## Contents

Preface v

Introduction ix

1 Preliminary Matters 1
   What is ethics? 1
   Why should nurses study ethics? 6
   The inherent moral dimension of nursing practice 9
   How can moral issues be identified? 12
   Conclusion 17

2 Judgements, Rules, Principles and Theories 18
   Moral judgements 19
   Moral rules 20
   Moral principles 26
   Moral theories: utilitarianism, deontology, virtue theory 29
   How are the four levels related? 47
   Arguments for the priority of moral principles 49
   Conclusion 55

3 The Four Principles: Respect for Autonomy, Beneficence, Non-maleficence and Justice 56
   The principle of respect for autonomy 57
   The principle of beneficence 74
   The principle of non-maleficence 80
   The principle of justice 86
   Respect for autonomy as the weightiest principle? 98
   The principles and the NMC Code (2008) 101
   Conclusion 105
Contents

4 Conflicts between the Principles 106
   Respect for autonomy in conflict with beneficence and non-maleficence 106
   Autonomy in conflict with justice: allocation of scarce resources 127
   Conclusion 146

5 Care-Based Ethics: A Challenge to the Principle-Based Approach? 147
   Clouser and Gert’s critique 148
   A care-based approach: the first wave 149
   The second wave 169
   The third wave 174
   ‘Principles infused with care’ approach 176
   Conclusion 180

6 Applying the ‘Principles Infused with Care’ Approach in the Context of Genetics 182
   Case one: Prenatal screening for Down’s syndrome 184
   Case two: A request to keep genetic information confidential 196
   Case three: A decision to have radical surgery on the basis of genetic information 200
   Conclusion 202

7 Supererogatory Actions in the Context of Nursing 203
   What are supererogatory acts? 205
   To whom do nurses have obligations? 207
   Do nurses undertake supererogatory acts? 211
   Five nurse case examples 211
   Conclusion 220


Bibliography 228

Index 237
Chapter 1

Preliminary Matters

This chapter begins by offering a definition of ethics, and highlighting three different senses of it. Then it is explained why it is important for nurses to think about, discuss and study ethics. Then, following introduction of the ideas of moral awareness, perception and imagination, a strategy to develop sensitivity to the moral dimension of nursing practice is presented.

What is ethics?

Consider these four examples of ethical issues, three of which are being widely discussed at the time of writing (May 2008).

The first one concerns so-called ‘mixed sex’ wards (BBC, 19/5/08, ‘Mixed-sex NHS still a problem’). This news item refers to the distress and embarrassment which many people feel when they are patients in a mixed-sex ward. It makes plain that patients should not need to walk past patients of the opposite sex when they are going for a wash or to use the toilet. Many patients strongly dislike being cared for in such circumstances. At a vulnerable time in their lives, it seems, they are subjected to yet further humiliation.

The second item concerns midwifery services in South East Wales. Concern has been expressed about the standards of maternity provision
in two hospitals in the region. It is reported that due to low staffing levels, it has not been possible to provide a safe service for mothers-to-be. As a result, an enquiry has taken place and happily the situation looks now to be on the way to being improved. The concerns about poor levels of care in the region were expressed by the Royal College of Midwives (RCM) (BBC, 20/5/08, ‘Urgent action on maternity units’).

The third item involves abortion. Last night (20/5/08) MPs in the UK had the option of voting to lower the current limits within which an abortion can legally take place. The current upper limit is 24 weeks. Some MPs thought that should be lowered to 20 weeks because advancements in medical science now make it possible for some very premature babies to survive, even though they are born before 24 weeks. Thus, some argued, because babies are ‘viable’ below 24 week gestation, then abortions at 24 weeks should not be legally permitted.

The fourth example of an ethical issue to be described briefly now, is not one which will feature in any newspaper headline. Suppose you are working as a nurse. You are giving a patient his or her medication. You place the tablets in the plastic container in his or her hand, and you have checked he or she has a glass of water within their reach. In your previous interactions with this patient he has seemed quite cheerful. But now he looks anxious. You ask him if everything is ok? Is there anything on his mind? Does he need some help?

This isn’t the kind of episode of care which will make a news story, but it is an ethical issue. You show your concern about the patient by, first of all, noticing that all might not be well with him, and by responding to this.

These are four descriptions of situations which raise ethical issues. They are situations with an ethical dimension, as we will say here. In the first example, patients feel distressed at having to be cared for in a mixed-sex ward. In the second, there are risks of harm to pregnant mothers and their babies. In the third, there are disagreements about how to balance a woman’s rights over her own body against the right to life of the foetus. And in the last example, a nurse notices and responds to her suspicion that a patient is worried about something.

All the situations involve various kinds of harms and benefits to those involved and this indicates that they are situations with an ethical dimension to them.

Shortly, we will attempt to describe how situations with an ethical dimension can be identified more systematically. But before this it will prove useful to set out a rough distinction between three senses of the
term ‘ethics’: personal ethics, group ethics, and philosophical ethics. For present purposes, we can follow the convention of regarding the terms ‘ethics’ and ‘morals’ as synonyms (Singer, 1979, p. 1, 1991, p. v; Seedhouse, 1988, p. 18).

Personal ethics

The first sense of the term ‘ethics’ to be mentioned here concerns its use in the personal sense. When invited to offer a definition of ethics, many people understand the term in this fashion. Ethics in the personal sense, they suggest, refers to the beliefs which individuals hold about ethical issues. Such beliefs stem from the informal moral education received from various sources: parents, schoolteachers, religious figures and the media. These sources influence the views of people about moral matters and typically inform the intuitive responses people offer about ethical issues.

