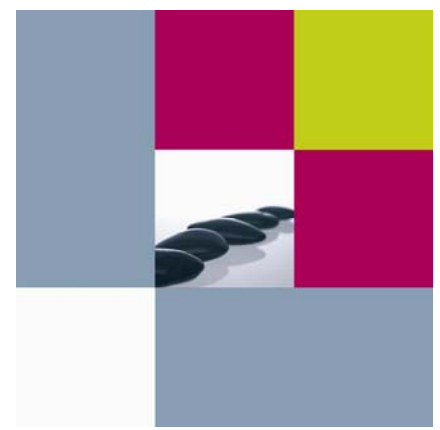




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**A Short History of Nursing Ethics:
Observations on
Character, Duty and Consequences**

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Introduction

Thanks for coming. Thank-you Vice Chancellor¹ for your kind welcome to Anglia Ruskin University, and to Professor Jenny Hunt for your personal insight into working with Winifred Raphael. I would also like to thank Professor Kate Gerrish and the Research Society Executive for this very kind invitation and the RCN Research Society Eastern Region and Dr Les Gelling for hosting the event so well. A special thank-you to Professor Annie Topping for her support over many years.

I am grateful to the Royal College of Nursing Research Society for supporting this important annual event which acknowledges the influence that Winifred Raphael, though not a nurse herself, had on early nurse researchers in this country. She was really an occupational psychologist keen to study organisations and their effects on people. Her work, (see, for example, Raphael, 1967) is a breath of fresh air, being completely jargon free and unpretentious whilst getting to the heart of people's opinions. I wish I could say the same of many research articles I read now, including some of my own.

I am going to talk a little about nursing ethics, based mainly on my interest and professional experience. After general medical and nursing experience I worked in intensive care units, rich with ethical dilemmas, even being a subject in the '*Care to Communicate*' study by Pat Ashworth (1980), who was invited to give this lecture in 1989 (Ashworth 1989). I then practiced as a charge nurse on a ward for people with serious blood disorders. Young men were on a treadmill of treatment, often experiencing unendurable suffering, mostly, it seemed to me, for the benefit of future patients rather than themselves. But it was working on the unit for older people with advanced dementia at Withington Hospital, Manchester that I first realised that people were writing papers about the concerns I had. One such was Norberg et al.'s (1980) paper about 'double bind' or conflict of motives experienced by carers of such patients who chose not to be fed. This paper was powerful, implying that inserting naso-gastric tubes and giving antibiotics when they were very ill might not be what these people would really want for themselves. My own experience was of a rather excessive use of such treatments for people in this condition, even when clearly reaching an end point in the life cycle.

Tonight I plan to undertake a whistle-stop tour through some key ideas in nursing ethics as they appear in the (selected) literature, with some key examples. These will include problems with notions of 'good character' or 'virtue ethics', duty, autonomy and risk-benefit (consequential) approaches. Accepting that, if I have a reputation at all, it is as something of a critic, I wouldn't wish to disappoint on an occasion such as this. I will therefore begin with what I think about the Royal College of Nursing's policies on at two important things. I shall finish on a third and even more controversial one.

First, despite quite a history of both supporting, and funding research in-house the 'RCN' has decided that it no longer needs a research institute and this is to become part of Warwick University. This is disappointing, since most funded research from the Government Agencies examines 'flavour of the month' organisational systems, and what the Government deems priority services and treatments. These days hardly any funded research examines those things that really matter to patients in a very basic way. The day to day nutrition of those with head injury, bowel care, care of the mouth, physical and emotional comfort, in short; patient problems which nurses need to develop their repertoire of interventions for. These are the kinds of things that were investigated, admittedly with Government support, in the 1960s and 70s in the RCN Research Series, also reported on in one of these lectures (McFarlane 1990). It took a woman of enormous vision (unlike more recent Government nurses) to make this happen; the late Marjorie Simpson who gave the founding lecture in this series. The RCN, if it is not to fund and maintain its own research unit, should give much thought to establishing a new '*Study of Nursing Care*' series, where the topics of study would be the fundamental aspects of nursing that matter to patients. It might be timely to examine why, over 150 years since the Crimean Campaign (when it was the

¹ Professor Mike Thorne

major cause of death), people are dying in very large numbers from acquired bowel infections in British Hospitals.

