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Introduction

Life is short, and Art long; the crisis fleeting, experience perilous, and decision difficult.

Hippocrates, 5th Century BC

Practical questions such as Should this patient continue to be fed artificially? are rarely simply technical matters. They carry concerns of fairness, rights, compromised freedom and justice. We often speak of the moral dimension of practice but it is perhaps more accurate to regard moral matters as being so bound up with the technical and social aspects of caring that to separate them out as a discrete item for discussion is not easy and possibly not helpful. The work of nurses and other health care professionals entails human contact. Decisions about care are matters of judgement; these are clinical judgements which, of course, also involve the patient. There will also be circumstances where this is not possible and the patient's relatives[1] and/or legal representative can be involved. Nursing practice does not occur in a moral vacuum; the organisation of health care means that nurses work with other professionals making up the multidisciplinary team. The wider social context within which the decisions are made also has its influence on practice. Given all of this, we need to be clear about what ethics is and why we should be concerned with it in nursing practice.

Ethics, or moral philosophy, is the branch of philosophy that is concerned with the study of morals and the nature of morality. It is of practical value to clinicians in health care as it provides the language and concepts with which to argue for and justify a particular decision or action. In other words, it allows us to judge our own moral convictions and values against wider, socially accepted principles and rules for behaviour. Morality has to do with a sense of right and wrong. But where does this come from? Can it be taught?

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[1]Throughout the book I use 'relatives' to refer to family and friends representing the patient's interests. I do so on the grounds that friends are related by friendship, whereas family need not imply friend.

This book concerns the moral dimension of nursing and health care practice. It is in no way a rule book, or even guide as to how to avoid ethical traps. Health care is a complex matter and nursing plays a central part in its practice. Situations arise in daily nursing practice which involve a decision to be made that is both a clinical and moral decision. In this book we take a down-to-earth, case-based approach to ethics. Essentially ethics is about the reasoning behind the decisions we take, and it forces us to think about what is the right thing to do in life. In the case of nursing practice, ethics is about how to decide how to act as a nurse.

In a society that has advanced to the point that a complex division of labour exists, health care is a professionalised activity and those being cared for will be, by and large, unknown to those doing the caring. Put simply, we have two sets of strangers, patients and professionals, who have to relate to each other in order to produce a working partnership, however transient. This is not, of course, to say that relationships do not develop; long-standing professional–patient relationships exist in all areas of practice. However, the point stands because even strong patient–professional relationships had to start somewhere. Nursing practice involves patient and professional coming together and arriving at a position where communication and care are brought about in a relationship which should be based on trust.

This book is an introduction to ethics for nursing and health care practice and stresses the importance of the social context in which this takes place. The idea is to introduce the moral philosophical language in which practical clinical issues[2] are discussed. The relationship between ethics and the law is a theme that runs through the book and so provides a basis for a good understanding of ethics and law as they relate to nursing practice. Ethical decisions are arrived at in practice in a social and legal context. Sociology is drawn upon where it can help to explain the social and organisational context of practice. Whilst this is an introductory text to ethics for practice, the aim is to discuss some of the complexities of ethical debate. The book starts from scratch, assuming no prior knowledge of ethics or law; however, the discussions can lead to a sophisticated level of debate, but a debate which remains firmly rooted in practice.

Ethics Morals and Practical Reasoning

Nursing practice is a complex business and it is expected, indeed assumed, that nurses will behave in an ethically acceptable way. In this book we explore exactly what this entails and through the discussion of cases we enter the world of the moral philosopher, and in so doing see what light moral philosophy can shed on the moral dimension of nursing. This book is not a comprehensive account of ethics for nursing

[2]'Issue' in this text carries the long-standing meaning and does not equate to 'problem'. Issue, meaning a topic for discussion, is a more neutral term used to describe matters worthy of discussion which may or may not be problematic. In many places I have used 'concerns' or 'matters' instead of 'issues' to avoid confusion for those who do equate 'issue' with 'problem'.

practice, rather it seeks to convey the central principles and their relationship to ethical debates in such a way as to nudge readers towards an examination of their own clinical experience and focus on the ethical aspects of practice.

Whilst ethics and morals have to do with right and wrong, they are not about dictating what we should and should not do. The distinction between morals and ethics is worth spending a little time on, although the terms are often used interchangeably. 'Morals' refers to the values and associated rules and practices by which people live, whereas 'ethics' is that branch of philosophy called moral philosophy, which is concerned with the study of morality.

