model used is judged to be effective in realising the goals set by patient/client and nurse, and the patient’s/client’s rights are respected, and this will emerge from the formative assessments done.
USING THE ETHICAL ANALYSIS MODEL

The validation criteria, detailed later, will be utilised in the Ethical Analysis Model firstly to guide the nurse in choosing an appropriate nursing model, and then the criteria will be used to validate the ethical constructs/components presented in the Ethical Analysis Model (Figure 4c).

The nursing model to be utilised will be validated using the criteria outlined (pages 199-202); then the ethical constructs/components will be validated (pages 203-214) utilising the same criteria as used for the nursing model.

Some problems of adopting this Analysis

(i) Attitudinal problems

One of the main reasons for nurses not believing or accepting research findings is likely to be refusal of the individual to change existing attitudes or beliefs (Hunt 1981: 189-194). This resistance to a new idea may be generalised in adopting this Analysis. The underlying values, attitudes and ethical positions which produce positive adjustments to new ideas may however be enhanced if a new idea, such as this Analysis, is presented in a simple way with guidelines for practice.
(ii) **Practical problems**

This Analysis requires a time frame which may present some difficulty for the nurse, as it requires additional time in the assessment phase.

**The Validation Criteria Utilised in the Ethical Analysis Model**

There are varying ways of establishing the validity of nursing models or models of care and ethical models which guide nursing practice, and all of these ways are interrelated as they seek to collect certain kinds of evidence. **Validity** is "the degree to which the instrument measures what it is intended to measure" (Phillips 1986: 465).

According to Phillips (1986: 351) a study is judged to be valid by assessing the predictability of variables or attributes, the content, the association of variables, and the statistical support for the predicted structure of the variables.

Guion (1977: 1-10) has identified five main criteria for assessing content, and these will be adapted by the author and used as validation criteria. **Content Validity** means the "degree to which the desired domain is adequately represented" (Phillips 1986: 219). These five criteria are
now discussed under sub heading for convenience viz:-

Criteria 1 : Knowledge base
Criteria 2 : Clarity of definitions/linguistic interpretation
Criteria 3 : Measurable behaviour (inferred)
Criteria 4 : Adequate sampling
Criteria 5 : Content consistently presented
The author has examined nursing models, which are purported to guide nursing practice, and has established that past and current nursing models do not appear to contain any criteria for validating these models (page 24). The validation criteria adapted from Guion (1977) for use by the author is the main focus of the Ethical Analysis Model, and is the key to enabling the effective utilisation of ethical nursing models in the future.

**Criteria 1: Knowledge base**

Firstly, the content domain is rooted in behaviour with a generally acceptable meaning. For example, the content domain of a proposed nursing model is based on what the nurse knows about the use of nursing models generally and that knowledge is directly related to their knowledge of the theory behind the model. More specifically, the nurse will need to know the underlying theory of the proposed nursing model, and the training advocated by the author prior to utilising the Ethical Analysis Model has already been highlighted (page 172). Thus the philosophical background is of paramount importance in the content domain and includes the values, beliefs and assumptions upon which the specific nursing model to be used is based. Assumptions are clearly explained and the concept and propositions comprehensive.
Criteria 2: Linguistic interpretation

Secondly, the content domain is clearly defined in order to judge whether each item fits into the boundaries. For example, the proposed nursing model would have to include all the notions, implicit and explicit assumptions and values advocated, in order to be truly valid as a nursing model on which to base practice. The clarity of the assumptions stated and how these assumptions relate one to another, the central components and concepts and their relative importance are to be expressed in operational definitions. In other words the linguistic interpretation must be clearly expressed for the content domain to have any meaning.

Criteria 3: Measurable behaviour (inferred)

Thirdly, the content domain is related to the purpose of measurement in the design. For example, if the concept of 'autonomy' is included in the underlying theory of the proposed nursing model, then the expected outcome is that the patient/client and nurse would need to demonstrate behaviour that reflected self-determination, such as the ability to make decisions. The ethical principle of autonomy can only be inferred from this behaviour, and the inference may not be a correct one. However, the utilisation of the chosen/selected nursing model may be measured by the way in which the nurse and patient/client assesses, plans and implements the nursing model.
Criteria 4: Adequate sampling of qualified staff

Fourthly, the content domain is judged to be adequately sampled by qualified individuals - whose qualifications to judge is based on a degree of knowledge of the content under study. In other words the content of the nursing model may be utilised by nurses who are appropriately competent and knowledgeable about the nursing model to be used and who are able to translate the nursing model into practice. The nurse will also be required to articulate answers about the nursing model to be utilised.

Criteria 5: Content consistently presented

Fifthly, the communication of the content requires consistency, that is, the same facts are presented at all times to the patient/client. In other words, the health care team will need to decide on the information given to each patient/client at health care team meetings. Thus all health care team members may ensure consistency of information to the patient/client. This may be achieved by the effective utilisation of the Nursing Care plan by recording the facts that the patient/client has been told, and the effective use of the hand-over of patient care reports play an important role. Thus a consistent or reliable method of validation can be achieved which can be generalised or transferred easily to other aspects or perspectives. Inherent in any model also is the capacity for change, and so the nursing model may need to have a certain amount of flexibility to allow for the changes which are
constantly occurring, and the health care team need to be aware of any changes made so the information to the patient/client can also be changed accordingly.

All the concepts, whether they be nursing model or ethical, which are defined operationally will need to be defined consistently or used in consistent ways throughout. The underlying assumptions need to be seen to be consistent with the concepts advocated.

At this stage the nurse has used the validation criteria to judge the appropriateness of the nursing model which will guide nursing practice. The next stage is to discuss with the patient/client, where possible, their rights and this is achieved by utilising the ethical constructs/components and the validation criteria in the Ethical Analysis Model (Figure 4c).

The Ethical Analysis Model (Figure 4c) presents a matrix which embodies the ethical constructs/components which are depicted vertically, and the five criteria of validation which are depicted horizontally.

At the bottom of the Ethical Analysis Model (Figure 4c) are the preferred cognitive, effective and affective outcomes. This is one way in which the nurse can assess the behaviour the patient/client demonstrates.
<table>
<thead>
<tr>
<th>VALIDATION CRITERIA</th>
<th>Criteria 1</th>
<th>Criteria 2</th>
<th>Criteria 3</th>
<th>Criteria 4</th>
<th>Criteria 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>ETHICAL CONSTRUCTS</td>
<td>Use/knowledge of model and constructs</td>
<td>Linguistic interpretation</td>
<td>Measurable behaviour (inferred)</td>
<td>Adequate sampling by qualified, experienced personnel</td>
<td>Content consistently presented</td>
</tr>
<tr>
<td>a) Respect for Person Sanctity and Quality of life</td>
<td>Capability of individual as a person. Assumptions about sanctity and quality of life. What does individual know?</td>
<td>Sanctity of life Quality of life Person</td>
<td>Can patient/client understand information, and ask relevant questions</td>
<td>Is nurse qualified and experienced to:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>i) Articulate answers and explanations to procedures and treatments</td>
<td>Are information and attitudes from nurse and healthcare team presented:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>b) Liberty/Freedom Choice</td>
<td>Individuals have option to choose based on personal values. What does individual know?</td>
<td>Liberty/Freedom Values</td>
<td>Patient/client/advocate/trustee responsible for final choice. What does individual want?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>c) Autonomy Respect for persons Individual rights Paternalism Advocacy Trusteeship</td>
<td>Individuals not treated as means to an end. Sharing of perceptions. What does individual know?</td>
<td>Autonomy Self-determination Rights Confidentiality Privacy Paternalism Advocacy Trusteeship</td>
<td>Individuals given opportunity to talk, with evidence of listening skills by nurse, with appropriate responses. What does individual want?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>d) Truth telling or honesty Personal integrity Informed consent</td>
<td>Individual is facilitated to set realistic goals as all facts known. What does individual know?</td>
<td>Honesty/Truth telling Integrity Fidelity Informed consent</td>
<td>Patient/client must demonstrate participation in informed decision-making.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>e) Justice Fairness Equality</td>
<td>Individual must be ensured fair share of resources. What does individual know?</td>
<td>Distributive justice Fairness Equality/Equity Resources</td>
<td>Can patient/client identify the resources to which they are entitled to meet their healthcare needs?</td>
<td></td>
</tr>
</tbody>
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Figure 4c: The Ethical Analysis Model
The author now details the ethical constructs/components and how they may be utilised. Each construct/component or ethical principle is taken in turn and discussed using the validation criteria.

(a) Sanctity and quality of life

The traditional cultural value of saving life at all costs, with medical research directed toward time, effort and energy in creating new life-prolonging drugs and techniques/procedures is the current trend. This, according to Benoliel (1983: 211) has contributed to the "development of a system in which the care of the person is secondary to the diagnosis and treatment of disease."

In ensuring that patients/clients and/or their families or significant others, have a full understanding that the nurse respects their right to life and the quality of that life, then it is paramount that the model of care advocated for use clearly delineates these aspects. For example, the model of care will need to incorporate ethical principles and guidelines for practice, and so will need to incorporate assumptions about intervention measures to prolong/preserve life, or the measures to ensure a "good" quality of life. It may also need to include assumptions about the consideration given to "special" (page 86)
people who are unable to participate in decision-making. If it does not, then the Ethical Analysis Model is utilised.

Some understanding by both patient/client and nurse, where possible, is required (Criteria 1) and a sharing of their views about the mutual expectations concerned within this principle. What exactly does the patient/client know about the sanctity of life. The values, beliefs and assumptions upon which the nursing model is based defines (Criteria 2) what the individual is capable of, and the assumptions about the sanctity and quality of life. Inherent in this are the assumptions about what a "person" is, for only then can the patient/client be fully informed about the care they are to receive and the consent required of them.