I am concerned that together with the RCN's disestablishment of first its face to face and now its distance learning programmes², which its executive and council probably didn't realise were world-leading, mean that the core funded RCN is now merely a Trades Union. It certainly can hardly claim also to be a learned society as once it did, hence its royal charter.

The RCN has long been a powerful amalgam of trade unionists, managers, academics and expert clinicians (White 1983). Without this combination its claims to formulate important policy on behalf of the whole profession will falter. Perhaps they should, as we will see.

'Another Pair of Eyes' (Kramer 2007)

<http://www.pilgrim.myzen.co.uk/patientvoices/clips/0017pv768r2.wmv>

(This high quality clip can be downloaded but is a large file. Please give it time)

A smaller file is available at:

<http://www.pilgrim.myzen.co.uk/patientvoices/clips/0017pv150r2.wmv>

The person in the video is Ian Kramer who suffered bipolar disorder and was HIV positive. The clip is short and to the point, but what Ian says is highly relevant to my purposes today. Reading previous papers from this Winfred Raphael Series was very instructive. Although I thought I was acquainted with much that previous speakers may have written, I had not noticed the degree to which most focus, as did Winifred Raphael herself, on the importance of getting patients' views³.

Analysing Ian's statement, I think the two main points are these. First, patients can tell us what is really going on, and second, some kind of observation of direct care is a vital mechanism of accountability, but that this must be repeated, consistently, not just a one-off assessment or 'audit'.

I think a little of each of these themes will resurface throughout the talk tonight.

Character and Nursing Ethics

Florence Nightingale gets a lot of credit for beginning 'modern' nurse training at St Thomas's in 1860, building on public funds raised as a result of the publicity she gained in the Crimean campaign. Nightingale certainly had a vision for the duties of nurses, and the kind of people nurses ought to be. We might say she felt 'character' to be important, and strove to encourage women of the right qualities to take up what she hoped would become a more respectable 'profession'.

In a previous lecture in this series Joyce Prince reminded us that Miss Nightingale delegated virtually all of the supervision of training to the Matron, Mrs Wardroper, but in 1872 she was minded to write of her:

“she may overstep the line between excitement and insanity any day....the probationers' home is a failure – there is no rule, nor governance, no influence whatever except for bad...The word training is a mere jest...she exercises a patronage for which she is unfit, a discretion which is indiscretion, a selection which is not only her caprice but the caprice of an hour – her appointments are disappointments, her rule misrule, her government anarch(y).....”
(Prince 1983, p 26)

² I believe they are being transferred to the Open University

³ I have difficulty the term 'user', as do most 'patients'.

Miss Nightingale was concerned about 'character' and that the regime in 1872 was far from either recruiting probationers with the right qualities or developing them in those in training. Christopher Maggs argues that towards the end of the 19th Century many hospitals had attempted to follow Nightingale's prescription for the ideal nurse. The probationer was assumed to be an unmarried 'Christian Lady' who had qualities of 'order, gentleness and quietness' but it was noted by a probationer of the time that:

"...no true woman would object to scouring, provided it was for the good of the patient...no woman of refinement of any feeling would deem it degrading". (Maggs 1980, p 21; his emphasis)

Marsha Fowler shows that early nursing ethics focused on the character of the 'moral agent' (Fowler 1997). As she puts it, it was what the nurse *was* not what the nurse *did* that was important. There was a presumption "that good character would produce the right action, i.e. that virtue accomplished duty." (p 19). So what virtues were said to be desirable? Fowler examined the nursing ethics literature for the hundred years 1875-1975, producing an enormous list of 157 qualities. From these she culls 24 'virtues'.

Benevolence, care, compassion, competence, courage, devotion, faithfulness, honesty, integrity, justness, kindness, knowledgeable, loving, loyal, nonmalevolent, prudent, skilled, teachable, temperate, tolerant, trustworthy, wise, understanding, truthful. (Fowler, p 23)

The virtues or 'good character' approach might seem outdated, of importance when Miss Nightingale was trying to improve the public image of nursing and create a respectable profession for upper and middle class ladies, but surely not relevant today. Sadly, it persists at the point of registration in current UK Nursing and Midwifery Council requirements. An excellent paper by Derek Sellman reminds us that in the UK, in order for nurses to be eligible to register, educators have the responsibility of signing to certify that:

...to the best of my knowledge...[I] believe the above named student's health and character are sufficiently good to enable safe and effective practice and that there is an intention to comply with the Code of Professional Conduct: NMC standards for conduct, performance and ethics. (Sellman 2007 p 762).