Most of us have opinions on ethical issues whether or not we have formally studied ethics. Someone may claim that it is wrong to abuse children or to kill animals for sport, for example. Such personal beliefs may be the result of deliberation by the persons concerned, in which case it could be expected that they are able to supply reasons in support of their views. They may argue, for example, that it is wrong to kill animals for sport because it is wrong to kill humans for sport, and humans are animals. A person who argues against killing animals in this way may assume there to be no significant distinction in morality between killing humans and killing non-human animals.

Alternatively, a person might not be able to provide any reasons in support of his or her view; such a person may say simply that he or she knows it is wrong to kill animals for sport without being able to say just why it is wrong. In everyday arguments about moral issues, people frequently appeal to their moral intuitions: they claim simply to know that some courses of action are wrong even though they cannot say why. Child abuse presents a useful example here. Most of us find this practice morally abhorrent, and, generally, do not believe that any reasons are required in support of such a view: ‘it is wrong to abuse children and that’s that’ we think.

Almost all people, able to express a view, hold positions on many situations with an ethical dimension. These positions reflect their own ethics: their own views of what is right and what is wrong. Let us turn now to look at ‘group ethics’.
Group ethics

A second sense of the term ‘ethics’, of particular relevance to nurses, involves reference to the ethics of a group. These may be formal statements of standards of behaviour which members are expected to act in accordance with. Such a group might be a professional group such as nurses, footballers or medical staff, or a religious group – we could think of the Ten Commandments in this context.

Nurses comprise a useful example of a professional group which has proposed various codes of ethics. For example, the American Nurses Association (ANA) has set out a Code of Ethics which identifies the standards of behaviour expected of its members (see Benjamin and Curtis, 1986, pp. 179–81). The equivalent bodies in the UK, the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) and the Nursing and Midwifery Council (NMC) have set out Codes of Conduct which perform a similar function (UKCC, 1992; NMC, 2008). Since there is a plethora of literature concerning codes of conduct for nurses, this second sense of the term ‘ethics’ will not be pursued for now. (For further information on codes of conduct, see Burnard and Chapman, 1988; Chadwick and Tadd, 1992; Thompson, Melia and Boyd, 2000.)

Philosophical ethics

The third, and last, sense of the term ‘ethics’ to be identified here refers to ethics as a more formal, academic enterprise, which we can usefully describe as philosophical ethics. Within this, we can distinguish three general types of activity.

1. The development of ethical theories which attempt to set out prescriptions for morally right action. This may be done by attempting to show that acts which accord with certain specified criteria are morally right and others morally wrong. Such criteria comprise a set of justifications for particular actions, or types of actions. Hence, a particular act, A (say, telling the truth), may be judged to be morally obligatory since A accords with the criteria proposed in the theory. Two examples of theories devised in this way are Utilitarianism (Mill, 1863) and Kant’s duty-based moral theory (Kant, 1785). Crudely, according to the Utilitarian, acts are right in so far as they maximize benefits or minimize harms. And, equally crudely, according to Kant,
the rightness or wrongness of an act depends upon the motives of the actor.

We will be looking at these two moral theories, together with virtue theory, in greater detail in the next chapter. They are given here as examples of one of the kinds of activities which fall within philosophical ethics. It should be added that the approach to ethics to be set out in this book may amount to a theory in the sense under discussion here, for, as will be seen, the approach attempts to identify justifications for acting in one way rather than in others.

2. A second component of philosophical ethics consists in the analytical enterprise of examining moral claims, concepts and theories. This involves, for example, searching for inconsistency in moral argument and lack of clarity in moral concepts. This enterprise differs from the first activity discussed above in that it does not itself involve the proposal of substantive claims concerning what constitutes right or wrong action.

We will be required to engage in philosophical ethics in this second sense. As will be seen, it is important to be especially clear when it comes to definitions of key terms and principles. Attention to clarity reduces the risk of misunderstanding and fosters a rigorous approach to the subject matter.

3. The third kind of activity describable under the rubric of philosophical ethics is so-called metaethics. This involves an examination of the language of morals itself. From the perspective of metaethics one asks questions such as: Can there be any moral facts? Is moral language meaningful? This differs from the second type of philosophical ethics in the sense that it queries the whole nature and language of morals.

We will not be engaged in any metaethical tasks in this book. It will simply be presumed – not unreasonably – that moral language is meaningful. Nor will the question of whether there can be moral facts be addressed (those interested may find Raphael [1981] a useful introduction). It is not being presumed that there are such facts, rather, it is supposed here that that question is less relevant to our concerns than the matters to be investigated during the course of this book.

This, then, completes a description of three senses of the term ‘ethics’. Before moving on to the next section, it is worth pausing briefly to consider the relations between these three kinds of activity, and also to consider their relevance to members of the nursing profession. It is
clear that the majority of nurses hold ethical views; hence they have an ethics in the first sense of the term described above. It is also clear that these beliefs about moral matters which individual nurses hold carry implications for the way certain moral problems encountered in professional practice will be viewed. For example, nurses who believe homosexual relationships to be morally wrong may find it difficult to deal with patients who are homosexual.