Clearly, the ethical principles may be validated (Criteria 3) in terms of behaviour by observing if the principles are applicable to each individual and so the model for care facilitates activity which enables the nurse to observe and infer the patient/client behaviour. In addition, a nurse who is competent and knowledgeable, and who is able to give appropriate answers and explanations (Criteria 4) to patients'/clients' enquiries is essential. Finally, the information, which has been decided upon by the health care team, is consistent when it is presented to the patient/client (Criteria 5). If a conflict of interest arises, such as the nurse caring for a relative or friend, then this must be declared to enable clear decision-making by all members of the
health care team and the patient/client. The patient/client is required to recognise and realise where possible his/her maximum health potential and if this is not possible then advocacy is required (page 107).

(b) **Liberty/Individual freedom, and Choice**

As discussed previously (page 90), liberty or individual freedom may be considered an essential aspect in the exercise of rights, though some individuals may not have the freedom to exercise their rights, the mentally ill. The patient/client is given the opportunity and option to choose (Criteria 1) from competing stimuli, based on their personal values, and what they know about their freedoms/liberty. Clearly, those patients/clients who are unable to make a choice for reasons, such as mental illness, are protected. The terminology used (Criteria 2) may again be articulated for the patient/client, and terms such as "liberty" and "values" will require discussion.

The nurse will not be able to measure whether patients/clients fully understand the freedom of choice, but by the responsibility they accept for the final choice/decision taken (Criteria 3), it may be inferred that they have some understanding. It may be that the patient/client makes a choice which, in the opinion of the nurse is the wrong choice, or the patient/client may decide that the nurse is the 'expert' and so transfers the responsibility of the decision to the nurse (page
183). Discussion and the appropriate referrals have already been discussed (page 189).

Again it is vital that the nurse is competent and knowledgeable to make a decision as to whether to act as a patient/client advocate (Criteria 4), and to initiate strategies in the event that the patient/client makes a choice of refusing treatment or care. The nurse may need to ensure that the information communicated by the nurse on each occasion is consistent (Criteria 5), so the patient/client is not confused with differing information on each occasion.

It may be necessary for the nurse to assume the role of advocate, or trustee, in the event that the patient/client is unable to make a decision and accept the final responsibility for their care, and any decisions made for/on behalf of the patient/client must be justified.

(c) Respect for persons; Autonomy; Individual rights and notions of paternalism, advocacy and trusteeship

The notions of autonomy, paternalism, advocacy and trusteeship are the basis of many ethical principles and concepts. The nurse is required to direct care "toward the good of patients and loyalty to co-workers" which are both ways of showing this respect (Jameton 1984: 125).

Respect for persons incapsulates two main concepts. Firstly, individuals ought not to be treated as means to an end (Criteria 1), that is, patients/clients must not be exploited, and their "autonomy" or self-determination must be
respected. Any research trials or human experimentation techniques requires the patient/client to be fully informed of all the aspects concerned (page 131). What do they know about these aspects?

Secondly, the nurse is required to understand what the terms "person", "autonomy", "self-determination", "rights" "advocacy", "trusteeship" and "paternalism" mean (Criteria 2), as they have great significance for the health and the care of the patient/client. This is evidenced by the varying health care decisions that are concerned with issues such as abortion and euthanasia.

The concept of "autonomy", a non-achievable state (page 96), assumes that the patient/client is rational, able to govern their own lives, and free to express their views. For example, if a nurse should prevent a suicide it may be viewed as interfering with the patients'/clients' right to choose to take their life. Conversely, if a nurse leaves a potential suicidal individual to carry out the suicide, it may be viewed as respecting the patients'/clients' privacy, choice, or "autonomy". Both these examples may be viewed as notions of respect for the patients'/clients' welfare, and respect for their freedom to choose, respectively, and both involve the notion of paternalism (page 102), as the nurse is seen to be acting in the patients'/clients' interest. Arguably, a nurse who is concerned for the health and welfare of a patient/client may be said to be acting paternalistically, and it may be a
morally acceptable form of paternalism, that is acting in the "best interests" of the person, if a suicide attempt was averted, as a suicidal attempt/intent is not an exercise of patient/client "autonomy", but rather may be due to an underlying psychiatric disorder.

When an individual becomes ill, certain assumptions are made which undermine the patient/client "autonomy" and increase the dominant role of the nurse and further legitimise that role. These assumptions are that the individual becomes a patient by name, that patients in turn depend on the nurse for advice and care, and that the patient is obliged to comply with the advice given. This is based on the belief that only the nurse has the knowledge therefore to make the resulting decisions for the patient, and so all decision-making is relinquished to the nurse.

The patient/client is given the opportunity, therefore, to be listened to, be understood (Criteria 3), and the nurse is required to respond empathically. This clearly for the nurse means being empathic, that is, the ability to put oneself in another's place, which involves emotional and intellectual sensitivity, and a common regard for the subjective accounts of the patient/client at all times. Nurses also need to be able to justify and be challenged on any of the issues being discussed.

Clearly this collaborate approach to mutual goal-setting is based on the knowledge of competent personnel (Criteria 4), and the resulting patient/client
self-determination will include the rights (page 74) to which the individual is entitled. The ideology of patient/client "autonomy" results in rights for the individual, such as the right to confidentiality and privacy, the right to refuse treatment, the right to informed consent, and the right to die with dignity, however that may be interpreted by the individual.

Ultimately, whatever decision the nurse or patient/client takes there is consistency in the information presented (Criteria 5), across the health care team.

(d) Truth telling/Honesty/Personal integrity and informed consent

Truth telling or honesty is central to good human relations, and the nurse shares in the responsibility for telling or not telling the patient/client the truth as it facilitates more realistic goal-setting by the patient/client if all the facts are known (Criteria 1).

"Good human relations are the basis of good nursing, and that such relations ought to be based on trust"

(Sheehan 1985: 334)

The role of the nurse in the process of giving information is not clear. How much information is the nurse obliged to offer the patient/client, or entitled to tell them, and what sorts of advice can they give or withhold?
Traditionally, the nurse is only allowed to give information which has already been given by the doctor, thus any new information constitutes amplifying or re-stating the information already given by the doctor.

This definition of the nurses’ role may be unacceptable, as often doctors do not have the time to explain the procedures or their consequences to the patient/client.

The author has argued for honesty to patients/clients and relevant disclosure of information to them, and has presented relevant questions to ensure this (page 144). Non-disclosure cannot be justified simply by showing that disclosure does some harm (Jameton 1984: 175) especially when the harm cannot be measured (page 137). Nurses need to adopt an assertive stance whereby they can give information on equal terms, but in consultation with the health care/multi-disciplinary team to ensure patients/clients receive accurate information so that they may participate in health care decisions (Criteria 4). This can be asserted on several grounds. Firstly, at the core of patient/client education is the disclosure of information. Secondly, as possible advocates of patients/clients, nurses may need to prove themselves as "autonomous" entities, perhaps by gaining professional status, and the ability to disclose information as of right. Thirdly, nurses generally spend more time with the patient/client and so have more time to discuss issues, and to judge when and what to say will arise out of these discussions.
Despite the grounds described earlier, nurses still appear to doctors to be less capable of understanding and explaining the diagnosis and this raises two issues. If the nurse has less authority than the doctor then the patient-nurse relationship may be affected when a judgement has to be made by the patient/client; and how will the patient/client judge if a conflict in opinion arises between doctor and nurse.

The nurse needs to facilitate the patients'/clients' understanding of the terminology used such as "integrity", "truth telling", and "informed consent" (Criteria 2), and that the information is consistent when presented to the patient/client (Criteria 5).

Whatever the decision in truth-telling, the nurse needs to facilitate participation of the patient/client in decision-making (Criteria 3), as it is only this participation that the nurse can use to adequately infer the required behaviour.

(e) Justice, fairness and equality

Distributive justice, fairness and equality are clearly significant for the nurse on the grounds that the nurse ensures, as far as able, the fair allocation of resources for the patient/client (Criteria 1). Resources in this thesis includes time, finances, personnel, care and equipment, and in each case the nurse ensures appropriate criteria for the allocation of these scarce resources (page 151). Clear policies
and guidelines are required which are flexible enough to take into consideration the individual needs of each patient/client, that each patient/client gets equal consideration, and that the decisions and subsequent actions are justifiable. However, as not all humans act morally, and there are varying degrees of morality, the nurse may need to adopt a non-judgemental stance when a choice is taken by the patient/client.

All the terminology used (Criteria 2) in the text requires clear definitions, such as "distributive justice", "fairness", "equality", and "resources". What exactly does the patient/client know?

With the help of the nurse patients/clients may be able to identify the resources to which they are entitled (Criteria 3), and in so doing may meet their health care needs. The problems of ensuring a fair share of resources has already been highlighted (page 147).

The health care resources require a well informed competent nurse (Criteria 4), able to aid the patient/client in identifying their share of the resources, and be able to articulate for/on the patient's/client's behalf if required to do so.

Finally, consistency (Criteria 5) in the information presented is important, and this will be manifested in what the patient/client does. Nurses may need to be cognisant of the fact that the expectations of the consumer and health care-givers are increasing and ever changing, as health
care is perceived differently by nurses and patients/clients alike (pages 51-57). Any ethical action taken in the allocation of scarce resources requires justification and so the ethical enquiry which underpins the ethical decision as to how resources are to be allocated requires rigorous discussion in order to satisfy public opinion.