When a Head of a large University Nursing Department I signed many hundreds of these, rarely knowing the students as individuals. Sellman's argument that this requirement is misplaced hangs on three very strong premises.

Leaving 'health' aside completely for another occasion, we can say first that the NMC has no idea what constitutes 'good character'. Although from Fowler we have lists of up to 157 qualities that might make a good nurse, the NMC and its predecessors have singularly failed to define what they mean by 'good character'. If we are to judge by the nursing professional body's own performance in restoring those guilty of child abuse, rape and other serious crimes to its register (Johnson 2004a, Long 1992), it must be setting its standard of 'good character' quite low. Second, Sellman argues, those responsible for signing have no special qualifications in the assessment of good character. Third, the NMC must be assuming that we know of a causal link between 'good character' and safe and effective practice. Two substantial reviews of this literature found little to support such claims. Students might be said to benefit in their level of moral reasoning through education (Ketefian and Ormond 1988), though the predictive ability of 'character' assessment requires further work and disentanglement from context (Numminen and Leino-Kilpi 2007).

Sellman is therefore right to find the NMC's hypothesised relation between character and safe and effective practice seriously wanting. He argues that we have no real evidence that apparent personal qualities translate into good practice, indeed there is strong evidence that social context is the most important determinant of behaviour. I showed the clip of Ian Kramer's HIV nurse changing to and from 'safe and effective practice' depending on whether she was being observed by a manager. I myself saw a patient lifting device being used, obviously for the first time in

months, when doing non-participant observation of care for a limited time on an intensive care unit. The nurses had to read the instruction manual and wipe the dust off the device before doing things 'properly' for once.

Some well-meaning educator signed to say that these nurses were 'of good character' and they of course they probably are. But working in the real world 'character' isn't enough, which brings me to the next main development. We might say that focusing on 'duty' was the second important phase in thinking about nursing ethics.

Duty and Nursing Ethics

I think I can safely say that all, or virtually all of the books about nursing ethics take a 'principles' line, but which does not reflect the real world of nursing. That is to say they suggest that principles such as beneficence (doing good), non-maleficence (avoiding harm), respect for autonomy, justice and their sub-principles of keeping things in confidence and providing informed consent are the best framework for decision-making in health care. The extremely popular work by Beauchamp and Childress (2001) has many imitators among nursing writers, perhaps because the book does appeal to popular, or professionally respectable ideas. It may be fair to say the emphasis is that of professional duty to uphold these principles which, it is presumed, will protect patients' rights.

According to Fowler the 'Nightingale Pledge' was penned by Lystra Gretter in Detroit in 1893 in honour of Florence Nightingale. Borrowing heavily from the medical 'Hippocratic Oath' the original pledge was:

"I solemnly pledge before God and in the presence of this assembly to pass my life in purity and to practice my profession faithfully. I will abstain from whatever is deleterious and mischievous, and will not take of knowingly administer any harmful drug. I will do all in my power to maintain and elevate the standard of my profession, and will hold in confidence all personal matters committed to my keeping, and all family affairs coming to my knowledge in the practice of my calling. With loyalty will I endeavour to aid the physician in his work, and devote myself to the welfare of those committed to my care."

(Fowler 1997 p 25)

This contains many of the elements of later codes, and establishes certain principles that nurses should hold dear in their work, whilst cherishing certain virtues or qualities. Indeed one might say that it makes the transition from virtues to principles. Analysing this text, along with an implication of chastity one can see 'maintaining confidentiality', 'working in a collaborative way with other health professionals', 'beneficence', and the 'avoidance of harm'.

As regards chastity I fear all was lost in the sexual revolution of the 1960s and 70s. Training and 'living in' in 1971 perhaps I should consider myself fortunate. The home wardens did their best to protect, if not nurses from themselves, then the reputations of the Nurses' Homes from the press and angry parents. Hospital Matrons still considered themselves acting somewhat in 'loco parentis' (on behalf of parents).