Furthermore, a nurse who believes homosexual activities to be morally wrong, might find that this particular moral view conflicts with certain clauses in the NMC Code, for example, ‘You must not discriminate in any way against those in your care’ (NMC, 2008; see Appendix). If the nurse found she could not care for patients who are homosexual she would then experience a conflict between her personal ethics, which inclines her to avoid homosexual patients, and the standards of behaviour required by the NMC Code. Thus there is a conflict between the personal ethics of the nurse and the ‘group ethics’ of the professional group to whom she belongs. This is so, of course, because the NMC Code is compiled largely by members of the nursing profession. It is evident, then, that courses of action which accord with one’s personal ethical beliefs can conflict with courses of action required by the code recommended by one’s professional body.

Engaging in some philosophical ethics can help to expose the source of such conflicts; this can be done by analysing and making explicit the moral principles which clash in such situations. We spend some time doing this in the explication of the four principles in chapter four below. Hopefully, the reader will be better equipped to undertake such analyses of moral conflicts after reading this book. For now, we move on to consider just why nurses should study ethics.

**Why should nurses study ethics?**

Ethical problems are faced continuously in our day-to-day lives. Suppose you are walking down a city centre street, a person who looks unwell, and painfully thin asks you for money for food. Should you give him or her some? The situation has an ethical dimension to it since you are in a position to benefit the person by giving them some money; and you might be said to cause harm, if only indirectly, if you walk by without helping the person.
Take another example. You notice an appeal in a newspaper which points out that a donation of £250 can save someone’s sight, maintain the life of a person in an extremely poor country (if only for a month or two) or fund an operation to repair a cleft palate. Should you send a donation? There are countless other, more mundane, examples of moral problems encountered on a regular basis: Should you tell your friend the horrible truth about his new haircut? Should you try to avoid paying the bill at a restaurant? Should you ‘jump the queue’ at the supermarket checkout because you are in a hurry? Clearly, we are capable of arriving at decisions concerning moral matters and can do so without doing a course in ethics. So why should nurses study ethics?

Below are some reasons which are relevant, and which help to support the claim that the moral intuition acquired and relied upon in ordinary, everyday circumstances is of limited use in the health care setting (Hussey, 1990).

- First, it is true to say that as a nurse one is faced with many more ethical problems than most ordinary members of the community have to face. In some kinds of occupations it is possible to drift along happily without ever facing a serious moral dilemma. The sheer quantity of moral problems faced in the health care setting differs greatly from the quantity of moral problems one faces, generally speaking, in ordinary life. So, the moral context within which every day moral intuition is developed differs from the health care setting at least in the respect that in nursing practice the number of moral problems faced by nurses is significantly greater than is encountered by many people in many other types of occupations.

- Second, in our normal dealings with people on a day-to-day basis, we find people in their normal state – at home, at work, or in the shops etc. They are in familiar surroundings with people they know, and typically they are in a situation in which they feel comfortable. Clearly, none of this is true when patients are in hospital or when they or their close relatives are seriously ill. Patients may be anxious, feel insecure, or perhaps be unconscious. So the usual, conventional setting within which we make moral decisions can again be seen to be radically different from the health care setting.

- Third, it may be the case that as a nurse one comes into contact with people who have had a different kind of moral education, and so have developed different ways of responding to moral
problems – they have a personal ethics which differs radically from one’s own. Consider, here, people from different ethnic backgrounds or people with different religious or political views. Many people do not have any prolonged contact with others who have had a radically different moral education than themselves. So, again, it can be seen that moral decision-making in nursing practice may differ from moral decision-making in ordinary circumstances. This is so because the nurse needs to take into account the perspective of the person who has a different moral outlook than he or she. The nurse is, in fact, required to do this by the NMC (2008).

In ordinary, everyday life some people consider their own moral intuition to be unfailingly correct. For such people, moral conflicts do not arise. They simply assume that any moral views which diverge from the ones they themselves endorse must be wrong. But such an attitude is unsupportable. It is necessary to consider at least the possibility that other moral views may be correct before it is possible to make any kind of adjudication between conflicting moral claims. It is not enough just to assert one’s own moral views without considering other perspectives, and it is especially important for health care professionals to recognize this.

- Fourth, the availability of complex medical technology and advances in sciences such as genetics again makes the situation in the health care setting radically different from the normal context within which moral decisions are made. In the health care setting the nurse will encounter moral dilemmas of a type which he or she will not have encountered previously in ordinary everyday life. These might be very dramatic, such as end of life decisions, or less dramatic but still of vital importance, for example how to deal with a patient who feels anxious and vulnerable due to their health problem. Again, these points reinforce the view that the moral intuition developed in ordinary life is unlikely to be adequate to cope with the complex moral problems which arise in the health care context.

These last four points seem enough to support the claim that nurses should study ethics. It does seem plausible that the moral intuition developed and relied upon in normal circumstances may be inadequate to cope with the quantity and the complexity of moral issues encountered in the health care setting. But there is an even stronger reason
why it is important to learn about ethics and to develop a capacity to respond in the right way to ethical problems in practice. This stems from the inherent ethical dimension of such practice.

The inherent moral dimension of nursing practice

There is an inescapable ethical dimension to nursing practice. Every action undertaken by a nurse in the course of that practice has an ethical dimension to it. This is because nursing acts are directed towards moral ends. They aim to bring about states which are important to patients and which patients value. Obvious examples include being free from pain, feeling well, feeling calm, feeling that one has a good quality of life, or at least that its quality has improved and not deteriorated. Nurses come into contact with patients who are vulnerable, who suffer.