(f) Beneficence and Non-Maleficence

These principles are subsumed in all the other principles throughout this Chapter. The active provision or promotion of good, or beneficence, and the obligation not to harm other individuals, or non-maleficence, is an integral part of all the ethical principles (page 23). For example, in the principle of the sanctity of life the nurse is faced with weighing the potential harm against the benefits in cases of the prolongation and preservation of life, and in both cases the nurse needs to be cognisant of the "do no harm" principle.

In the exercise of liberty/freedom the nurse may need to ensure that this principle does not conflict with another principle, thus causing harm to the patient/client. It has been argued (page 91) that in using freedom rightly it may be used to promote good, such as the promotion of health, and this correlates with the principle of beneficence and non-maleficence.
In the principle of autonomy the individual may need to employ the principles of beneficence and non-maleficence as consideration needs to be given to what the patient/client wants, but the nurse has to be careful that in acceding to the wishes of patients/clients and respecting their "autonomy" that patients/clients do not come to any harm.

The patients'/clients' right to know the truth includes knowing all the benefits and the harms of the treatment proposed. Withholding the truth from a patient/client may violate the principles of beneficence and non-maleficence if the patient/client suffers as a result of the truth being withheld.

In the distribution of scarce resources in the justice/fairness principle, the beneficent and non-maleficent principle may again be violated if individuals are not given the same consideration and treated fairly.

The author now turns to the curriculum considerations.
4. CURRICULUM CONSIDERATIONS

The Ethical Analysis Model bridges the gap between theory and practice and thus the focus for intervention in curriculum planning is for nurse educators to move from theoretical considerations to the active incorporation of the Ethical Analysis Model in all nurse educational programmes. The author proposes to modify the current curriculum to include the Ethical Analysis Model, and in so doing will be suggesting later how the Ethical Analysis Model may be implemented. This includes aims, suggested teaching strategies/learning opportunities and resources, and the assessment approaches which may be employed.

**Theoretical basis for the Ethical Analysis Model**

Education is an activity which takes place at different levels, that is, in the theoretical setting and in the practical setting. Both are interdependent thus the theory of education is dependent on the practice. The theory of education is a series of directions and is not descriptive, and is an attempt to find a rationally defensible basis for educational practice, or a way to justify rational principles for practice (Hirst 1969: 29-58). Educational theory generally has a certain structure comprising a major premise or aim, a minor premise or method, and a conclusion or end. To be a valid theory it must have this structure and be well corroborated. This structure culminates in rationally justified principles for educational practice. These principles state what ought to done in a range
of practical activities. The Tyler (1950) methodological model is used to guide curriculum development in this thesis.

**Aims and Objectives**

The aims for the nurse in the use of the Ethical Analysis Framework and Model is detailed (page 187), but it is up to the facilitator/educator to develop individual objectives and learning experiences for each phase/stage in the introduction of the Ethical Analysis Model. For example, in phase/stage Four (Figure 4a) the specific objectives which will enhance the patient/client understanding of the validation criteria and the ethical constructs/components will need to be developed by the nurse and facilitator.

**Teaching and Learning Strategies**

As the author is presupposing that some ethics education precedes or is used as a foundation to the Ethical Analysis Model, then some of the teaching methods and learning strategies such as detailed in Appendix 9 may be utilised in this Ethical Analysis Model.

**Assessment Approaches**

For the purposes of research Schools of Nursing may need to know what factors are said to influence the application of ethical principles, such as the concern the nurse may demonstrate towards patients/clients in respecting their rights. The facilitator introducing the Ethical Analysis Model may also need to know the performance of the nurse in applying the Model (Figure 4c). Thus it becomes important to know the content to be assessed and the assessment techniques.
Hard quantifiable data and statistical results are not appropriate in ethics education on two grounds. Firstly, ethical principles cannot be measured, and secondly, by reason of the predictive nature of these assessment techniques the results fail to clarify distinct characteristics or the reason for certain behaviours.

The author has already outlined assessment techniques and their limitations in ethics education (Rodmell 1985: 117-118) in the cognitive and affective domains. Some of these include ambiguity in definitions and interpretations used in assessment, and the difficulty in assessing rational behaviour and the individual's reasons, rules and principles underlying the action. The results may only be induced or inferred, especially if the behaviour to be assessed is specified.

The evidence suggests that a holistic approach, such as one which appraises the teacher, the learner and the situation, be adopted. For example, the use of competencies to evaluate behaviour and reactions in situations may be used, and this is detailed later.

The author now turns to the implementation guidelines:-
5. **IMPLEMENTATION GUIDELINES FOR PRACTICE**

The author now presents the implementation guidelines for the Ethical Analysis Model proposed by the author (Figure 4c).

For convenience and clarity sub-headings will be used.

(a) **Educational strategies**

(i) **Assessment perspectives**

The educational perspectives cannot be addressed nor can they be materialised unless all those nurses responsible for the supervision of staff and students assume a facilitator role, or act as role-models in the clinical advising of these individuals in the Ethical Analysis Model. In order for the Ethical Analysis Model to gain acceptance it is important that the environment and the attitudes are appropriate (page 24). This can only be achieved by discussions with staff at all levels using the knowledge nurses have of implementing change. In addition, an assessment of need for the Ethical Analysis Model is required, and this is now detailed. This assessment is a requirement in all settings whether it be hospital or community.

**Assessment of need for the Ethical Analysis Model**

A clear assessment of the needs of these individuals is made as to:

i) **Why**, that is, the rationale underlying the Ethical Analysis Framework and Model. In other words, why is this Model needed?

ii) **What**, that is, the knowledge base that is required to facilitate the introduction of the Ethical Analysis Framework and Model, advocated by the author (Figure 4a and 4c). What are the aims for the nurse in the use of the Model (Figure 4c)?
iii) Where, that is, the setting in which the teaching will be carried out, and what resources are available.

iv) How, that is, the teaching methods to be used, and the benefits/advantages and disadvantages to patient/client, the nurse and health care team, and any improvements in standards and quality of care.

v) When, that is, the timing of the sessions and the exact placement in the curriculum where the teaching will occur, both in the pre-registration and post-registration and continuing education/professional development programmes. A clear implementation programme will need to be developed.

vi) Who, that is, the nurse facilitator, educator or theorist who is very familiar with the use of the Ethical Analysis Framework and Model and can apply it to differing situations.

It may enhance the introduction of the Ethical Analysis Model if all concerned fully understand the strategies and rationale so that continual reinforcement and consolidation of material is occurring in all scenarios.

(b) Teaching strategies, learning opportunities and experiences

The teaching methods or strategies to enable understanding of the Ethical Analysis Model will be derived from the discussions of the rationale, purposes/aims and objectives of the material to be presented in the assessment phase. These will obviously vary to achieve the goals intended. As already mentioned (page 214) each facilitator/educator using the Ethical Analysis Model will set the goals for each phase/stage within the broad framework provided.
Any teaching strategy (Appendix 9) such as group discussions, seminars, lectures, and role-playing and role-taking, will require thorough preparation as timing and the degree/depth of information imparted is of utmost importance in increasing motivation for the effective utilisation of the Ethical Analysis Framework and Model (Figure 4a,4c). However the Ethical Analysis Framework and Model is presented, then the clarity and simplicity of the Model are stressed, the benefits to patient/client, and the possible improved standard and quality of care.

(c) Evaluation of the Ethical Analysis Framework and Model

Whatever tool is used to improve, expand, or heighten the awareness and the learning potential of the individual, will vary, and every effort by nurse facilitators/supervisors will be made to:

(i) Ensure participation of individuals in the educational setting using tried and tested techniques such as enquiry-based, information-based and creative methods such as experiential, awareness and/or skills training/modelling as in role-playing and role-taking, as advocated by Davies and Gibson (1967: 40). This may increase the individuals understanding of the Ethical Analysis Framework and Model, using a facilitative model and a model based on the concepts of andragogy. Andragogy is the "ideology about teaching and learning
with adults that may lead adult educators to produce an environment that enhances adults' learning processes" (Jarvis and Gibson 1985: 46).

(ii) Ensure understanding of the Ethical Analysis Framework and Model (Figure 4a, 4c) by the presentation of case studies and role-playing and role-taking in a controlled setting with a facilitator present. Individuals are afforded opportunities to share clinical experiences, to share their knowledge of current research, published and unpublished. This heuristic strategy is aimed at discovering knowledge, rather than verifying it, otherwise "ecological fallacies" arise, that is, trying to infer something about the behaviour of one individual or group, of analysis from the observed behaviour of another individual or group (Robinson 1950: 351-357).

(iii) Observe the nurse-patient/client interaction to ensure the Ethical Analysis Framework and Model (Figure 4a, 4c) is being utilised effectively and confidently.

Participation in the use of, understanding of, and interaction in the use of the Ethical Analysis Model may only be judged by the inferred behaviour of the individuals concerned (page 200). It may be that the use of a set of competencies whereby nurses and facilitators rate themselves in situations, or are rated by others in the health care team, in their competency in skill related to practice may prove beneficial. For example, the skill, such as whether the nurse upholds the
confidential rights of patients/clients in given situations would be graded. The nurse judges or is judged on that graded hierarchy, and moves up the levels as competency in the skill improves.
6. **THE ETHICAL ANALYSIS MODEL: THE IMPLICATIONS FOR RESEARCH, EDUCATION AND PRACTICE**

**INTRODUCTION**

As an assessment for the future the author now wishes to examine the implications nationally and locally for research, education and practice. These implications may serve to highlight the problem areas which may occur in the implementation of the Ethical Analysis Model proposed by the author.

For convenience and clarity sub-headings will be used.