Some writers prefer not to draw the distinction, pointing out that both words – ethics and morality – have their roots in words meaning 'customs' and as such are not really different, despite the distinction. 'Ethics' derives from the Greek *ethikos* which gives us the word 'ethos'. 'Morals' derives from the Latin *moralis*, meaning mores. Both words mean customs and ways of life followed and passed down through generations (Singer, 1994: 5). Singer also notes that ethics is a more neutral term and the word morality can convey a particularly religious resonance.

Within the health care literature I find that both ethics and morals are used interchangeably whilst at times the distinction is recognised, and so in this book I do not adopt a rigid approach to their use. Ethics is essentially about the study of morals and is generally about right and wrong. The terms ethics and morals whilst distinct can be used interchangeably without much harm coming to the discipline of moral philosophy. Nor, indeed, will any harm come to the study of ethics for nursing practice if we slip between the terms morals (the values and mores of behaviour) and ethics (moral philosophy, concerned with the study of morals).

The business of ethics is to examine the justifications offered for the various moral stances that people take on questions where there are various opinions and where decisions have to be made. In the face of an ethical dilemma where, by definition, it is not clear which action is the best option to take, moral philosophy offers the language and concepts with which to debate the matter. It also allows us to draw on a wider range of principles and theoretical positions which have stood the test of time and public debate. For example, the idea of respecting individual's rights to be treated in ways which are deemed to be acceptable and fair forms the basis of many discussions of resources. The use of resources can give rise to everyday questions which might appear to be trivial matters, such as making the best use of the available staff time on a shift in order to achieve the best outcomes for the patients on that unit.

A busy morning on a ward which has been the main admission ward overnight. There is a shortage of linen. There are not enough sheets to enable as many to be changed as would be desirable. The nurses on duty, having established that there will be no more sheets delivered to the ward until the afternoon, have to do the best they can. The

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practical solution is to change those that cannot be left, and catch up later in the day with the rest when new stocks arrive.

There are organisational and maybe even financial considerations here. How should nurses react to this compromise of optimum patient care? In a busy ward the answer may be to make do and move on. But what if this is a common occurrence? If nurses always manage to cope, the situation may go unchanged, like the sheets! Is there an obligation to speak out in an attempt to make things better? And what if managing, quietly getting on with it, extends to other areas of care? Where should nurses hold, or even draw the line and speak out?

This question, which set out as a matter of what to do when there is a shortage of bed linen, has moral aspects to it. Moral choices, albeit small ones, are made in deciding who gets a clean sheet, and by default who does not. The right to a clean sheet is not an absolute one; our rights are often set against those of others – if one person's need is satisfied in a rationing situation, another person's is not. The greater need that one person has of the clean sheet does not alter the fact that the person with less need did not get a clean sheet. This not very dramatic example of moral choice is just one of many similar choices made by nurses in relation to the daily care of patients.

Ethical Debate

It is worth rehearsing the reasons why ethical debate is important; one of the main ones is that when vulnerable people are being cared for by strangers, there has to be an atmosphere of trust. We create this by developing a context for a professional–patient relationship. In order to achieve this we need some ground rules, and some of these rules are the concern of ethics. Ethical analysis and debate provide a way of examining and discussing the rights and wrongs of behaviour in health care. What is in the patient's best interests? How should we be caring for this patient? Is this a reasonable way to run a ward? How should we respond to aggressive behaviour in patients and their relatives? These are all questions for moral philosophy. We need a common language and a way of debating the rights and wrongs of how to go about nursing and health care, especially when things are not straightforward. We find this language in moral philosophy.

One of the interesting aspects of ethical debate is that there are no rights and wrongs about it. Leaving aside views that might be regarded as being beyond anyone's pale, ethical debate takes on board all moral arguments that are reasoned attempts at making a genuine effort to decide on the right action to take when faced with a difficult situation.

Philosophy is very much concerned with what is the right thing to do, how people justify their positions when making moral decisions. Moral decisions are very much

like clinical decisions, they have practical connections and consequences and a social context. Ethics is a very practical business: decisions in health care have legal, moral, clinical, economic and psychosocial aspects.