In a context of professionalisation, confidentiality grew not so much out of a need to protect patients from knowledge about them becoming public, but to promote confidence in health professionals as keepers of personal information.

Working collaboratively is a benign interpretation of the loyalty expected to the physician, when really this doctrine enshrined the subjugation of nurses to medical authority. Although invocation of Nazi War Crimes is commonly used in attacks on 'consequential' (broadly utilitarian) forms of ethical argument, Hoskins gives many stark examples of how a principle such as loyalty to medical authority can result in the worst possible harms (Hoskins 2005). She documents nursing testimony that of 18,000 patients taken to Meseritz-Oberwalde under the Nazi eugenics programme 10,000

were killed by nursing personnel. Many of these nurses gave evidence that, under the ideology of the time, they thought they were doing the right thing.

Non-maleficence (doing no harm) seems self-evident as a principle all would hold dear. However, I have argued that behaviour is probably mostly context-dependent, and certainly the examination of any nursing situation demonstrates that the principle 'do no harm' is untenable. I make no apology for repeating a point I have made before (Johnson 2004b), which is that virtually all nursing and other health care interventions contain an element of harm. Giving your first injection is a benchmark skill for student nurse, 'a rite of passage', and most of us remember where and when we did it. Even when done correctly it involves pain and discomfort, and it has significant risks such as accidental intravenous, or even intra-arterial drug administration. Mistakes cannot easily be corrected, and side effects can include anaphylaxis and death. A host of other examples serve to make the point that few if any nursing interventions are risk free, but we must balance the risk or the harm with consequent benefit. Doing this means taking a consequential viewpoint.

I have left the principle of autonomy until last as it remains of great importance here too. Just as virtue ethics overlap with those of duty and rights, so the principle of autonomy is inescapably a part of modern consequential viewpoints.

Consequences

Utilitarian approaches are rarely promoted in nursing ethics texts despite the centrality of doing good and reducing harm in nursing codes. The human quality of doing good (beneficence) ought to be a clear aim, not just for nurses but for everyone. The problem with doing good is in the definition of good: when and for whom. On my own 'five minute'⁴ principle, I generally avoid claims to comprehension of the 'Greats' such as Plato, Socrates and the neglected Democritus, but I find Aristotle has much to say that is clear on this subject, and has been but little improved in two and a half thousand years.

"What is it (the good)? ...It is one thing in medicine and another in strategy, and so in the other branches of human skill. We must inquire, then, what is the good which is the end common to all of them. Shall we say it is for the sake of which everything else is done? In medicine this is health, in military science victory, in architecture a building." (Aristotle 4th Century BC)

Aristotle, very clearly, but at much greater length than this, is arguing that goodness is happiness or pleasure, but conscious of the different interpretations that people apply to these ideas, his view is best summarised as 'living or fairing well'; in other words the satisfaction of preferences within certain reasonable limits, or in moderation. Virtue ethicists claim Aristotle as their own (Crisp and Slote 1997), and certainly Aristotle was adamant that rather than us being born virtuous, 'good character' is learned through action, an idea surely of considerable import for a practice-based profession such as nursing.

To return to consequential ethics in nursing, I will examine one particular issue, that of killing and letting die. I think it proper to continue with this example, if only to refute some of the implications of the historically important but disturbing paper by Hoskins (2005) in which she shows how nurses in the Nazi Regime killed many thousands of innocent adults and children, people with handicaps and those with mental health and other problems. Hoskins admits that the Nazis had a rather loose definition of 'euthanasia'. Let us remember that euthanasia really means 'good death'. I think that now, especially with autonomy being so prominent in most moral theories, we would assume this has to be 'good' from the patient's or their advocate's point of view. Not so the Nazis. They saw 'good' as 'fulfilling their warped ideology in which autonomy was subjugated absolutely to the will of the state.

⁴ One should not drop 'names' in papers, theses or lectures unless prepared to speak intelligently about them for at least five minutes. I don't guarantee to pass such a text this evening.

To interpret helping people to die in extreme circumstances as a slippery slope towards a Nazi extermination policy, as Hoskins implies, is as misplaced as mis-labelling the foundation of these ideas as social 'Darwinism', as Hoskins does. Darwin would have been mortified by such a suggestion, and such thinking is fundamentally to misunderstand the idea of 'natural' selection (Darwin 1929, First published 1859).