1. **NATIONAL LEVEL**

a) Research, Education and Practice (Policy implications)

i) **Statutory Policy statements**

Specific guidelines may need to be issued from Statutory organisations such as the United Kingdom Central Council (page 79) and the English National Board (page 79) to guide curriculum content and programme development/curriculum planning. The author hopes to translate these guidelines into nursing education philosophy, the philosophy of nursing, and the philosophies of nursing models. Further to this, ethics education discussions may need to form part of the Statutory requirement for continuing nursing practice and incorporated into Statutory refresher courses.
ii) Union organisation policy statements

The Royal College of Nursing Professional Services Committee has reaffirmed its commitment to improving the practice of Nursing, in particular in the awareness of patient's/client's rights arena (Gartside and Wright 1987: 5). The six main themes include the patient's/client's right to:

1. Skilled nursing to meet his needs, working in partnership with him to achieve health and happiness.

2. Know how and why he is being treated and what is being done to help him and what alternatives are available.

3. Be given enough information and skills, in language he can comprehend, to enable him to be as independent of nursing as possible in health care.

4. Have choice in his care, with the obligation that nursing will give him knowledge on which to base a rational decision.

5. Be treated as an individual and accorded respect, dignity and equal quality of care regardless of age, sexual orientation, religion, race or beliefs.

6. Have total nursing support with the nurse acting as his advocate and in his "best interests" when he is unable to make such choices himself.

These rights are made explicit on admission to hospital to both patient/client and relatives. However, these rights are controversial on the grounds that the dilemmas that arise for
the nurse are not easily solved. For example, the right to have a choice in care (item 4) is paramount, but what decisions are made when the patient/client refuses a choice because care is rejected. In addition, anecdotal evidence suggests that what "ought" to happen and what does happen in practice, that is, the reality gap, is of continuing concern, and clarification may be required before use can be made of these guidelines for practice. It has already been argued (page 124) that nurses may need some training in advocacy roles. This question of rights may imply that the nursing philosophy be created by team staff in the clinical or community setting, and not imposed from some hierarchical nursing structure above this practical setting level.

(iii) **Specific Policy statements**

Statutory organisations may need to issue specific policy statements explicitly stating the role and training of nurse advocates, including advice on how to handle suspected malpractice by colleagues may be required. The National Association of Health Authorities (NAHA) in England and Wales (1985) has already issued guidelines for handling staff complaints, and the subsequent investigations and support to patients/clients, complainants and accused.

In addition to this, appropriate policies which reflect the proper selection of an ethical nursing model may be required, and the use of an ethical model such as advocated by the author (Figure 4c) is suggested.
More strict adherence to the Research policy statements regarding patient/client experimentation (Appendix 6) and informed consent may be required, and monitoring of this by the Ethics Committee at a National and Local level may be required.

Some guidance for nurses in their role of aiding in research is required.

b) Research implications

(i) Nursing Research experiment candidates

The patient/client requiring advocacy is usually a vulnerable individual, for one reason or another, and it would therefore be unethical to use these individuals in research techniques, as in drug trials, as their rights may not be protected by informed consent.

Patients/clients who are unable to give their own informed consent may not to be used as research subjects, if other subjects can be used. Clearly, the less able patients/clients are at protecting themselves, the more vigilant the nurse becomes in protecting them.

A critical look at the mandate for nursing and the ethical and legal implications could be the forerunner of the research, which may prove that the nurse might encompass the informing and supporting role of the patient/client advocacy and leave the pleading of their cause in their "best interests", whatever they may be, to other health care professionals.
(ii) Future Research

Future research in ethics may require the nurse to have a basic knowledge of ethics before research in this area is undertaken. The type of research will be detailed later.

(iii) Ethical Committees

Based on the need to improve the skill of the nurse in applying ethical principles, it may be that a National body to whom the local ethical committee can refer, and who is responsible for detailing the terms of reference and membership status of the local committees will need to be formed. It would also have a watchdog/monitoring and research remit. This may already be the role of the recently formed Standards and Ethics Group of the United Kingdom Central Council, but to date their terms of reference have not been published (page 34). All nurses could be afforded the opportunity of attending national ethical committee meetings in order to improve their understanding of the national machinery.

c) Education implications

(i) Nurse teacher and specialist training

Nurse teacher training courses may be required to incorporate the experience of recognising ethical dilemmas in all settings; utilisation of hypothetical situations using critical incident techniques and discussion; a knowledge of the remit of all support groups such as Ethical Committees; a knowledge of teaching ethics by way of such methods as case studies, or the use of an ethics education model such as the
Moral Education Model proposed by Rodmell (1985: 119-131) in a Masters Degree dissertation; and utilisation of the Ethical Analysis Framework and Model proposed in this thesis (Figures 4a,4b,4c).

(ii) Theory development

It has emerged that nursing models appear to be deficient in ethical principles and so nurse theorists may need to look to developing nursing models for the future which give greater emphasis to the philosophical content.

(iii) Health Education/Prevention

As health education/promotion now has primacy in nursing, recently emphasised by the World Health Organisation (WHO) dictum "Health for all by year 2000", (1984) then nurses may need to concentrate on anticipating the needs of patients/clients, as is their right, identify the vulnerable individuals, and by so predicting these vulnerable groups, then appropriate and timely intervention can reduce the need for advocacy in crisis situations.

(iv) Ethics education

The study of philosophy for nurses seems to have been borrowed or adapted for specific usage in nursing, and many misunderstandings and misinterpretations have occurred at the expense of the philosophers original meaning or thoughts. This may be due to a lack of ethics education, or it may be due to poor critical analysis skills. Nursing theorists have built their nursing models on these sometimes misunderstood
foundations, and it is these weak foundations on which it is purported that nursing care is directed.

d) **Clinical/Practice implications**

The implementation of the Ethical Analysis Model has implications for staff in the clinical and community setting. It may require changes in attitudes, and further skills training, such as in communication techniques, to effect the Model (Figure 4c).
2. **LOCAL LEVEL**

a) **Research implications**

(i) **Policy statements**

The National Research policies will be disseminated to local settings in the hospital and community, and these policies will be effected locally. This may require researchers to record and utilise research findings by demonstrating that the use of ethical models of care may contribute to improved communications and relationships with the patient/client, improved standards of care, and the securing of the patients'/clients' and nurses' rights. The results of the research may prove to be negative, and so nurses may have to search for other ways to improve patient care standards. This may require a look at consumer surveys, patient satisfaction questionnaires, and audit techniques used in evaluating, for example, the quality of nursing intervention. Such approaches link practitioner involvement with quality improvement.

(ii) **Ethical Committees and future research**

Research at a local level is required and monitored by the national group. Such research may include research into ethics educational theory and how principles are applied in the clinical settings; the effectiveness of the utilisation of the Ethical Analysis Model advocated by the author in this study; the role and contribution of nurses in Ethical Committees; and the nurse-patient/client interaction when ethical dilemmas arise.
b) **Education implications**

(i) **Ethics education**

It would seem appropriate to suggest that nurses who intend to embark upon any aspect of theorising for other nurses, ought firstly to study, discuss, debate, analyse, and simplify philosophical intentions with philosophers of some repute, or with medical and nurse ethicists with an applied knowledge of ethics and ethical theories, and to continue to do so once they have utilised the ethical theories. It is this constant dialogue which gives credence and credibility to the professional, and which enhances the professional’s chance at being a recognised authority in their chosen field. Further to this, continued debate increases understanding, adds to the body of nursing knowledge, and so keeps abreast of the societal and ethical changes as they occur.

(ii) **Continuing education**

Provided the Statutory requirements are explicitly stated then it may be necessary for all nurses to keep abreast of current developments in ethics education. It may be that this will form part of the Statutory refresher programme or part of the hospital or community post-registration or Continuing Education programme, or both. These programmes may need to incorporate specific workshops on change strategies and attitude training.
Highly developed communication skills are required, as providing answers to patients'/clients' questions is not enough. Some patients/clients do not know what questions to ask.

Accepting the role of patient/client advocate requires a professional assertive (page 123) stance, whereby the quality of care and the rights of these individuals and public accountability outweighs loyalty to the internal bureaucracy. For the Ethical Analysis Model to be accepted the need has to be identified and this may only be possible if there are the appropriate attitudes and an environment which fosters enquiry.

c) Practice implications

(i) Clinical perspectives

Kippels and Perry (1978: 107-108, 110) has already suggested alternative models of advocacy in specially appointed independent counsellors or hospital administrators, and with the increasing threat of litigation in the United Kingdom the need for a Bill of Rights for patients/clients, students and qualified nurses is urgent. Alike the American Hospital Association Patients' Bill of Rights (Appendix 5) it must include rights to considerate and respectful care, to complete current information, confidentiality, and to reasonable continuity of care. It may be that to facilitate most of these changes restructuring of the patients'/clients' day in hospital may be necessary.
The speciality areas will now be discussed:

**Primary care**

Education of the public about the role of the nurse as patient/client advocate is of paramount importance, utilising the media as a source of information.

**Terminal illness and care**

Advocacy for the terminally ill is a central part of palliative nursing care, in the absence of a cure. The quality of life for the dying patient/client, improving the act of dying, and the environment in which the individual will choose to die, is well within the remit of the nurse and care-givers and may be improved with patient/client advocacy. The nurse may well be advocating for an unconscious individual and may be required to articulate the previously discussed verbal and/or written views of the patient/client and family. It is crucial that the "best interests" of the patient/client be served.