In the midst of everyday practice there is rarely time to step back and ask are we doing the right thing, what should we do? In this day of protocols, evidence-based practice, audit trails and the rest, there is not a moral procedure book to consult. Yes, there are codes of conduct, ethical discussions, but in day-to-day practice there comes a point where practitioners working together with patients have to arrive at a decision; this is very much the social production of action. In other words, it is a practical matter, it is practical reasoning. Ethical debate gives an opportunity to explore moral issues using the language and concepts of moral philosophy. This means that we cannot take our usual ideas and stands on particular issues for granted, and this includes our prejudices. We do not tend to regard our own views and opinions on social matters as prejudices, they are just what we think. They may be strong enough convictions to make us disapprove of others who do not happen to share our opinion. When someone expresses what in our view is an unacceptable opinion during a general conversation, it can be difficult, especially if their assumption is that it is a shared view, and an unproblematic one at that. These views may be racist or sexist or offensive in some other way. These situations make two things clear: first, what we might assume to be a reasonable and common-sense view to hold is not necessarily a universal understanding; and second, it is not always easy to register our objection because it takes us out of the normal expectations and conventions of conversation in social life. Clearly there has to be a good deal of common understandings and beliefs if society is to function, and later in the book we return to this idea in a discussion of societal norms and expectations and the law.

My general point at this juncture is that we cannot always assume that others will automatically share the views that we, as individuals, hold about right and wrong. This is especially important for a professional group such as nursing where there is a need for shared values in the profession. There also has to be a means of engaging with a wide variety of patients who have other views and values.

In everyday life we do not normally try to investigate the justifications for the values that we hold. Moral philosophy at its simplest gives us a means by which to do this. As we have said, ethics is a deeply practical business; without real life practical examples to relate to, ethical debate is somewhat sterile. The discussions in this book are centred around a few classic and some hypothetical cases which give rise to ethical and sometimes legal and ethical debate. The clinical context can be supplied by the reader. The main aim of the book is to demonstrate, through discussion of some of the common themes of ethical debate, how such discussion can be of assistance in arriving at decisions in the practice of nursing and health care. The inclusion of classic and hypothetical cases giving rise to ethical and sometimes ethical and legal debate: this means that the book can be read and re-read at different stages in the reader's experience of practice.

In health care the patient is the prime concern. However, the social and clinical organisation of health care is complex and involves various health care professionals working in multidisciplinary teams, and often with the patient's relatives. The

care takes place in a social context and so all concerned are constrained by social and economic circumstances, all of which makes the business of multi-disciplinary care often far from straightforward. The whole system operates on the basis of trust. Trust is a moral concept. We cannot see trust, it manifests itself through the behaviour of individuals towards one another. We have rules and regulations and laws, but these do not make the notion of trust redundant. Trust has to exist throughout the health care system from trust in the relationship which the patient has with the health care professionals to the inter-professional working relationships of the health care team which also require a basis of trust.

How Ought We to Live? From Aristotle (384–322 BC) to the 21st Century

Ethical questions that we raise today have a long history; the social context has changed, but the questions persist. In the spirit of giving the reader a good understanding of ethics I offer a preview, as it were, of Aristotle's approach to moral philosophy early in this book. We return to this in later chapters. It is useful to glimpse Aristotle's work early on in getting to grips with ethics because it is more relevant and engaging than one might be forgiven for thinking the ideas of a 4th-century BC Greek philosopher might be.

This question of how we ought to live is by no means new. The ancient Greek philosophers' central question was just that: how ought we to live? The goal for Aristotle was to grow towards the good. Their goal Singer (1994: 3) describes as 'wisdom about how to live our lives'. The idea of wisdom may seem rather arcane and not very 21st century, until we consider it in terms of judgement. Wise men, and wise women for that matter (although that term is too closely associated with witches to be entirely helpful), have existed through the ages. They have been looked to for help in times of difficult decision making. Believers will seek the wisdom of their gods in order to help when choices have to be made. If we move this idea of difficult choices from 4th-century BC into the 21st-century health care setting, we are talking about clinical judgement. Many clinical decisions taken in health care have a moral element and so we cannot escape the fact that clinical judgement and moral judgement are linked in practice.