An essential part of their role is to respond properly to that vulnerability and suffering.

The fact that nursing has this intrinsic ethical dimension to it is a good reason for nurses to develop their appreciation of ethical issues and also their capacity to respond properly to them. The bulk of this book is aimed towards trying to develop that capacity. But before getting on to that task it is important to say a little bit about what is involved in the capacity to appreciate the ethical dimension of practice.

If a nurse says she is unsure about how to deal with an ethical problem in her practice, it is obvious that she has already identified the problem as an ethical problem. So if one even gets to the stage of trying to develop responses to moral problems, one has already succeeded in identifying those problems in practice. This demonstrates that, like most of us, the nurse has the capacity of moral awareness. Without this it is not possible to recognize situations as situations with an ethical dimension to them. Such a capacity is analogous to being able to see the world in colour as opposed to seeing it in monochrome. An important realm of human life is available for us to notice – the moral realm. Awareness of the moral realm makes moral perception possible (see Blum, 1994). Moral perception occurs when we perceive of situations as having an ethical dimension to them. We can also make use of the idea of moral sensitivity. The idea here is that some people, in contrast to others, have very good powers of moral perception. This enables such people to identify situations that
have a moral dimension; only if one does this, can one respond to such situations of course.

An example might help to illustrate the point being made.

Sandra is a nurse walking down her ward doing a ‘final check’ on the patients before finishing her shift. Having not noticed anything amiss, she goes in to the ward office satisfied all is well and that she can handover promptly to the nurse leading the next shift. A nursing colleague, Freda, on the same ward, is heading to the same office a second or two later. Freda notices one patient, Mrs. Jones, who is sitting up in bed, but at a slightly awkward-looking angle. Freda goes to ask Mrs. Jones if she is comfortable. She says she isn’t and so Freda adjusts her pillows to make her comfortable again. Freda then proceeds to the ward office.

Let us suppose that Mrs. Jones had been in the same, slightly awkward-looking, position when Sandra walked past, but Sandra did not notice.

Freda’s acts manifest sensitivity to a moral dimension of the ward area that Sandra’s acts lack. This is what is meant by the kind of sensitivity being mentioned here. It is an ability to perceive moral aspects of one’s environment. In the example just given, the relevant moral aspect perceived is the slight discomfort of Mrs. Jones.

A well-developed capacity of moral perception makes it much more likely that one will see relevant moral dimensions of situations in nursing practice. If one lacks this sensitivity, or one’s sensitivity is insufficiently developed, one is more likely to fail to attend properly to situations of the kind under discussion here, in which a patient is in need; even if, perhaps, a relatively minor need.

It makes sense to suppose people differ in terms of the power of their moral perception. Some people’s moral perception is extremely sensitive, others less so. If one thinks of moral awareness as analogous to the turning on of a light in a darkened room which makes it possible for one to see the contents of the room, those with a high degree of sensitivity see the room and its contents clearly. For those with less developed moral sensitivity the contents of the room will be less well evident. For such people the moral domain is illuminated less sharply and less extensively. Thus, Freda saw more than Sandra. Sandra did not even notice Mrs. Jones’ discomfort.

In all likelihood, both nurses in the example above possessed moral awareness, and are capable of moral perception. But the moral perception of Freda is more acute — at least if we are to assess
moral perception in terms of how Freda responds to Mrs. Jones’ discomfort.

In addition to moral awareness, sensitivity and perception, a further component of the moral domain needs to be mentioned. This is moral imagination (Scott, 2000). What this refers to is the capacity to appreciate the significance of something as another person might see it. So, to stick with the example given above, in attempting to exercise moral imagination one might try to imagine what Mrs. Jones might be feeling. Is she thinking that she will be stuck in an uncomfortable position for several hours? From the perspective of Mrs. Jones, this is likely to have a negative effect on her overall morale. Feeling uncomfortable and being powerless to do anything about it is a terrible thing. These are the kinds of considerations which are revealed when one exercises moral imagination. The conscious exercise of moral imagination is a good way to develop one’s sense of moral perception – to make it more acute, so that one is more able to identify, and thus respond to, ethical aspects of nursing practice.

So far then, we have drawn attention to the pervasiveness of ethical issues in practice, set out an argument in support of the view that nurses should study ethics, and introduced the ideas of moral awareness, sensitivity, perception and imagination. A nurse with well-developed capacities in these areas would have no difficulty in identifying ethical aspects of practice. For most of us these capacities stand in need of much further development. And also for many of us, when we first go into the clinical area it is such a strange environment that we feel our normal parameters for assessing what is right and what is wrong might not apply in this peculiar context. As mentioned above, in the clinical area one might see people who are barely clothed, who are unconscious, confused, anxious, distressed, in pain and so on. Also, whereas in ordinary life one is typically in environments that are familiar, where there are familiar expectations, none of this may be true of the clinical area. One is a novice. So all these factors can generate what might be called ‘ethical disorientation’. Familiar conventions to which one is accustomed in ordinary life, such as ‘wear clothes in the presence of strangers’, ‘don’t have any physical contact with strangers’, and ‘don’t sleep in public places’ are all transgressed in the clinical area. One might suppose that since standard conventions governing behaviour don’t apply in the clinical area, this is true of familiar moral strictures too. Or one may be unsure about how the ethical views one subscribes to outside the clinical area apply within it.
Here is an example to illustrate the kind of phenomenon that is being pointed to. Rhys is an inexperienced, student nurse on placement in an acute mental health admissions unit. One of the first tasks assigned to Rhys, or that he is witness to, is that of trying to rouse patients from their beds whilst they are sleep. This is the kind of task undertaken routinely, every day by the nurses who work on that unit. For them there is nothing strange about such a practice at all. But to an inexperienced nurse such as Rhys, and for most of us, this runs counter to many ethical conventions concerning, for example, privacy. Outside the clinical area it would not be appropriate for a stranger to walk into the sleeping area of another stranger, not to mention to try to wake them. Yet this is considered routine behaviour in the unit. Such events can produce the kind of ethical disorientation under discussion here. So many unusual acts are taking place – unusual by ordinary non-clinical standards – that one can become unsure of whether familiar ethical conventions apply.