(ii) **Nursing Process implications**

The effectiveness of the care delivered at the bedside may be increased if explicit contracts are agreed during the assessment phase, provided the patient/client is competent, that is, rational and capable, so to do. The agreement would include the identifying of expectations (page 174) flexible enough to allow for behavioural changes when continuous review and evaluation occurs.
The agreement incorporates all the five elements as outlined in the goal-setting process of the Nursing Process (page 37), such as who is to undertake the desired outcome/behaviour; the actual behaviour; the relevant conditions or circumstances, level of assistance required to undertake behaviour, and where it is to be performed; the standard or criteria for success; and the timing, that is, when the agreement starts, review and outcome dates. These five elements are realistic or achievable and simple, that is, within the capability of the patient/client to perform; comprehensive or easily understood by all; measurable, that is, those concerned in deciding if the outcome has been realised must be able to observe the specific behaviour. It is preferable that the goals or agreements are written, so the health care team participating are aware and involved in realising the mutually expected goals. It also implies a commitment, as each patient/client agreement is specific to that individual.

The review or evaluation of the goals must be renegotiated if circumstances change and the patient/client and relevant health care team members must be involved and informed.

In the case of a child, or a patient/client who is unable to participate in decision-making, such as a mentally ill individual, then an advocate may be appointed for and on behalf of the patient/client, or a trustee may already be cognisant of what has to be done.
This approach to mutual goal-setting facilitates the advantage of making the patient/client and/or their trustee/advocate/family responsible for health care, and according to Wallace (1987: 34) "reduces unwarranted demands on staff .......... and the apparently manipulative behaviour of patients, and force staff to plan treatments and communicate aspects of treatments to all concerned ...... and provide an opportunity for the collection of objective data".

Ostensibly, it is the assessment process that is of paramount importance in sensitively interpreting or translating the facts communicated to the nurse from the patient/client and/or relative. Through identifying the problem, measuring the depth or scale of the problem, clarifying the pattern of the problem and any variances, explaining or judging the meaning of the problem, is the problem structured and given shape. The method of assessment is patient/client-specific and embodies all the communication skills of observation, listening, and clarification, in an effort to enable the patient/client to express, where possible, their own image, and not that of the nurse.

(iii) Nursing model perspectives

Future nursing models used by nurses to set standards of care and on which practice is based or guided, will need to include validation criteria such as in the Ethical Analysis Model advocated by the author (Figure 4c) to ensure the basic human needs of all patients/clients are being met and their rights are respected.
Kitson (1987: 2) in addressing the Research Society emphasises the need to include patient autonomy, recognition of the need to respect the individuals dignity, whether their environment is aesthetically pleasing, and an attempt to measure the quality of the life of the patient/client, by comparing their admission life-style with their discharge or post-discharge lifestyle.

The choice of a nursing model plays an important role in this Model advocated by the author (Figure 4c). Choosing a nursing model whether it is derived deductively, that is, a theoretical model, or inductively, that is, a conceptual model is measured against its social usefulness, significance and congruence (Johnson 1974: 376). Johnson's (1974) criteria for evaluating a nursing model is useful, and addresses three questions. Firstly, will educators, researchers and nurse practitioners find the model clear and complete enough to utilise in curriculum planning, identifying research problems and providing nursing care. Secondly, will the model make a significant impression to benefit nursing; and thirdly, does society expect the kind of nursing suggested from the model.

Smith (1982: 120-121) has noted the relationship between nurse training and actual nursing practice highlighting that models tended to be selected to support the prevailing beliefs about nursing functions, and curriculum are subsequently devised. This would seem to be in keeping with the inductive approach to the development of a conceptual model which purports to arise from practice.
Adam (1983: 41) and Aggleton and Chalmers (1986: 4-10) have also advocated guidelines for building and choosing a nursing model respectively. What has emerged for consideration is that these theorists have common themes. Clearly the model must be appropriate for understanding the particular patients/clients and their needs. If the assumptions, values, and beliefs about nursing in the nursing model are explicitly stated, are reasonable, that is, acceptable to the patient Darbyshire (1987: 28), are amenable to verification by other nurse theorists, reflect the value system of a larger society that nursing serves, then, according to Adam (1983: 44), these elements are the building blocks of a nursing model. Moreover, if the ideal and limited goals of nursing are stated, such as broadly, to promote health and prevent health problems or educate to adjust to those problems which are difficult to alleviate, but discrete enough to distinguish the contribution from that of other disciplines, then the concepts are further consolidated.

Furthermore, if the beneficiaries of nursing are identified and viewed as bio-psychosocial individuals, and considers the spiritual/religious, political and economic aspects of these individuals; the social role of the nurse is defined; the source of patient/client problems identified; the focus and mode of nurses intervention and the intended consequences of nursing care are explicitly stated, then these "building block" elements will be formalised into a theory.
Thus this "cohesive supportive linkage of selected, interrelated concepts" (Santora 1980:3) provides the basic structure for the curriculum.

Aggleton and Chalmers (1986: 105) have offered clear guidelines to ensure that following selection of a model the nurse must evaluate how well it has fulfilled the expectations. For example:

(a) Did the nursing model provide guidelines on assessment that enable the patient's problems to be clearly identified?
(b) Did the planning of care and the setting of goals match the patient's expectation of care?
(c) Did the model suggest a range of nursing interventions which were practical in that particular care setting?
(d) Did the nursing interventions carried out enable the nurse to provide a standard of care acceptable both to her/himself and the patient?

(Aggleton and Chalmers (1986: 105)

The author would add one further guideline:

(e) Does the nursing model enable the rights of the patient/client to be identified, clarified, and their choices determined?

(iv) Role-modelling in the clinical setting

As in any new experience or learning situation role-modelling by peers will enable positive attitudes towards patient/client and a resulting improvement in the delivery of care.
Preparation of the health care team in the clinical setting

The nurse theorist/supervisor/facilitator must expect some resistance to the concept of the Ethical Analysis Framework and Model as an inevitable phenomena which occurs when change is imminent. To this end, a knowledge of change theories and coping strategies may be built in so that eventually with practice and increasing experience, the utilisation of the Ethical Analysis Framework and Model proposed in this thesis (Figures 4a,4b,4c) becomes a familiar and effective tool in the everyday life of the practitioner.

Supervision/Support systems

Because of the transient or constantly changing nature of the nurses work, whereby nurses move between wards/units/departments, and hospitals, then it is essential that the nurse at the bedside and in the community, be supervised in ethical decision-making, and be aware of and have access to the support systems available locally. Supervision is not intended "to measure success ........ but rather to raise open-ended questions ........ to develop insight into the skills and qualities" (Rodmell 1985: 140-141) required and possessed.
SUMMARY

This Chapter presented an Ethical Analysis Model for practice which will aid nurses in utilising and applying ethical principles when models which guide nursing practice are used.

As nursing is an interdependent discipline with ethical relationships, the mutual expectations between nurse and patient/client were examined and it emerged that reciprocity of commitment is essential for the nurse-patient/client relations, in a climate of cooperation and freedom. Clearly the "expert" knowledge with which the nurse is invested may be exercised in an environment whereby both nurse and patient/client are fully cognisant, informed and able to make rational decisions for the shared responsibility (page 27) of the outcome of the patient/clients health status. If these mutual expectations (page 174) are met or are congruent then a mutually rewarding experience for patient/client and nurse evolves. Evidence was presented as to the contractual agreements being currently practised, whereby nurse and patient/client interacts successfully (page 175) to achieve the agreed desired behavioural outcomes. Models, such as the engineering, priestly and contractual models were outlined to demonstrate varying viewpoints of how nurses structure their nurse-patient/client relationships.
Consideration was given to the individuals or ethical agents involved in the Ethical Analysis Model. The essential elements and phases of the Ethical Analysis Framework and Model (Figures 4a, 4b and 4c) were presented in detail and the author makes clear that it is only one method of guiding action that may need to precede the choice of a nursing model, if greater consideration to the inclusion of ethical constructs/components are to be ensured in the content and delivery of nursing care. The four basic elements or assumptions that of autonomy, mutual interaction, validation and shared responsibility were detailed to ensure that mutual expectations and interaction are realised. In this way consumer needs may be effectively met. These elements/assumptions were set against the background of the cognitive, affective and effective domains. The phases of the Ethical Analysis Framework (Figure 4a and 4b) and its utilisation are self-explanatory.

Finally, the guidelines for implementing the Ethical Analysis Framework and Model were presented and it was seen that the enthusiasm engendered and the motivation required is necessary if full commitment to the Ethical Analysis Model is to be realised.

The author now turns to the conclusions, and raises discussion and recommendations for the thesis.
"Experience without theory is blind, but theory without experience is mere intellectual play"

Kant,
1781.
CONCLUSIONS AND RECOMMENDATIONS FOR THE THESIS

INTRODUCTION

This thesis has presented a new ethical model to encourage the safeguarding of patients'/clients' rights and nurses' rights by improving the process of the application of ethical principles. It provides a basis for further debate in ethics education and the decision-making skills required in ethical dilemmas. In so doing the implementation of the Ethical Analysis Model may be effected in pre-registration and post registration and continuing education programmes/curriculae, and may prove to provide more sensitive nursing care.

Firstly, the author identifies the general conclusions of the study, followed by the specific conclusions that emerge from each chapter; secondly, the recommendations are presented, and finally dissemination of the findings are discussed.
FINDINGS AND CONCLUSIONS

This study has shown that in the present system of nurse education and practice in England there is a case for the introduction of an Ethical Analysis Model, as advocated by the author, as it may enhance the application of ethical principles.

The data strongly emphasises the need for a partnership approach between nurse and patient/client, nurse education and clinical staff, nurse and medical staff, and nurse and para-medical staff. This will hopefully aid in the utilisation and eventual acceptance of the author's proposed model.