Aristotle's work appears in many textbooks on medical ethics, biomedical ethics, and nursing ethics because Aristotle's work is practical, concerned as he was with questions about what constituted the good life and how one should live the good life. Campbell et al. (2005: 3) note that Plato in the 4th-century BC, in answering his own question 'What sort of person ought one to be?', said that the good person was guided by the 'form' of the good. Campbell et al. say that Plato was referring to

> divine and eternal reality only imperfectly seen in everyday human existence, but supremely disclosed by the calm contemplations of wise men. (2005: 3)

Campbell et al. go on to note that we need to recognise that:

> great thoughts do not always mean good deeds, and that morality is essentially to do with our attitudes, behaviour and relations to one another. (2005: 3)

Some Christian writers, Aquinas being one, have according to Campbell (1984) added to Aristotle's theory the idea that the ideal way of being (of living) is consistent with God's design for humankind. In this way, Campbell explains, 'natural' and 'good' become fused. This is clear when we examine some of the ethical theories. Aristotle's response to Plato's 'What sort of person should we be?' question was pragmatic, according to Campbell et al., as:

> for Aristotle the qualities that make us human were shown in our thinking, our associations with each other and our functions as members of the natural order. (2005: 3)

Campbell et al. remind us that Aristotle and Hippocrates[3] approached their work in much the same way and

> began with observations of the actual world in which they lived, rather than beginning with theories about life, the universe and everything. (2005: 3)

This empirical approach – that is, starting with the 'facts' as observed – we will see was the approach taken by the 18th-century philosopher David Hume. It was, in his day, a break away from the more commonly encountered way of working when philosophers proceeded through reason and logic to theory. Campbell et al. describe this as the leap from Aristotle to Hume.[4]

Singer (1993: 88) reminds us that whilst in Western philosophy we look back to Greece and the great philosophers, Socrates, Plato and Aristotle, it was not the case that all their values are ones we would recognise today. There was no equality in society, slaves did not enjoy autonomy, newborns were not automatically preserved. We need, Singer cautions, to be careful not simply to adopt unthinkingly the ideas from the ancient Greek philosophers, because some would plainly not meet the expectations of contemporary life.

Singer tells us, for example:

> There was no respect for the lives of slaves or other 'barbarians'; and even among the Greeks and Romans themselves, infants had no automatic right to life. Greeks and Romans killed deformed or weak infants by exposing them to the elements

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[3]Hippocrates, 5th-century BC Greek philosopher and teacher of medicine on the island of Kos. He is regarded as the 'father of medicine' and was author of the first code of practice for medicine, still read today in many medical schools at graduation ceremonies.

[4]Hume returns to this tale in Chapter 4.

> on a hilltop. Plato and Aristotle thought that the state should enforce the killing of deformed infants. (1993: 88)

We can see from this that the state has for centuries had a role in what we would now call 'health care ethics'. Also we can see most starkly in Singer's example that moral values can and do change. This is why there are no absolute rights and wrongs about moral debate.

One of the things that remains constant is human nature, a concern with doing the right thing with fairness and justice and working out the right thing to do, how to behave. Looking around the world this would seem something of a Utopian proposition with misuse of power, unnecessary wars, famines that could be ended if people behaved in a way that was decent. It is worth pondering for at least a few minutes what the world would look like if everyone behaved in the way that they are supposed to do. Police forces and armies would be redundant save for humanitarian work required as a result of natural disaster and accident. Fraud squads, anti-computer hacking teams, war correspondents, hours of medical and nursing staff time in Accident and Emergency departments could be saved and redeployed when drunks and related casualties are removed from the patient list. All very fanciful and, of course, dependent upon one vital definition of a condition that I slipped in at the start of this paragraph, namely what is the *right* thing to do? How does society arrive at an agreed version of the right thing to do?

Notwithstanding all this, Aristotle's work is particularly useful in relation to health care ethics because his work has resonance for today's practice. There is no need to read the original (equally no reason not to!). There are many introductions to Aristotle's work, and those writing in the field of bioethics make clear Aristotle's meanings when they draw upon his work. Aristotle's ideas have a very contemporary ring to them; the translations are to an extent responsible for this, and the style adopted makes it possible to draw a direct line from 4th-century BC ancient Greece to 21st-century Western health care ethics.

One of Aristotle's ideas that has utility in terms of ethics for nursing practice comes in his writing about habituation, in the sense of doing something repeatedly so that it becomes second nature – a habit. He says that 'moral virtues, like crafts, are acquired by practice and habituation' (Book II, 1103a14–b1). A virtue in the ancient Greek world was an excellence. Its meaning was not dissimilar from our notion of competence.[5] In an uncannily relevant example of prudence, or practical wisdom, Aristotle says:

> Prudence is not concerned with universals only; it must also take cognizance of particulars, because it is concerned with conduct, and conduct has its sphere in particular circumstances. That is why some people who do not possess [theoretical] knowledge are more effective in action (especially if they are experienced) than

[5]Competencies form the basis of the regulatory mechanisms used to approve university programmes in nursing. This is the case too with medicine and other health care professions.