If a nurse experiences this kind of thing, that is one way of identifying ethical issues in practice. Rather than to suppress the ethical rules (‘dos and don’ts’) which one took into the clinical area – in the above example that concerning respect for the privacy of others – one should take their transgression as an indication of the presence of an ethical issue in practice. To say that transgressing the privacy of patients and waking them from sleep is an ethical issue, is not necessarily to say that such acts are morally wrong. They may be perfectly justifiable, imagine there was a fire on the ward and those patients were in danger. Plainly, respecting their privacy is not as important as saving their lives. Hence experiencing moral disorientation of the kind just described is a useful indicator of an ethical issue in practice. Too often, novice nurses simply suppress their own moral intuitions assuming they must be flawed if they conflict with what is common practice in the clinical area. Rather than suppress those intuitions it is advisable to think about the nature of the conflict and try to work out which way of acting is the most ethically justified.

A further way of identifying ethical issues in practice is by using a strategy described in the next section.

**How can moral issues be identified?**

The kind of unease experienced by Rhys, the novice nurse we have just described, is a useful indicator of the moral dimension of practice. So
as mentioned, rather than try to suppress this, it is useful to use it as a worthwhile tool to facilitate identification of moral issues in practice. In addition to this, some find the following, much more crude, strategy of help too.

Some moral issues seem easy to identify: for example, those concerning the rightness or wrongness of abortion, of mistreatment of persons with severe learning disabilities, and of injustices in the distribution of health care resources. But as we have seen moral issues pervade nursing practice. Consider the act of moving a person from one chair to another without speaking to them; removing the coat from a conscious, confused patient without their permission; preventing a confused, older patient from leaving a day care unit; trying to persuade a person with learning difficulties to have a bath, or a wash; and so on. These kinds of examples are much less likely to be cited by nursing staff as examples of moral problems encountered in practice. Yet, situations such as those just described do have a moral dimension and do raise moral questions. The following strategy is one way of trying to develop further one’s sensitivity to moral issues.

The motivation for devising this strategy stemmed from speaking to student nurses who claimed never to have encountered a moral issue during their clinical placements. Undoubtedly, one has to learn to recognize such issues and in this section an attempt is made to try to outline a crude way of overcoming the difficulties which some people have in this area. The strategy has to be consciously applied and this can require a certain determination on the part of the person concerned to put the strategy into practice. Nonetheless, some nursing students (pre and post-registration) have claimed to find the strategy helpful and so it is set out below in the hope that others may find it so.

Typically, certain terms are employed, or can be employed, to describe situations with an ethical aspect. Such terms include the following:

- right
- wrong
- good
- bad
- duty
- obligation
should
ought
harm

and so on. For the sake of brevity, let us refer to this list henceforth as *The List*. When one hears sentences with these terms occurring in them being used, it is likely that some kind of ethical claim is being made. For example:

- That was a good (or bad) thing to do;
- You ought to act in the best interests of your patients;
- You should have intervened when you saw a man in the street being assaulted;
- It is the duty of health care professionals to prolong life where possible;
- Nurses have an obligation to protect patients;
- Patients have a right to be told the truth about their condition;
- It is not right that some people are homeless;

and so on. These sentences each include one of the terms identified in *The List*.

Of course, some of the terms may be used in contexts which seem unrelated to ethics. For example, someone may say to a lost motorist, ‘You should have turned right at the lights’. Here, the terms ‘should’ and ‘right’ occur in a context which seems not to have anything to do with ethics. However, it is plausible to hold that, in general, when the terms in the list offered above are employed, it is often the case that some kind of ethical judgement is being made. The terms in *The List* constitute indicators that an ethical claim is being made, they are not a cast-iron guarantee of the expression of such a claim. So, one way to identify situations with an ethical dimension in the health care setting is to listen out for the words in *The List*. When they are being used, or when one finds oneself using them, it is likely that some kind of ethical judgement is being made.

Clearly there are many situations which arise and about which no comments are made. For example, in a hospital ward (W ward) in the mental health context, it may be that patients are expected to queue up
for their meals whilst these are served out by nursing staff. This routine may take place three times each day without anyone, nurse or patient, passing a comment upon the nature of the routine. From the fact that nobody offers a description of this routine, it does not follow that the situation lacks an ethical aspect. What this indicates is that in applying the strategy one has not simply to listen to actual descriptions of situations offered by people (colleagues, patients, patients’ relatives), one must also ask the following question: Could someone describe this situation (that being witnessed, or reflected upon) in a way which involves a sentence containing one of the terms given in The List?