There are many factors, such as the ethical perspective of nursing, the ethical knowledge base of nursing, and research influences which indicate a case for the application of ethical principles in the clinical and community setting. As ethics education is a recent phenomena in nursing education curriculae, nurses may need to reconcile their approaches to results which are appropriate in integrating the application of ethical principles in their daily lives.

It has emerged from this study that it may only be possible to utilise the Ethical Analysis Model within a philosophical framework, such as one which gives consideration to the patient/client as a rational, self-determining agent capable of understanding, where possible, and making informed decisions.

Certain principles may be asserted if applied ethical principles are to be utilised in the clinical and community setting. It is clear that all nurses and patients/clients may
need to be involved, certain strategies or approaches used, and guidelines for the implementation of the model have been made explicit (page 219). From the arguments presented it would seem that the Code of Professional Conduct (Appendix 1) may be limiting for the future. It has emerged that nurses who do not adhere to this Code may be disciplined (page 61) and this may have implications for nurses in the wider legal setting. The present reliance on the Code may give nurses a false sense of security when exposed to criminal or civil action.

The author now proposes to examine the conclusions which arise specifically from each chapter.

Chapter Two investigated the issues which contribute to the development of the Ethical Analysis Model, in the absence of ethical constructs/components in current nursing models which are reputed to guide nursing practice.

The author concluded that a knowledge of ethical theories are important if the ethical choices to be made are to be grounded in theory and reasoned argument. Ethics is concerned with how the individual uses morality in life situations, and three concepts which serve as a philosophic foundation for nursing ethics knowledge emerges for consideration. Firstly, the Code of Ethics for nurses which guides ethical standards; secondly, the formal agreement or contract which outlines the parameters for ethical practice; and, thirdly the context in which the ethical standards and practice occurs. The author concludes that the conflict with the nurses Code of Professional

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Conduct (Appendix 1) which results in the nurse’s blind obedience to the Code at the expense of acting unethically towards the patient/client may also be at the expense of the nurse’s personal and professional integrity.

The characterisations, mind-sets of nurses or how health care is perceived by nurses, have clear implications for ethical practice, though this is only one theory. The first three mind-sets on views of health care demonstrated that nursing practice which is congruent with the goals of employing authorities, doctors, or patients/clients is seen to be engaging in demeaning and limited ethical practice, as it uses other individuals as means to an end. The fourth mind-set or characterisation, which focuses on the responsible and accountable nurse, does not give any consideration to care receivers/givers as means to the ends of others, and thus creates a paradigm for ethical decision-making and practice. From the varying interpretations of human rights can be drawn two conclusions. Firstly, not enough consideration has been given to closing the reality gap between concern for the patients’/clients’ rights in the theoretical setting and the clinical setting; and secondly, often the nurses’ rights are sacrificed for the patients’/clients’ rights. The author concludes that the implementation of the Ethical Analysis Model may help the nurse and patient/client to bridge this reality gap and to give consideration to the rights of both nurse and patient/client alike.
Chapter Three revealed that nurses are faced with interdisciplinary team decision-making that characterises the use of advanced health care technology and are often faced with the ethical conflict involved in balancing potential benefits against potential harm. A judgement is required as to who exercises rights, bearing in mind the mental and physical capacity of the patient/client. This research/study has tried to identify a method of identifying the relevant ethical principles and how they may be applied.

By their very nature not all ethical dilemmas can be clarified, as often moral principles do conflict, as in the principle "tell the truth" versus "do no unnecessary harm", and there are obvious difficulties when some principles take precedence over others. It may be important therefore, for nurses to recognise that these principles are culture-bound and even vary between social groups within a culture or sub-culture, and that conflict arises when patient/client priorities are not the same as the nurse.

Discussion on the preservation, sanctity or valuing of life principle (page 84) revealed that decisions reached by nurses would depend on the moral judgement of each individual but only following rigorous debate and reasoned argument. The nurse is still left with the conflict of respecting patient/client "autonomy" and respecting the moral imperative of not killing, and together with the ordinary and extraordinary means principle (page 165) it is concluded that the preservation of life will
depend on the degree, outcome, relevance and worthwhileness of that life. The concept of liberty or individual freedom (page 90) embodies the notion that individuals make choices based on their values, and the nurse must therefore be prepared to accept the responsibility for the resulting consequences.

The honesty or truth telling (page 128) inherent in communicating on a daily basis is fundamental to ethics. The arguments for telling the patient/client the truth outweighs not doing so, in order not to violate their rights. In daily practice arguments may be advanced for deception and examples may be provided for justifying deceit, especially if the end result is a utilitarian (page 53) view. However, the author concludes that the important issue is that what each patient/client wants in a particular situation must be facilitated by the nurse if the nurse-patient/client relationship is to be based on trust. The overlap of the role of the doctor and nurse in informing the patient/client of their diagnosis remains an emotive issue as both are accountable to the patient/client for care given. However, the author concludes that clarification in terms of the ethical position, is required from the relevant Statutory bodies which gives the nurse equal authority with the doctor, and less of a deferent role, so that information neglected, consciously or otherwise by the doctor, may be supplemented by the nurse. The parameters of information to be given to the patient/client would have first been discussed with the health care team.
The principle of distributive justice (page 146) was examined and conclusively the author believes that the competitive aspect between need and merit is problematical, and the varying interpretations of the acts and omissions doctrine revealed that double standards are practised. Procedures for resolving these problems may be within the remit of Ethical Committees, and may require a universalising of standards and justification for the actions taken.

In Chapter Four, the Ethical Analysis Model was presented to ensure the application of ethical principles in the clinical and community setting. It emerged that collaborative systems of care which support the personal preferences and values of the patient/client may be realised or effected with the utilisation of the Model. A major tenet of the Ethical Analysis Model presented by the author (Figure 4c) is that through discussion the nurse and the patient/client can arrive at a compromise, or a congruent view. If this is not possible then nurses ought not to impose their views or values on the patients/clients, but rather will need to decide the relevant action, which may be to act as advocates or trustees to enable realistic outcomes which are in the "best interests" of the patients/clients. However, this behaviour would have to be justified.

The increasing use by nurse education programmes in integrating nursing models into their curriculum, which reflect the philosophies of the institutions and of learning, may provide
a sound basis for curriculum content and learning strategies. Similarly, in the clinical and community setting a nursing model can improve the nurses' practice by facilitating the organisation of observations and the interpretation of data.

It will be assumed that the choice of nursing model selected to give the required purpose and direction to nursing care, and which aids in the organisation of observations and interpretation of data, will facilitate the discipline to emerge as a "profession". To date, this has not been the case but the author believes that if philosophical content is introduced or supplemented to these nursing models, then more sensitive nursing care may emerge. This can only happen if consideration has been given to the congruency between the values and assumptions inherent in the selected model, and the philosophies of the nursing school, learning, and course purpose.

However meaningful the selected nursing model may appear, and however meaningful the assessment phase of the Nursing Process (page 37) is, it requires the nurse and the patient/client to identify their expectations, so that care can be effectively and realistically planned, with all the knowledge concerned, and which is acceptable to both participants in the interactive process. The realisation of the Ethical Analysis Model is dependent on a number of factors such as the attitudes and derivation of the morals of both nurse and patient/client, the needs of the individual, the resources available, and the competence, motivation and skill of the health care team.
The author does not accept that ethics in nursing is simply applied ethics or the application of philosophical principles to the ethical dilemmas that arise. Rather it is a complex relationship between the ethical principles in nursing practice and philosophy; the formation and meaning of theories; and the nature of philosophical debate.

**RECOMMENDATIONS**

Changes in nursing curriculae are taking place to accommodate past and present innovations in health care, so it would seem appropriate to reflect these changes in the way nurses are taught.

In order to link the theory to practice, that is, the application of ethical principles in the clinical and community setting, and to encourage nurses and patients/clients to share in the responsibility, where possible, for their own health care, the following are recommended.

That:

1. The Ethical Analysis Model, or a similar model, be incorporated into pre-registration, post-registration and Continuing nurse education programmes.

2. The Ethical Analysis Model, or similar model, be implemented.

3. Research proposals in ethics form part of post-registration and Continuing nurse education programmes.
DISSEMINATION OF FINDINGS

As outlined in Chapter One (page 22) the author proposes to submit the Framework and Model from this thesis (Figures 4a, 4b, 4c) to the United Kingdom Statutory bodies for consideration in national curriculum guidelines. Further to this the author intends to bring this study to the attention of the Ethics Advisory Sub-Committee of the Royal College of Nursing, the Nursing Professional Services Committee of the Royal College of Nursing, the Department of Health and Social Service (Research Abstracts), and the Standards and Ethics Group of the United Kingdom Central Council.

Copies of this study will be submitted to the Royal College of Nursing (Steinberg Collection); the Regional Office of the World Health Organisation/Pan American Health Organisation (WHO/PAHO), Commonwealth of the Bahamas; and the University of the West Indies (Mona Campus), Jamaica.

In her new job as Educational Consultant/Curriculum Specialist the author proposes to recommend and utilise the Ethical Analysis Framework and Model for implementation and clinical practice in hospitals and community settings. This will include formative and summative evaluations of the proposed Ethical Analysis Framework and Model in this thesis.

The author also hopes to disseminate the work done in this study to nursing periodicals nationally and internationally.