> others who do possess it. For example, suppose that someone knows that light flesh foods are digestible and wholesome, but does not know what kinds are light; he will be less likely to produce health than one who knows that chicken is wholesome. But prudence is practical, and therefore it must have both kinds of knowledge, or especially the latter. Here too, however, there must be some co-ordinating science. (Book VI, 1141b8–27)

Aristotle's discussion of nutrition nicely demonstrates the relevance of his thinking to today's health care, especially with his emphasis on practice. Indeed, Aristotle's view was that unless ethical theory was related to practical examples in life, it was poor philosophy. This is why the ethical debates we have in nursing move between theoretical, abstract principles and cases, clinical examples in everyday practice.

Working in the Theory–Practice Gap

Practice disciplines present particular challenges when it comes to the relevance of theoretical debate to the everyday practice. Moral philosophy can be rather abstract and theoretical, somewhat removed from the concerns of the practitioner faced with the need to make decisions and, importantly, the need to act. An under-staffed ward, where too many beds are currently occupied by patients who should have been either discharged home or transferred to a more appropriate unit, is not the place to have a theoretical discussion about justice and resources. Moral philosophy is characterised by a capacity to move between the theoretical ideas and practical examples.

In the nursing literature, and in that of other professionals in health care, there is much ink spilled over the matter of bridging the perceived gap between theory and practice. This idea on the first encounter appears to be a good one. However, on reflection not only does it prove to be of little help in seeing anything more clearly, but also the idea itself seems to be somewhat flawed. It is not clear what a bridge would look like and what it might link to. The same question might be raised in the case of a perceived gap between moral theory and nursing; that is, how do moral philosophy and ethical theory relate to everyday nursing practice?

> Eliciting informed consent from a patient who has mood swings, which make their capacity for taking decisions transient, is a practical matter. The patient's capacity for reason and decision making may change from day to day or even hour to hour.

This is the reality of daily care, a practical matter with theoretical underpinnings. This is not so much a gap to be bridged as a situation where different orders of knowledge and understandings are required. The practical and proper response at the time is important for good practice to result. This is not so much a theory–practice

gap as a matter of there being a time and a place for these debates. A theoretical discussion of autonomy and the reasons why it should be respected can tell us why the principle of respect for autonomy is a good thing.

The gap is more one of perspective and changing priority depending on the situation; thus it is a gap between theory and practice. Working with or in this gap holds more promise than does bridging it. In a typical discussion of the theory–practice gap, the idea is that theory is 'all very well' until it is tried in practice, and it is then that the gap is encountered. This is not a purely nursing phenomenon: newcomers to any practice discipline will encounter experienced practitioners who may be more concerned with practicalities and appear to have little interest in theory. It may be that this is, in fact, the case. However, it is just as likely that experienced practitioners have adjusted to working with, or in, the gap and so know when it is appropriate to give more attention to the theory and when practical matters, albeit informed by theory, take precedence.

Making Judgements

Judgement is an essential clinical skill which comes with practice. However, the opportunity to have the discussion in a calmer setting is a useful way of considering the moral concerns of everyday practice. There is also a place for debate about the best approach to the care. This might be patient-specific or policy oriented; either way it is a practical matter, assisted by some theoretical input. When confronted with ethical decisions there is sometimes a temptation to try to convert the problem into a technical one or to characterise it as an organisational matter such that the real nature of the moral question is avoided. If there is a moral question to be confronted, whether it is a *moral choice* or a *dilemma*, it is a judgement that is called for, not a technical fix.