Nurses have always confronted the relief of intractable suffering by trying to ease the pain of death. In my own practice, once individuals with terminal diagnoses were at a certain point on their trajectory towards death, it was customary for morphine or heroin to be prescribed four hourly with an anti-emetic as necessary. Often enough we would give the medicine or injections to people who had little or no idea of their fate. Perhaps they had been an 'open and close' patient with terminal cancer of the pancreas, (always a bad prognosis). Perhaps in agreement with the relatives, but not always, the decision had been made paternalistically and often the patient died, believing, so far as we knew, that they were making a recovery. Glaser and Strauss (1965) showed us these dimensions of awareness and we gradually realised that infringing autonomy in this way, that is, failing to discuss the options with the patient while they were still capable, was increasingly unacceptable.

Since the 1970s we have made enormous strides. First, there is no doubt that health professionals are much more likely to want to be honest with patients about their diagnosis. Work our team at Salford have published recently which examines the differences between nursing students in the 1980s (N = 176) and 2005 (N = 617) shows clear changes in attitudes to lying to patients about their diagnosis (Johnson et al. 2007)⁵. Among current students something like twice as many (66%) feel it would be wrong to keep the truth about their illness from patients than students 20 years ago (34%).

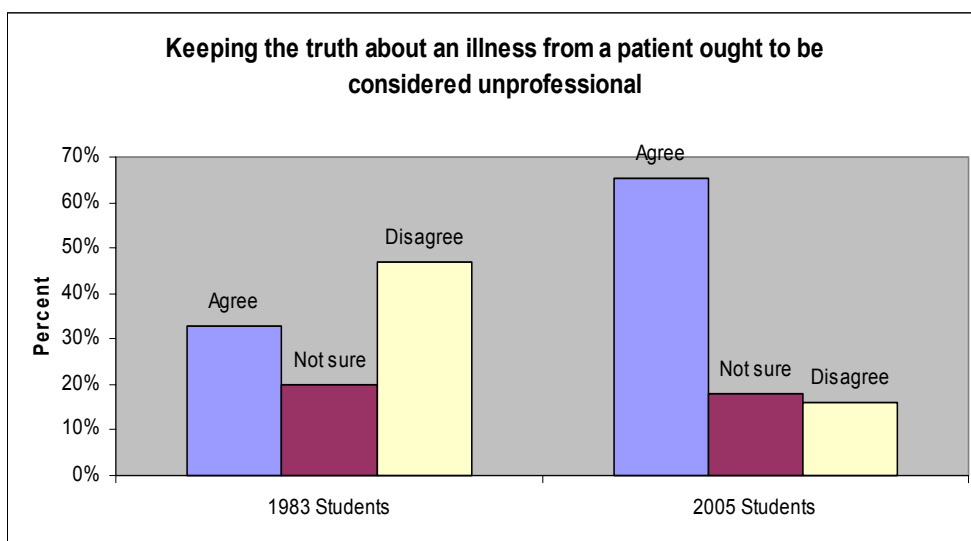


Chart 1

Comparison of Greater Manchester Nursing Students' attitudes to diagnosis disclosure 1983 (N = 176) to 2005 (N = 617)

(Source: Johnson, M., Haigh, C.A. and Yates-Bolton, N. (2007) Valuing of altruism and honesty in nursing students: A two-decade replication study. *Journal of Advanced Nursing*. 57, 4, 366-374.)

⁵ We are grateful for support from the GNC Trust

However, in an ethnographic study of a hospital ward in 2001 John Costello found that despite the rhetoric:

“with two exceptions, the 41 terminally ill patients in the sample observed during the fieldwork on Elm Ward, were not told their diagnosis by the hospital medical staff.”
(Costello 2004; p 47)

Rather, the consultant was minded to tell the patients’ relatives, and certainly patients ‘discovered’ their situation by other means. Costello acknowledges that each ward’s disclosure norms were different, but clearly progress in this respect is very varied.

Surely we can say that disclosing the truth about illness to patients is a good thing to do? Well, yes, if in a particular situation it helps them to discuss treatment options, be informed fully about the risks and benefits of further treatments, and when further treatment is not successful put their affairs in order and make plans for the best death possible, perhaps at home. We might reserve our judgement in special circumstances, and certainly the timing and skill with which such disclosure is made is a real challenge. Just as with other principles and values, autonomy cannot always be absolute. At best, preserving it takes time and judgement. Dealing with such mortal fears is the most profound emotional labour, one reason for certain why previously we have avoided it.