F.E. RODMELL
MSc SRN RCNT RNT
APPENDIX
UKCC : Code of Professional Conduct for the Nurse, Midwife and Health Visitor (1984) .......... 1

Moral Education and Identification
(Moral reasoning) .......................................................... 2

American Code of Ethics ................................................. 3

Royal College of Nursing : Association of Nursing Students Bill of Rights ................. 4

American Hospital Association Bill of Rights .......... 5

Declaration of Helsinki .................................................. 6

Hippocratic Oath ............................................................. 7

Declaration of Geneva ................................................... 8

Teaching and Learning Strategies ......................... 9
Each registered nurse, midwife and health visitor shall act, at all times, in such a manner as to justify public trust and confidence, to uphold and enhance the good standing and reputation of the profession, to serve the interests of society, and above all to safeguard the interests of individual patients and clients.

Each registered nurse, midwife and health visitor is accountable for his or her practice, and, in the exercise of professional accountability shall:

1. Act always in such a way as to promote and safeguard the well being and interests of patients/clients.

2. Ensure that no action or omission on his/her part or within his/her sphere of influence is detrimental to the condition or safety of patients/clients.

3. Take every reasonable opportunity to maintain and improve professional knowledge and competence.

4. Acknowledge any limitations of competence and refuse in such cases to accept delegated functions without first having received instruction in regard to those functions and having been assessed as competent.

5. Work in a collaborative and co-operative manner with other health care professionals and recognise and respect their particular contributions within the health care team.

6. Take account of the customs, values and spiritual beliefs of patients/clients.

7. Make known to an appropriate person or authority any conscientious objection which may be relevant to professional practice.

8. Avoid any abuse of the privileged relationship which exists with patient/clients and of the privileged access allowed to their property, residence or workplace.

9. Respect confidential information obtained in the course of professional practice and refrain from disclosing such information without the consent of the patient/client, or a person entitled to act on his/her behalf, except where disclosure is required by law or by the order of a court or is necessary in the public interest.

10. Have regard to the environment of care and its physical, psychological and social effects on patients/clients, and also to the adequacy of resources, and make known to appropriate persons or authorities any circumstances which could place patients/clients in jeopardy or which militate against safe standards of practice.
11. Have regard to the workload of and the pressures on professional colleagues and subordinates and take appropriate action if these are seen to be such as to constitute abuse of the individual practitioner and/or to jeopardise safe standards of practice.

12. In the context of the individual's own knowledge, experience, and sphere of authority, assist peers and subordinates to develop professional competence in accordance with their needs.

13. Refuse to accept any gift, favour or hospitality which might be interpreted as seeking to exert undue influence to obtain preferential consideration.

14. Avoid the use of professional qualifications in the promotion of commercial products in order not to compromise the independence of professional judgement on which patients/clients rely.

NOTICE TO ALL REGISTERED NURSES, MIDWIVES AND HEALTH VISITORS

This Code of Professional Conduct is issued by the United Kingdom Central Council for Nursing, Midwifery and Health Visiting.

It is issued for the guidance and advice of all registered nurses, midwives and health visitors.

Further explanatory notes, discussion papers or comments on specific points in the Code of Professional Conduct may be issued by the Council from time to time.

The Code will be subject to periodic review by the Council.

The Council expects members of the profession to recognise it as their responsibility (as well as the Council's) to re-appraise the relevance of the Code to the professional and social context in which they practice.

The Council will welcome suggestions and comments for consideration in its periodic review of the Code of Professional Conduct.
<table>
<thead>
<tr>
<th>STAGES</th>
<th>CHARACTERISTICS</th>
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<tr>
<td><strong>LEVEL 1:</strong> Preconventional moral reasoning</td>
<td><strong>STAGE 1:</strong> Egocentric viewpoint. (obedience) Lacking in insight. Follows rules to avoid punishment.</td>
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<td><strong>STAGE 2:</strong> Awareness of conflicts of opinion and interests. Begins to compromise because &quot;right&quot; is perceived as an exchange that satisfies others interests.</td>
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<td><strong>STAGE 3:</strong> Begins to fulfill others expectations and enjoys &quot;being good&quot;, i.e. showing concern for others, loyalty and trustworthiness.</td>
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<tr>
<td><strong>LEVEL 2:</strong> Conventional moral reasoning</td>
<td><strong>STAGE 4:</strong> Develops awareness that social stability depends on adherence to rules.</td>
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<td><strong>STAGE 5:</strong> Realisation that values are not absolute but are based on principles and a commitment to people and society.</td>
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<tr>
<td><strong>LEVEL 3:</strong> Post conventional moral reasoning</td>
<td><strong>STAGE 6:</strong> Commitment to a rational belief in the validity of universal moral principles, i.e. they behave contrary to laws and customs they believe to be invalid as their commitment to justice and human rights is independent of the values of any community.</td>
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(after Kohlberg 1963)

"Moral Education and Identification"
in *Child Psychology*
H. Stevenson (ed)
62nd Year Book
National Society for the study of Education
University of Chicago Press : Chicago

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AMERICAN CODE FOR NURSES

1. The nurse provides services with respect for human dignity and the uniqueness of the client unrestricted by considerations of social or economic status, personal attributes, or the nature of health problems.

2. The nurse safeguards the client's right to privacy by judiciously protecting information of a confidential nature.

3. The nurse acts to safeguard the client and the public when health care and safety are affected by the incompetent, unethical, or illegal practice of any person.

4. The nurse assumes responsibility and accountability for individual nursing judgements and actions.

5. The nurse maintains competence in nursing.

6. The nurse exercises informed judgment and uses individual competence and qualifications as criteria in seeking consultation, accepting responsibilities, and delegating nursing activities to others.

7. The nurse participates in activities that contribute to the ongoing development of the profession's body of knowledge.

8. The nurse participates in the profession's efforts to implement and improve standards of nursing.

9. The nurse participates in the profession's efforts to establish and maintain conditions of employment conducive to high quality nursing care.

10. The nurse participates in the profession's effort to protect the public from misinformation and misrepresentation and to maintain the integrity of nursing.

11. The nurse collaborates with members of the health professions and other citizens in promoting community and national efforts to meet the health needs of the public.

[Adopted by the American Nurses' Association in 1976 and reprinted by permission]
1 The nursing student has the right to question educational methods and curriculum content.

2 The nursing student has the right to say 'I don't understand'.

3 The nursing student has the right to practice safely under supervision.

4 The nursing student has the right to decline responsibility for managerial problems outside their sphere of practice or competence.

5 The nursing student has the right to bring to the attention of the appropriate authority any act of patient abuse or poor standard of care.

6 The nursing student has the right to be treated with respect as an equal human being.

7 The nursing student has the right to privacy in respect of her personal life.

8 The nursing student has the right to express her feelings, opinions and values.

9 The nursing student has the right to state her own needs as a person independent of any other roles which may be assumed in her life.

10 The nursing student has the right to question and to receive an informed answer.

Royal College of Nursing
Association of Nursing Students (31)
Bill of Rights
Nursing Times, 83(34),
26 August 1987, pp 20
A Patient's Bill of Rights: American Hospital Association, 1973*

The American Hospital Association presents a Patient's Bill of Rights with the expectation that observance of these rights will contribute to more effective patient care and greater satisfaction for the patient, his physician and the hospital organization. Further, the Association presents these rights in the expectation that they will be supported by the hospital on behalf of its patients, as an integral part of the healing process. It is recognized that a personal relationship between the physician and the patient is essential for the provision of proper medical care. The traditional physician-patient relationship takes on a new dimension when care is rendered within an organizational structure. Legal precedent has established that the institution itself also has a responsibility to the patient. It is in recognition of these factors that these rights are affirmed.

1. The patient has the right to considerate and respectful care.
2. The patient has the right to obtain from his physician complete current information concerning his diagnosis, treatment, and prognosis in terms the patient can be reasonably expected to understand. When it is not medically advisable to give such information to the patient, the information should be made available to an appropriate person in his behalf. He has the right to know by name, the physician responsible for coordinating his care.
3. The patient has the right to receive from his physician information necessary to give informed consent prior to the start of any procedure and/or treatment. Except in emergencies, such information for informed consent, should include but not necessarily be limited to the specific procedure and/or treatment, the medically significant risks involved, and the probable duration of incapacitation. Where medically significant alternatives for care or treatment exist, or when the patient requests information concerning medical alternatives, the patient has the right to such information. The patient also has the right to know the name of the person responsible for the procedures and/or treatment.
4. The patient has the right to refuse treatment to the extent permitted by law, and to be informed of the medical consequences of his action.
5. The patient has the right to every consideration of his privacy concerning his own medical care program. Case discussion, consultation, examination, and treatment are confidential and should be conducted discreetly. Those not directly involved in his care must have the permission of the patient to be present.
6. The patient has the right to expect that all communications and records pertaining to his care should be treated as confidential.
7. The patient has the right to expect that within its capacity a hospital must make reasonable response to the request of a patient for services. The hospital must provide evaluation, service, and/or referral as indicated by the urgency of the case. When medically permissible a patient may be transferred to another facility only after he has received complete information and explanation concerning the needs for and alternatives to such a transfer. The institution to which the patient is to be transferred must first have accepted the patient for transfer.
8. The patient has the right to obtain information as to any relationship of his hospital to other health care and educational institutions insofar as his care is concerned. The patient has the right to obtain information as to the existence of any professional relationships among individuals, by name, who are treating him.
9. The patient has the right to be advised if the hospital proposes to engage in or perform human experimentation affecting his care or treatment. The patient has the right to refuse to participate in such research projects.
10. The patient has the right to expect reasonable continuity of care. He has the right to know in advance what appointment times and physicians are available and where. The patient has the right to expect that the hospital will provide a mechanism whereby he is informed by his physician or a delegate of the physician of the patient's continuing health care requirements following discharge.
11. The patient has the right to examine and receive an explanation of his bill regardless of source of payment.
12. The patient has the right to know what hospital rules and regulations apply to his conduct as a patient.