The high-profile complex cases that get into journals and law reports often represent the classic moral dilemma. A *dilemma* is a situation where there is no clear solution, when the alternative courses of action carry disadvantages. A *moral dilemma* is the same except that a moral principle will be compromised whichever course of action is decided upon. A classic, but mercifully rare, example of a moral dilemma is the difficult birth where it is only possible to save either the mother or the baby but not both. Moral arguments can be mounted to support saving the baby and for saving the mother. Each case is sound and can be based on a moral theory. The discussion of a moral dilemma sharpens the debate, makes clear the theories and how they relate to cases. For this reason, ethics is often taught by reference dilemmas. The least worse thing to do is often the best option. Moral choice is much more frequently encountered in daily practice. We should be concerned with the everyday as well as the not so every day moral situations. The moral dilemma is a classic way of approaching a discussion of ethics in health care. It has its uses, it sharpens our views, and allows us to consider cases from various standpoints with the assistance of theories.

In the face of a dilemma, where by definition there is no right way to go, the sides of the argument can be polarised and seem intractable. Moral theories come into their own more obviously here. In the case of the mother, the right to life argument hinges on different principles, a life already in existence, a biography to respect versus the imperative that a newborn helpless infant requires assistance. There is no good answer: this is why it is properly termed a dilemma. Where a solution can be found with no compromise of principle it was not a dilemma in the first place.

It is worth remembering, though, that the moral choices that are made in the practice of nursing have moral concerns and involve principles of rights, justice, respect and so on. The significance of moral choice, because it is more low-key, can be missed. The lowering of standards of care which are found when inquiries are made into hospitals and care homes reveal the obvious lack of attention to the principles which would not sanction the poor care were it planned with concerns for patients' rights and dignity. It is not surprising that some of the worst findings come in hospitals and units where there are organisational difficulties and managerial shortcomings which allow poor practices to persist. These poor practices include patients being left too long waiting for attention; food and drink being delivered and taken away untouched because patients are unable to reach it; and patients in need of personal care being left to their own devices. It would not be true to say that these practices are planned or designed. However, the fact that they are allowed to go unchallenged paves the way for them to become 'acceptable' and so to continue until they are institutionalised and eventually regarded as unavoidable. Everyone involved in such care, including those who find themselves going along with it and perceiving themselves to have neither responsibility for it nor power to do anything about it, has in some way made a moral choice to behave as they do.

There is a difference between a moral judgement and a professional clinical judgement. There will be elements of both in many decisions. The point about ethical debate and the theoretical positions offered by moral philosophy is not to come up with a checklist or rule book. The moral philosopher is concerned to make clear some of the expressions and ideas that we use with less precision than is useful. For example, we speak of something being in the patient's best interests, or being good for them, not always with a clear idea of what this entails, less still with an idea of what the patient would want for themselves. Philosophers spend their time exploring issues; in the case of ethics in practice, exploring moral positions being adopted in relation to various health care matters. They question things that are generally taken as understood or are not questioned at all. The famous statement made by the 4th-century BC Greek philosopher Socrates about the unexamined life not being a life worth living conveys the idea. Alternatively, one might envisage the philosopher as an academic two-year-old, forever asking 'why' and coming to subjects in unexpected ways. The 'why' of the moral philosopher will not be satisfied by the 'because that is how it is' answer of parents and sometimes offered by health care professionals and their institutions. Socrates met his end by a cup of hemlock, having taken his enquiry to the streets of Athens and pursued his quest for understanding of virtue and justice too far for the sensibilities of the day. In 21st-century nursing practice the sharing of information is smiled upon as it generally leads to good outcomes – so a cup of tea is more likely to be the beverage on offer.

The Question that Socrates Asked

Socrates asked 'What sort of person ought one to be?' This question is linked to a second question, 'What ought a good person do?' or 'How ought a good person act?'. These are questions that sustain down the centuries and are as relevant to this book on ethics for nursing and health care practice as they were for Socrates, his pupil Plato and Plato's pupil Aristotle. Campbell et al. say that:

> ethics is best thought of as the critical scrutiny of moral thought and practice. (2005: 2)

They go on to explain:

> For instance, we think it is wrong to kill, as a matter of moral law, but an ethicist would want to know why we think this, whether it is always wrong to kill, and how we justify our conviction of its wrongness in different cases. (2005: 2)

Campbell et al. make clear that Hippocratic thinking remains appropriate today for medical practice, and I would add that it is appropriate too for nursing practice because the focus is on the experience of the patients. As Campbell et al., put it:

> The Hippocratics warned us about becoming captured by theoretical systems, which narrow our thinking about the problems we actually face in real practice, and asked that we substitute reflective intervention and documentation for such theory driven ideologies. (2005: 241)

Aristotle's view was that:

> the qualities that make us human were shown in our thinking, our associations with each other, and our functions as members of the natural order. (Campbell et al., 2005: 3)

This idea has clear resonance with nursing practice. The ways that we relate to patients is the bedrock of care.