Letting people die

Assuming curative treatment is failing, and having faced up to telling people that they are probably dying, which is a big step, what options can we now put before them? Traditionally for people with malignancies, but increasingly with a broader brief, the Hospice Sector also has taken us forward. Openness about diagnosis and prognosis is generally a given, and treatment aims at palliation rather than cure. Palliative care as a speciality has developed enormously, and where provided by skilled staff, the management of pain and other sequelae of terminal illness are much better. Every effort is being made to ensure that all people who are dying in UK health care are properly assessed according to one or other protocol, such as the Liverpool Care Pathway or the Gold Standards Framework. This year I had the privilege of reading some of Jo Hockley’s work (Hockley 2006). She undertook an action research project in Scotland working with care and nursing home staff to develop strategies to improve the End of Life care that they were able to give. Hockley is to be admired since she faces up to an important reality; that for many people Nursing Homes are where they will die, predominantly from dementia and related illnesses. Sadly, Hockley found that rather than appreciating this fact, the treatment treadmill is still prevalent in this setting as one nurse reported:

“I worry about the amount of antibiotics given in this home...I know that there are different situations, but I really feel that certain people whose condition is not...hasn’t got a good quality of life...I feel we are just prolonging the agony... I do worry about the amount of antibiotics...when I am taking report – I am only in one night a week – there will be six or so people each week on a new antibiotic... for the 4th or 5th time.” (Hockley 2006; p 163)

Tackling such an important subject, where it’s actually happening in the Nursing Homes, Jo Hockley is a model to us all, though she doesn’t shrink from telling us how hard such work is. If we are looking for nursing and research virtues, she has a few.

Going further

I think Hockley is quite unusual in confronting the issue head on, as even allowing people to succumb to the ‘old person’s fiend’ (pneumonia), is seen by some as ‘passive euthanasia’, and by

this means is elevated to some kind of crime. Of course, our appeal to autonomy means that where practical we should be optimistic that our 'desired outcome' is what that person would have wanted. Let me be on record now, certainly, it's what I would want.

Allowing people to die of natural causes when, according to the best evidence available it is what they would have wanted, has to be reasonable. It upholds that ever important principle of autonomy, or allowing people to fulfil their preference. There has to be a common decency in allowing people a natural death in these circumstances, because I can believe that even if we don't have a statement of advanced decision or 'living will' common sense suggests that few of us would want to hang on to life as mere shells of our former selves.

Dying from natural causes is all very well if it is painless, dignified, free from discomforts like constipation and from symptoms beyond the current competence of the nursing and medical professions to control. Julia Lawton, whose work I commend to everyone I meet, undertook a study of a Hospice (Lawton 2000). One must not speculate on these matters lest we break some imagined moral rule of permanent anonymity (Long and Johnson, 2007), but since she was a Cambridge University PhD student, it might conceivably have been not far from here.

Having worked in the Hospice for several months as a volunteer but at the same time openly as a researcher, Lawton deconstructs the myth that dying in a Hospice is always a good thing. She notes in particular the areas where nursing fails to provide a solution to the enormous suffering of individuals. Given our sensibilities in the West in the 21st Century, we care greatly that our bodily contents remain under our control and that the act of excretion remains for the most part private. Lawton analyses the situation of several people, in as moving a text as I have yet seen. One such is 'Annie' who had a pelvic malignancy and was leaking malodorous fluid from a fistula between her bladder, rectum and vagina.

Gradually, relatives and other patients found her presence difficult, and probably conscious of her own depersonalisation Annie removed reminders of her previous self (such as photographs), presumably because these were emotionally too painful. Despite the Hospice culture that the dying should face death where they find it, Annie was removed to single room, with minimal visitation.

This situation, of 'dirty dying', is one which even the Hospice cannot yet prevent or significantly ameliorate, except by sequestration, that is removing or hiding the situation. It is this context, or a hundred others like it, that for me suggests that our nursing and medical ethics fails us completely. 'Doing good', and 'avoiding harm', even 'preserving autonomy' become mere platitudes in such circumstances. Many such patients like Annie make thinly veiled, or even more direct pleas for speedy relief of such suffering, by which they mean being helped to die more quickly than 'nature' intends. Doing good, avoiding harm, and allowing them autonomy to fulfil their own preferences would in many cases mean assisting their quick death.