Suppose Ann is a student nurse and has been on placement at Ward for three weeks. Nobody has passed comment upon the mealtime routine just described. Suppose further that Ann decides to apply the strategy outlined above. She asks herself the question: Could someone describe this situation (patients queuing for meals which are doled out by nursing staff) in sentences which include any of the terms on The List? It seems plain that another person, Bethan, might say ‘It’s not right that patients should have to queue for their meals like that’, or similarly ‘It’s wrong that patients are expected to queue for their meals in that way’, or, again similarly, ‘Patients should not be expected to queue in that way’. The possibility of Bethan legitimately making observations such as these indicates that the situation has a moral dimension. The student nurse who is applying the strategy – Ann – should then consider why Bethan’s observations might be made; that is, are her comments justified?

An important point to note here is that whether or not the practice of requiring patients to queue for meals is justified, the fact that judgements such as those made by Bethan may be made about the mealtime routine on Ward indicates that the situation does have an ethical dimension. The question of whether the routine is justified from the ethical perspective is not one which we are concerned with here. Our present task is to develop and enhance the ability of nurses to identify situations with a moral dimension. In terms we used earlier, this strategy helps to enhance the moral perception of nurses. The first stage in that process involves the application of the strategy just described.

To summarize: First, one needs to listen out for the terms which feature in The List. If these are being employed to describe a situation (e.g., the mealtime routine on Ward), it is likely some kind of ethical claim is being made and that the situation under discussion has an ethical dimension to it. But this first step in the strategy needs to be supplemented with a second step. The person applying the strategy...
needs to reflect upon the situation and ask: Could someone describe this situation in sentences which include any of the terms on The List? Of course, it is not plausible to apply the strategy during an emergency situation, but it is possible to apply it during quieter moments in one’s spell of duty, during ward-based teaching sessions, and in any period when one is reflecting upon one’s work.

As noted, the conscious adoption of these strategies can enhance the development of moral perception, sensitivity, and imagination (we can assume nurses have the faculty of moral awareness). Development of moral perception can enable the nurse to appreciate more of the ethical aspects of practice. And conscious attempts at moral imagination can enhance the nurse’s appreciation of the perspectives of others, both patients and colleagues. The strategies described above regarding ethical disorientation, and employment of terms in The List can help the nurse to learn to be more aware of the moral aspects of practice. The hope is that although one might have to consciously apply these strategies initially, they will gradually become part of the nurse’s outlook. So that ethical aspects of practice will have due salience.

Perhaps unfortunately, learning about ethics does not provide one with ready answers to the moral problems nurses face in their daily routine. What it does do is to enable them to recognize moral problems, to have the conceptual equipment (common distinctions, knowledge of moral principles, and types of ethical theory) which can aid clear thought about them, and consequently to feel less inadequate than they otherwise would when faced with moral problems. This last point is added since many practising nurses say they feel inadequate when faced with moral problems during the course of their work. The source of this, it turns out, is often the belief that there are experts in nursing, medicine, or even moral philosophy around who know, and can prove, just what the right course of action to take in a given situation is.

Studying ethics helps to dispel this illusion and indicate to nurses that they have at least as much to offer as other groups of people in moral decision-making. In fact, the terminology of moral philosophy provides nurses with a technical vocabulary within which to couch their explanations of their own moral decisions – as might reasonably be expected of accountable professionals. It should be added that this vocabulary is one which is recognized by medical staff, health service managers, paramedics, and health economists. Hence, employing the vocabulary can help nurses to voice their concerns about relevant moral matters in an effective way.
There is a useful passage from Seedhouse (1988, p. 64) which we might briefly consider:

The realistic aim of ethical inquiry is to clarify the issues, to show those who have to make decisions the full range of possibilities open to them, and to explain different perspectives and ways of reasoning.

Seedhouse indicates here that ethics, when applied to the health care context, has very modest aims; it cannot provide uniquely and indisputably correct solutions to moral problems. This is simply not feasible.

The chapter can be drawn to a close by making a quite general point. It was noted earlier that actions which result in harms or benefits to others form a major part of the subject matter of ethics. Since the point of health care is to promote the well-being of patients – to undertake actions which result in benefits to others – it is plausible to hold that every nursing action has an ethical dimension. This point underlies Seedhouse’s slogan ‘Work for health is a moral endeavour’ (1988, p. 17). Since, presumably, all nursing actions – filling in records, interacting with patients and so on – are ultimately undertaken for their benefit, it is evident that Seedhouse’s slogan is appropriate. It is true that some actions undertaken by nurses may involve causing harm to patients. Perhaps giving people medication against their will is an example, as is giving medication by injection. But these harm-causing actions are only justifiably undertaken if in doing so more benefits, or fewer harms, result.