Ethical decisions or judgements are not simply theoretical propositions, they must have relevance and meaning in everyday life. The thing about ethics is that it should be a guide to practice. Ethics, Singer tells us, is:

> about how we ought to live what makes an action the right, rather than the wrong thing to do? (1994: 3)

From the discussion so far we can see that ethics and practice belong together. Just as technical competence can be expected of health care professionals, so must there be a consideration of the moral dimension of care. Education for health care professionals includes the clinical aspects of the work, psychosocial concerns and ethics. It is only when all these aspects are brought together that good clinical decisions can

be made, decisions which are both clinically and ethically sound. Nursing, as the largest professional group in health care, has to take this proposition to heart.

'Paternalism' is a thing of the past. It is the sociologist's term used to describe that long established way of working in health care where the professionals, usually the doctors, know best and decisions about patient treatment and care are made on behalf of patients. Paternalism has no place in a 21st-century health service. Modern health care is not only characterised by a patient centredness,[6] with the organisation working to meet patients' needs, it is also open and transparent. In other words, patients are given a central position and the National Health Service (NHS) machine should work around this fact.

Is ethics practical or theoretical? Plato's question, as Mayo puts it:

> [W]hat is there about the nature of goodness and rightness which makes it impossible to teach in formal institutions? (1986: 2)

Aristotle, Plato's pupil, thought that virtue (remember, for the ancient Greeks this means an excellence) required to be taught, but that only when a person has gained the knowledge of a virtue practised and then made a habit of it could they become a virtuous person.

Good–Bad and Right–Wrong

Aristotle's question was: 'What is the good life?' A useful distinction is to be made between the ideas of 'good' and 'bad' and between 'right' and 'wrong'. These are not the same thing, even though at first glance good and bad seem to equate with right and wrong. Sometimes, of course, they do equate; for instance, it is wrong to kill and murder is a bad thing. But equivalence is not always the case. Good and bad are graded words, so that nursing practice, for example, can be evaluated along a continuum from *excellent* through *not bad* and *not very good* to *bad*, whereas the notion of right and wrong is about rules and principles being followed or not. Rules are either broken or they are not. The answer to the question 'Is this good or bad?' is not always a clear-cut response, it is not always one or the other. Whilst 'Is this right?' is a different order of question, it is about following rules and the context has a bearing on the answer, but the answer will be 'Yes it is right', or 'No it is wrong'. It is one or the other, rather like a test for pregnancy: it is positive or negative – it is not possible to be a little bit pregnant.

Mayo makes the helpful point that right–wrong, good–bad (or good–evil)

> are not interchangeable. 'Right' and 'wrong' apply primarily to actions. 'Good' and 'bad' or 'evil' apply much more widely, to states of affairs, to people, to characters, to motives. (1986: 40)

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[6]The idea of putting the patient in the centre was the main organising theme of the Labour government's modernised NHS started in 1997 (DH, 2000).

To give an example we could say that to feed someone is generally speaking a good thing to do. If, however, that person is about to undergo a general anaesthetic, it would be the wrong thing to do. That is to say it would not be the 'right' thing to do. So in such a case 'right' and 'good' are not the same thing. Likewise thumping someone on the chest is a bad thing to do. However, if that person's heart has just stopped, it would be the right thing to do. This does not make generalised thumping of people on the chest a good thing, it is still generally a bad thing. However, in certain circumstances it is the right, and not the wrong, thing to do.

Mayo (1986: 40) describes two kinds of criteria against which to judge something, a criterion being something we use to judge things by. There are two different kinds of criteria against which we judge a thing. First, there is the criterion called a *standard* which Mayo says:

> enables us to make judgements in a continuous range or scale, using terms such as 'good', or 'poor', 'mediocre', 'excellent' and so on. (1986: 84)

Standards of care are required of a qualified nurse, for example. Second, there is the criterion of judgement which is a *principle* or *rule*:

> [T]he judgement is not of the 'more or less' kind, but of the 'yes or no' kind such as a verdict. (Mayo, 1986: 84)

When rules or principles are the criteria of judgement then the judgement is not a graded one; in other words, the answer is not a very good, average, poor and so on kind of answer, it is a 'yes' or 'no' answer, 'yes' or 'no' because rules or principles either prescribe or proscribe, they say this is what should be done and that should not be done (proscribe). So when the criteria used for judging nursing care are the principles of beneficence (to do good) and non-maleficence (to do no harm), the judgement is not about nearly doing good or not doing much harm: the judgement is about whether the principle or rule has been obeyed or not obeyed. This is all very relevant to care and standards of care. In ethics for nursing practice we are interested in the morality of actions and also the character of the nurse. We return to this in later chapters. For the moment it is helpful to get these distinctions straight.