No catalogue of rights can guarantee for the patient the kind of treatment he has a right to expect. A hospital has many functions to perform, including the prevention and treatment of disease, the education of both health professionals and patients, and the conduct of clinical research. All these activities must be conducted with an overriding concern for the patient, and, above all, the recognition of his dignity as a human being. Success in achieving this recognition assures success in the defense of the rights of the patient.

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APPENDIX 6

WORLD MEDICAL ASSOCIATION

Declaration of Helsinki

Recommendations guiding medical doctors in biomedical research involving human subjects.
Adopted by the 18th World Medical Assembly, Helsinki, Finland, 1964, and revised by the 29th World Medical Assembly, Tokyo, Japan, October 1975.

Introduction

It is the mission of the medical doctor to safeguard the health of the people. His or her knowledge and conscience are dedicated to the fulfilment of the mission.

The Declaration of Geneva of The World Medical Association binds the doctor with the words. "The health of my patient will be my first consideration," and the International Code of Medical Ethics declares that. "Any act or advice which could weaken physical or mental resistance of a human being may be used only in his interest".

The purpose of biomedical research involving human subjects must be to improve diagnostic, therapeutic and prophylactic procedures and the understanding of the aetiology and pathogenesis of disease.

In current medical practice most diagnostic, therapeutic or, prophylactic procedures involve hazards. This applies a fortiori to biomedical research.

Medical progress is based on research which ultimately must rest in part on experimentation involving human subjects.

In the field of biomedical research a fundamental distinction must be recognized between medical research in which the aim is essentially diagnostic or therapeutic for a patient, and medical research, the essential object of which is purely scientific and without direct diagnostic or therapeutic value to the person subjected to the research.

Special caution must be exercised in the conduct of research which may affect the environment, and the welfare of animals used for research must be respected.

Because it is essential that the results of laboratory experiments be applied to human beings to further scientific knowledge and to help suffering humanity, The World Medical Association has prepared the following recommendations as a guide to every doctor in biomedical research involving human subjects. They should be kept under review in the future. It must be stressed that the standards as drafted are only a guide to physicians all over the world. Doctors are not relieved from criminal, civil and ethical responsibilities under the laws of their own countries.
I. Basic Principles

1. Biomedical research involving human subjects must conform to generally accepted scientific principles and should be based on adequately performed laboratory and animal experimentation and on a thorough knowledge of the scientific literature.

2. The design and performance of each experimental procedure involving human subjects should be clearly formulated in a experimental protocol which should be transmitted to a specially appointed independent committee for consideration, comment and guidance.

3. Biomedical research involving human subjects should be conducted only by scientifically qualified persons and under the supervision of a clinically competent medical person. The responsibility for the human subject must always rest with a medically qualified person and never rest on the subject of research, even though the subject has given his or her consent.

4. Biomedical research involving human subjects cannot legitimately be carried out unless the importance of the objective is in proportion to the inherent risk to the subject.

5. Every biomedical research project involving human subjects should be preceded by careful assessment of predictable risks in comparison with foreseeable benefits to the subject or to others. Concern for the interests of the subject must always prevail over the interests of science and society.

6. The right of the research subject to safeguard his or her integrity must always be respected. Every precaution should be taken to respect the privacy of the subject and to minimize the impact of the study on the subject's physical and mental integrity and on the personality of the subject.

7. Doctors should abstain from engaging in research projects involving human subjects unless they are satisfied that the hazards involved are believed to be predictable. Doctors should cease any investigation if the hazards are found to outweigh the potential benefits.

8. In publication of the results of his or her research, the doctor is obliged to preserve the accuracy of the results. Reports of experimentation not in accordance with the principles laid down in this Declaration should not be accepted for publication.

9. In any research on human beings, each potential subject must be adequately informed of the aims, methods, anticipated benefits and potential hazards of the study and the discomfort it may entail. He or she should be informed that he or she is at liberty to abstain from participation in the study and that he or she is free to withdraw his or her consent to participation at any time. The doctor should then obtain the subject's freely-given informed consent, preferably in writing.

10. When obtaining informed consent for the research project the doctor should be particularly cautious if the subject is in a dependent relationship to him or her or may consent under duress. In that case the informed consent should be obtained by a doctor who is not engaged in the investigation and who is completely independent of this official relationship.
11. In case of legal incompetence, informed consent should be obtained from the legal guardian in accordance with national legislation. Where physical or mental incapacity makes it impossible to obtain informed consent, or when the subject is a minor, permission from the responsible relative replaces that of the subject in accordance with national legislation.

12. The research protocol should always contain a statement of the ethical considerations involved and should indicate that the principles enunciated in the present Declaration are complied with.

II. Medical research combined with professional care (clinical research)

1. In the treatment of the sick person, the doctor must be free to use a new diagnostic and therapeutic measure, if in his or her judgement it offers hope of saving life, reestablishing health or alleviating suffering.

2. The potential benefits, hazards and discomfort of a new method should be weighed against the advantages of the best current diagnostic and therapeutic methods.

3. In any medical study, every patient - including those of a control group, if any - should be assured of the best proven diagnostic and therapeutic method.

4. The refusal of the patient to participate in a study must never interfere with the doctor-patient relationship.

5. If the doctor considers it essential not to obtain informed consent, the specific reasons for this proposal should be stated in the experimental protocol for transmission to the independent committee (1,2).

6. The doctor can combine medical research with professional care, the objective being the acquisition of new medical knowledge, only to the extent that medical research is justified by its potential diagnostic or therapeutic value for the patient.

III. Non-therapeutic biomedical research involving human subjects (non-clinical biomedical research)

1. In the purely scientific application of medical research carried out on a human being, it is the duty of the doctor to remain the protector of the life and health of that person on whom biomedical research is being carried out.

2. The subjects should be volunteers - either healthy persons or patients for whom the experimental design is not related to the patient's illness.

3. The investigator or the investigating team should discontinue the research if in his/her or their judgement it may, if continued, be harmful to the individual.

4. In research on man, the interest of science and society should never take precedence over considerations related to the well-being of the subject.
The Hippocratic Oath

I swear by Apollo Physician and Asclepius and Hygieia and Panaceia and all the gods and goddesses, making them my witnesses, that I will fulfill according to my ability and judgment this oath and this covenant:

To hold him who has taught me this art as equal to my parents and to live my life in partnership with him, and if he is in need of money to give him a share of mine, and to regard his offspring as equal to my brothers in male lineage and to teach them this art— if they desire to learn it— without fee and covenant: to give a share of precepts and oral instruction and all the other learning to my sons and to the sons of him who has instructed me and to pupils who have signed the covenant and have taken an oath according to the medical law, but to no one else.

I will apply dietetic measures for the benefit of the sick according to my ability and judgment: I will keep them from harm and injustice.

I will neither give a deadly drug to anybody if asked for it, nor will I make a suggestion to this effect. Similarly I will not give to a woman an abortive remedy. In purity and holiness I will guard my life and my art.

I will not use the knife, not even on sufferers from stone, but will withdraw in favour of such men as are engaged in this work.

Whatever houses I may visit, I will come for the benefit of the sick, remaining free of all intentional injustice, of all mischief and in particular of sexual relations with both female and male persons, be they free or slaves.

What I may see or hear in the course of the treatment or even outside of the treatment in regard to the life of men, which on no account one must spread abroad. I will keep to myself holding such things shameful to be spoken about.

If I fulfill this oath and do not violate it, may it be granted to me to enjoy life and art, being honoured with fame among all men for all time to come; if I transgress it and swear falsely, may the opposite of all this be my lot.
THE WORLD MEDICAL ASSOCIATION DECLARATION OF GENEVA

Physician's Oath

At the time of being admitted as a member of the medical profession:

I solemnly pledge myself to consecrate my life to the service of humanity;

I will give to my teachers the respect and gratitude which is their due;

I will practice my profession with conscience and dignity; the health of my patient will be my first consideration;

I will maintain by all the means in my power, the honour and the noble traditions of the medical profession: my colleagues will be my brothers;

I will not permit considerations of religion, nationality, race, party politics or social standing to intervene between my duty and my patient;

I will maintain the utmost respect of human life from the time of conception, even under threat. I will not use my knowledge contrary to the laws of humanity;

I make these promises solemnly, freely and upon my honour.

Adopted by the General Assembly of the World Medical Association, Geneva, Switzerland, September 1948 and amended by the 22nd World Medical Assembly, Sydney, Australia, August 1968.
## LEARNING OPPORTUNITIES OR EXPERIENCES AND TEACHING METHODS

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| 10       | REAL LIFE EXPERIENCES  
|          | - Critical incident techniques |
| 9        | REVERSAL ROLE-PLAYING/TAKING TECHNIQUES |
| 8        | SIMULATION SITUATIONS  
|          | - solving personal and moral problems |
| 7        | TAPE SLIDES or VIDEO TAPE RECORDINGS  
|          | - recording discussions on moral arguments and playing back material for further discussion |
| 6        | ACTING, DRAMA, PROJECT WORK |
| 5        | USE OF EDUCATIONAL TECHNOLOGY  
|          | - films, audio-visual aid material |
| 4        | DISCUSSION - small mixed groups  
|          | - emotions and personal relationships discussed |
| 3        | DEBATES  
|          | ESSAYS  
|          | CREATIVE WRITING or relevant moral questions |
| 2        | RELEVANT MATERIAL USAGE  
|          | - encouraging students to bring relevant material for discussion e.g. Newspaper articles |
| 1        | DIRECT TEACHING  
|          | - direct explanation of material |

After J.H. Wilson (1975:42)  
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