Conclusion

This introductory chapter has drawn attention to the inherent ethical dimension of nursing practice, described the concepts of moral awareness, perception, sensitivity, and imagination, and offered a strategy for both the identification of ethical issues in practice and also the development of moral sensitivity, perception and imagination. Having done all this, it is necessary in the next chapter to begin to introduce the approach to be put forward here for addressing ethical issues in practice.
# Index

abortion, 2  
Agar, 183  
acts and omissions, 83–6  
Act Utilitarianism, 26–7, 38, 39, 40, 44–6  
advocacy, 65  
Alderson, P., 150, 153, 154, 157, 158, 176, 177, 179, 195  
Alzheimer’s Society, 135–6  
American Nurses Association (ANA), 4  
Aristotle, 41, 44, 87, 153  
Armstrong, A.E., 41  
autonomy, 26, 57–63, 98–100  
Baier, A., 153  
Beauchamp, T. L. and Childress, J. F., 18–29, 47–9, 57, 59, 63, 66, 68–74, 80, 81, 85, 86, 87, 100, 110–21, 130, 134, 138, 148, 172, 202, 205–6, 214, 215, 217, 218, 220  
beneficence, 27, 74–81  
Benjamin, M. and Curtis, J., 4, 57, 63, 110–17, 120–1, 125, 143, 198  
Benner, P. and Wrubel, J., 149  
Bentham, J., 29  
Berghmans, R. and Widderhoven, G., 125  
Bloch, S. and Heyd, D., 124–7  
Blum, L., 162, 164, 177  
Bowden, P., 169  
Brabec, M., 154  
BRCA1/2 gene, 200  
British Medical Association, 108  
Buchanan, A. E. and Brock, D. W., 61, 73, 189, 195  
Burnard, P. and Chapman, C. M., 4  
Camus, A., 125  
Capuzzi, C. and Garland, M., 143  
Card, C., 169  
care as ‘moral orientation’, 174–6  
caring claim, 152, 161, 170, 172  
categorical imperative, 37–9  
Chadwick, R. and Tadd, W., 4  
Chamberlain, W., 96–7  
competence, 63–73  
confidentiality rule, 23–4  
Clouser, D. and Gert, B., 148  
Cox, P., 184  
Curtin, L. and Flaherty, M. J., 163, 210  
Daniels, N., 137  
‘David’ case, 79–80  
Deontology, 34–41  
de Raeeve, 22  
Dickenson, D., 129  
dignity, 103–4  
Dock, L., 45  
do not resuscitate (DNR) decisions, 108–9  
Dooley, D. and McCarthy, J., 204, 210  
Downs Syndrome, 184–96  
emotions claim, 152, 165  
ethical disorientation, 11  
expressivist objection, 188
<table>
<thead>
<tr>
<th>Name</th>
<th>Page(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Faulder, C.</td>
<td>65</td>
</tr>
<tr>
<td>fidelity rule</td>
<td>24–6, 21, 43</td>
</tr>
<tr>
<td>Friedman, M.</td>
<td>155</td>
</tr>
<tr>
<td>Gastmans, C.</td>
<td>174</td>
</tr>
<tr>
<td>Gilligan, C.</td>
<td>149–70</td>
</tr>
<tr>
<td>Gillon, R.</td>
<td>57, 75, 99, 129, 131, 135</td>
</tr>
<tr>
<td>Glover, J.</td>
<td>84, 126</td>
</tr>
<tr>
<td>Gough, E.</td>
<td>81, 121</td>
</tr>
<tr>
<td>Hare, R. M.</td>
<td>50, 160</td>
</tr>
<tr>
<td>Harris, J.</td>
<td>28, 126, 141</td>
</tr>
<tr>
<td>Harris, C.</td>
<td>136</td>
</tr>
<tr>
<td>Harris, L.</td>
<td>136</td>
</tr>
<tr>
<td>Herceptin</td>
<td>136</td>
</tr>
<tr>
<td>Hewitt, J.</td>
<td>125</td>
</tr>
<tr>
<td>hierarchy-web distinction</td>
<td>157–9, 167–8</td>
</tr>
<tr>
<td>HIV</td>
<td>213–14</td>
</tr>
<tr>
<td>Hunt, G.</td>
<td>210</td>
</tr>
<tr>
<td>Huntington’s Disease</td>
<td>197–9</td>
</tr>
<tr>
<td>Hursthouse, R.</td>
<td>47</td>
</tr>
<tr>
<td>Hussey, T.</td>
<td>7</td>
</tr>
<tr>
<td>Jehovah’s Witnesses</td>
<td>81, 121–2</td>
</tr>
<tr>
<td>Johnstone, M. J.</td>
<td>214</td>
</tr>
<tr>
<td>Justice</td>
<td>27, 86–98, 99, 171</td>
</tr>
<tr>
<td>justice-claim</td>
<td>152, 164</td>
</tr>
<tr>
<td>Kant, I.</td>
<td>34–41</td>
</tr>
<tr>
<td>Kohlberg, L.</td>
<td>149–51</td>
</tr>
<tr>
<td>Kuhse, H. and Singer, P.</td>
<td>84</td>
</tr>
<tr>
<td>Kymlicka, W.</td>
<td>97, 153, 155</td>
</tr>
<tr>
<td>life plan</td>
<td>59, 62, 190, 191, 219–20</td>
</tr>
<tr>
<td>Little, M.</td>
<td>174</td>