Whether something is right or wrong is conditional on the context. For example, it is not wrong to have a drink on some occasions, but the same action would be wrong in others. Driving, being on duty or being engaged in some other activity in which drinking is not a wise thing to do, are instances of occasions where drinking would be wrong. With right and wrong we are talking about following rules and laws or guidelines. These examples are fairly straightforward as there are clear contraindications in these situations. There are other areas of life where it is not so easy to say what is right or wrong. A generalised way of looking at this is to

consider the distinction between what 'is' (fact) and what 'ought' (value) to be. To talk about what 'ought' to be is to employ a value judgement. The distinctions are between 'is' the situation that exists, which is a matter of 'fact', and 'ought', which is the expression of a desirable state of affairs, a value. For example, to say that there are no empty beds in the hospital this evening is a statement of fact. To state that the Health Trust ought to ensure that there are always beds available for emergency admissions is to express an aspiration based on a value of justice. Or to take a rather more individual-level example of the difference between 'is' and 'ought', patients are sometimes treated badly – fact; health care professionals should always treat people with respect – value. This 'ought' statement is aspirational and might be based on the principle of respect for autonomy, or on the basis of the notion of rights.

The link between the two, between *is* and *ought*, is what Mayo calls 'a troublesome contrast':

> [G]enerally speaking, the facts are not what they should be, and what ought to be is not in fact the case; what ought not to be all too often is. (1986: 3)

A rather gloomy view, but it makes the point. This gap between the 'is' and the 'ought' is a puzzle. Philosophers since the ancient Greek times have debated the question of how life should be lived, what one 'ought' to do to live the good life. Philosophical ideas and religious beliefs are intertwined and so we are left with a rich heritage of philosophical theory and religious teachings available to us when we study and seek to justify the rights and wrongs of human behaviour. It is Aristotle's work[7] on ethics to which we still look in the context of today's ethics for health care practice.

Introduction to the Rest of the Book

This makes a good point at which to introduce the content of the chapters.

Chapter 2 introduces the main principles that lie at the root of ethical debates in health care. The four-principles approach shows how most moral debates come down to the four principles of beneficence, non-maleficence, respect for persons (autonomy) and justice.

In *Chapter 3* the sociological perspective is introduced to show how ethical debate in nursing and health care, whilst led by moral philosophy, does not take place in a moral vacuum but rather in the rather chaotic world of clinical reality. Individual conscience theory is explored in *Chapter 4*; this is to demonstrate that we need something less subjective than individual conscience theory for professional ethics.

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[7]Aristotle's *Nicomachean Ethics*, so called as it was produced by Aristotle's son, Nicomachus, is one of the most influential works in moral philosophy. The translation used in this book is Thomson (1976).

Adam Smith's idea of the 'impartial spectator' is introduced as a more objective approach to right and wrong. In *Chapter 5* Kantian or duty-based theory rests on the idea that acting according to one's duty and obligations will bring about the best for society. *Chapter 6* is concerned with the legal context of nursing practice and the relationship between law and ethics. *Chapter 7* discusses utilitarianism – greatest good theory. This is a consequentialist theory, propounded by Jeremy Bentham and John Stuart Mill.

Chapter 8 looks at rights-based ethics, which fits well with the 21st-century approach to health care. *Chapter 9* is about virtue ethics and its links to professional regulation. In *Chapter 10* the main themes of the book are drawn together, with a focus on trust.

- Morals are values and associated rules and practices by which people live; ethics – also called moral philosophy – is concerned with the study of morality.
- With right and wrong we are talking about following rules and laws or guidelines, whereas good and bad are graded words.
- Aristotle's idea of *habituation* means doing something repeatedly so that it becomes second nature – a habit. Aristotle held that 'moral virtues, like crafts, are acquired by practice and habituation'.
- Many of our ideas about ethics come from the Greeks and have a contemporary ring to them.