Some nurses might be reassured that they don't have to think such things. The Royal College of Nursing of the United Kingdom has a 'policy' on it. In response to the recent debate on assisted suicide we have:

"The RCN is against euthanasia and assisted suicide." Beverly Malone (2004) then General Secretary of the Royal College of Nursing.

Malone's commitment to a policy of being 'against' euthanasia was articulated at a time of wide national debate about Lord Joffe's wish to introduce a bill to legalise, under certain carefully controlled conditions, assisted suicide. I find the statement to be an example of policy without evidence. In a context of wanting to reassure the public that nurses will not easily resort to killing their patients this may be comprehensible. But the genuine evidence flies in the face of such a fear. Maura Buchanan, now president of the College goes further, and makes even less recourse to evidence:

“Our patients do not want nurses and doctors to be skilled in delivering lethal injections.”

Maura Buchanan (2005) Now President of the Royal College of Nursing.

The current policy does not reflect reality. Nurses assisted in ending patients lives more quickly than would occur naturally when I was in practice, and many do so today. Sometimes labelled ‘terminal sedation’, some commentators labour over whether or not it is the professional ‘intent’ to cause death. Of course it is, provided the patient wants it, or would have wanted it had they the ability to make it known in time.

Actually, in the United Kingdom, we know that about 80% of people would be happy with a change in the law to make medically assisted dying legal (Dignity in Dying, 2007). I don’t plan to use this platform to argue directly for assisted suicide or euthanasia. I do, as a member of the RCN Research Society, hope and expect that the RCN will sponsor some high quality research into this field and then, after careful consideration of more evidence, think seriously about a different policy. Here I return to our starting point. It should be of less consequence what nurses think or say. What is more important is the expressed preference of the people we care for. People like Ian Kramer, who has now died, people like Annie in Julia Lawton’s study, and people who are facing this reality right now. I suspect that the RCN fears what a serious piece of research would reveal, but from my generally consequential perspective, nothing would be more worth a big slice of my subscription.

Conclusions

I have argued that whilst the virtues, or good character approach to nursing ethics may have served well as a starting point, despite its weaknesses a principles-based approach underlay most books and codes of conduct for the subsequent hundred years. Nurses were seen as loyal servants of both hospital and medical bureaucracy and duty and rules were, and arguably still are, the dominant framework. The broadly utilitarian or specifically consequential view hardly surfaces as a viewpoint which is taken seriously and yet its use is somehow inevitable but unrecognised. Just about all of health care is a risk management situation.

This viewpoint can enable decisions to be placed in context, account to be taken of the views of several stakeholders, and it can help us break with traditional views. We might think about more use of surveillance for example, such as spot checks and even video. Professionals rail against it as some infringement of autonomy, but where repeated and sometimes unobtrusive observation raises standards why not? Professionals cannot be held accountable for the invisible.

The patients tell us this, when we listen. They don’t want MRSA, or Clostridium Difficile, they don’t want to die alone in a hospital or hospice sideward, and most of all they want us to believe them and do something about it when they’ve had enough.

In modern nursing the risks are profound. These might include, with the current ‘head in the sand’ policies against assisted suicide, the people we love and care for, perhaps even ourselves, enduring needless suffering like Annie in that Hospice somewhere in the South East of England.

The risks of modern consequentialism which underpin the progress we need to make in nursing ethics are the need to shake off the following of simple rules, the need for good evidence, the need for clear thought, and the chance that for once we might say or do something new. Sadly, despite the example of voluntary contributors such as the Research Society, the Royal College of Nursing itself is a long way behind.

Further acknowledgments

The RCN library for the timely loan of *‘They Speak for Themselves’*. Also to Lorraine Ellis, Les Gelling, Alison Johnson, Tony Long, Andrew McKie, Lillian Neville and Natalie Yates-Bolton for comments on draft 1.

Note

This document represents what I intended to say. I do not care to read a text word for word on such occasions, so speaking from slides, my words were different but hopefully much of the meaning was the same.

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