</tr>
<tr>
<td>Loach, E.</td>
<td>191</td>
</tr>
<tr>
<td>Loehy, E. H.</td>
<td>109</td>
</tr>
<tr>
<td>Lutzen, K.</td>
<td>58</td>
</tr>
<tr>
<td>Marquis, D.</td>
<td>194</td>
</tr>
<tr>
<td>Mason, J. K. and</td>
<td></td>
</tr>
<tr>
<td>McCall Smith, R. A.</td>
<td>61</td>
</tr>
<tr>
<td>Melia, K.</td>
<td>63</td>
</tr>
<tr>
<td>Mental Capacity Act (2005)</td>
<td>100</td>
</tr>
<tr>
<td>Mental Health Act (1983)</td>
<td>52, 58, 66, 83</td>
</tr>
<tr>
<td>metaethics</td>
<td>5</td>
</tr>
<tr>
<td>Midgeley, M.</td>
<td>167</td>
</tr>
<tr>
<td>Mill, J. S.</td>
<td>29, 57, 93</td>
</tr>
<tr>
<td>mixed-sex wards</td>
<td>1</td>
</tr>
<tr>
<td>moral awareness</td>
<td>7–8</td>
</tr>
<tr>
<td>moral judgements</td>
<td>18–19</td>
</tr>
<tr>
<td>morally relevant characteristics</td>
<td>77–82</td>
</tr>
<tr>
<td>moral perception</td>
<td>7–8</td>
</tr>
<tr>
<td>moral rules</td>
<td>20–6</td>
</tr>
<tr>
<td>moral sensitivity</td>
<td>7–8</td>
</tr>
<tr>
<td>moral subjectivism</td>
<td>167</td>
</tr>
<tr>
<td>needs/wants distinction</td>
<td>138</td>
</tr>
<tr>
<td>NMC Code</td>
<td>6, 45, 51, 54, 61, 74, 75, 80, 81–3, 90–2, 98, 101–4, 130, 145, 198, 208–11, 217, 219</td>
</tr>
<tr>
<td>Noddings, N.</td>
<td>149, 171, 178</td>
</tr>
<tr>
<td>nonmaleficence</td>
<td>27, 80–3</td>
</tr>
<tr>
<td>Nordenfelt, L.</td>
<td>50</td>
</tr>
<tr>
<td>Nortvedt, P.</td>
<td>174</td>
</tr>
<tr>
<td>Nozick, R.</td>
<td>94–8, 99, 145, 195, 196</td>
</tr>
<tr>
<td>nurses ‘station’</td>
<td>216–17</td>
</tr>
<tr>
<td>objective-subjective distinction</td>
<td>156–7, 166–7</td>
</tr>
<tr>
<td>O’Brien, A.J. and Golding, G.C.</td>
<td>63</td>
</tr>
<tr>
<td>Ochleford, E., Berryman, J. and Hsu, R.</td>
<td>190</td>
</tr>
<tr>
<td>Oderberg, D.</td>
<td>85</td>
</tr>
<tr>
<td>Oregon Plan</td>
<td>143–4</td>
</tr>
<tr>
<td>Paley, J.</td>
<td>41</td>
</tr>
<tr>
<td>paternalism</td>
<td>110–27, 198</td>
</tr>
<tr>
<td>person/human being distinction</td>
<td>28</td>
</tr>
<tr>
<td>persons, respect for</td>
<td>28</td>
</tr>
<tr>
<td>Pink, G.</td>
<td>204</td>
</tr>
<tr>
<td>Plato, 144, 153</td>
<td></td>
</tr>
<tr>
<td>privileged-view claim</td>
<td>152, 161, 163</td>
</tr>
<tr>
<td>public-domestic distinction</td>
<td>155, 165–6</td>
</tr>
<tr>
<td>Public Interest disclosure Act (1998)</td>
<td>205</td>
</tr>
<tr>
<td>privacy rule</td>
<td>22–3</td>
</tr>
<tr>
<td>Rachels, J.</td>
<td>38</td>
</tr>
<tr>
<td>Raphael, D. D.</td>
<td>5</td>
</tr>
<tr>
<td>Rawls, J.</td>
<td>93–8, 99, 142, 145, 153, 196</td>
</tr>
<tr>
<td>reflective equilibrium</td>
<td>48</td>
</tr>
<tr>
<td>Reinders, H.S.</td>
<td>191, 192</td>
</tr>
<tr>
<td>Rescher, N.</td>
<td>131</td>
</tr>
</tbody>
</table>
resource allocation
  desert-based, 139–41
  needs-based, 136–9
  rights-based, 132–6
  utility-based, 131–2
rights, positive and negative, 134
Robertson, G., 109
Rowson, R., 107
Royal College of Nursing, 108

Schecter, W. P., 216
Scott, P.A., 11, 178
Seedhouse, D., 3, 17, 50, 60, 138, 160, 208
self-project, 59
Sellman, D., 173
Sheldon, S. and Wilkinson, S., 183
Singer, P., 3, 60, 85, 90, 154, 162, 170
suicide, 123–7

Tadd, W., 210
Thompson, I. E., Melia, K. M. and Boyd, K. M., 4
Tronto, J., 162, 169–74
trust, 22
truth-telling, 107–8

UKCC Code of Conduct, 4, 74, 203, 204
UK-Plan, 144–5
UK resuscitation council, 108
uniqueness claim, 151–2, 160–1
Universalizability, 160–1
Utilitarianism, 4, 29–33
utility, principle of, 30
van Hooft, S., 62, 169
veracity rule, 21
virtue ethics, 41–7
Voluntary Euthanasia Society, 124

Wainwright, P., 173
Westwood, G., 184
Wilkinson, S. and Garrard, E., 85
Williams, B., 33
Wilmot, S., 204
withdrawing and withholding treatment, 85
Woods, S., 5, 61

Yarling, R. R. and McElmurry, B. J., 109