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Is health promotion promoting virtue or vice?

Structure

My overall claim is that health promotion is best practised in the light of a notion of the good life for humans and the place of health within it; when it fails to do this it may be promoting a vice. The structure of argument is as follows.

1. What forms does health promotion take? What are the criticisms of it? I argue that there are two philosophical criticisms made of health promotion. One is that it is sometimes coercive, violating Mill's liberty principle. The second is that what it promotes would not constitute a good life for most people.
2. What is the good life? I defend a version of Aristotle's argument. A good life for humans is one where they function well. In doing this they will live a life of eudaimonia (flourishing or happiness). Such a life consists in an active life of virtue, plus (or perhaps implying) a life in accordance with one's quiddity (taken from Mill)
3. What is health and illness? Roughly, illness can be seen as physical or mental barriers to good functioning that are not voluntarily chosen. Health exists where there are no such barriers.
4. How should we practice health promotion? Currently health promotion is practised as though health is a supreme value. A view combining Mill's quiddity and Aristotle's eudaimonia suggests that this does indeed leave some health promotion practice open to the two philosophical criticisms outlined.

Alan Armstrong

“Towards a strong practice-based virtue ethics for nursing”.

Illness creates a range of negative emotions in patients including vulnerability, powerlessness and dependence on others for help. The nursing literature is saturated with debate about a ‘therapeutic’ nurse-patient relationship. However, despite the current agenda regarding (a) the need for patient-centred care, (b) the need for nurses to develop good interpersonal responses and (c) the view that a satisfactory nursing ethics should focus on persons and character traits rather than simply actions, traditional obligation-based moral theories such as consequentialism and deontology remain extremely popular in the field of nursing ethics. In this session, I shall critically examine obligation-based moral theories and the role of obligation-based notions in nursing ethics. Because of several well-established flaws, which I outline, I conclude that obligation-based moral theories are incomplete and inadequate for nursing practice. Instead, I suggest that moral virtues and virtue ethics provides a more plausible and viable alternative for nursing practice. I discuss a tentative account of a virtue-based helping relationship and a virtue-based approach to nursing. The latter is characterized by three features: (1) exercising the moral virtues such as compassion and courage, (2) using judgment and (3) using moral wisdom – moral perception, sensitivity and imagination. Following MacIntyre, I conceive nursing as a practice; nurses who exercise the virtues and seek the internal goods help to sustain the practice of nursing and thus prevent the marginalization of the virtues. The strong (action-guiding) practice based version of virtue ethics proposed is context-dependent, particularist and relational. Merits and problems of this approach are noted. I close by identifying several areas for future philosophical inquiry and empirical nursing research so that this tentative account can be developed further.

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'There But For The Grace of God:' Moral Responsibility and Mental Illness

Setting the terms of praise- and blameworthiness has long dominated philosophers' discussions of responsibility. Analytic philosophy has most often looked to reason and the abstract relations between individual rational judgments and actions to advance the discourse on moral responsibility. Those whose capacity for reasoned judgment is impaired are deeply problematic. Is it proper to morally appraise 'the mentally ill'? The philosopher T. M. Scanlon discusses moral responsibility as a precondition of moral appraisal and contends it is not appropriate to appraise a person as (morally) praise- or blameworthy if that person cannot be held responsible for the action(s) for which he is being praised or blamed. What are the conditions, then, under which one can properly be said to be responsible for one's actions? Can one hold 'the mentally ill' responsible for their actions? If not, can it in any way be reasonable to expect them to 'take responsibility' for their actions and/or characters? The expectation that 'the mentally ill' will attempt to control, i.e., take responsibility for their behavior despite the fact of their mental illness is a pervasive feature of psychiatric approaches to the care and treatment of 'the mentally ill'. It would seem such treatment approaches are coherent only to the degree 'the mentally ill' can be considered responsible moral agents. This paper explores these issues with regard to mental illness in general and the personality disorders in particular. It describes the morally and clinically relevant features of personality disorder, explains how they do not fit traditional analytic paradigms of 'mental illness' and elaborates the argument that persons with mental illness are fully moral persons who are rightly subject to praise and blame.

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The tension between presentation and representation in nursing: Some nursing philosophical considerations

At the Philosophical Conference in Banff in 2003, I offered a paper where I began to address the notion of the unrepresentable in nursing. I evoked Lyotard's writing from the Postmodern Condition where he speaks about "the unrepresentable." The world situation then and today has brought into our midst a number of events that are in many ways a powerful showing of the unrepresentable. Thinking about these striking realities that we face today together with my work elucidating nursing practices has made me ponder not only how the unrepresentable shows itself in nursing but also if nursing in its present discourse is capable of addressing these situations that hold so closely the unrepresentable. Nursing conceptualizations are representations of nursing practices that often do not resonate with the daily lived nursing situations practicing nurses face. The problem with the theoretical representation is that it does not incorporate the unrepresentable so present moment by moment in practice. Yet the very difficulty in bringing the unrepresentable into a text is that it defies even presentational forms that stay close to nursing practices. How is it then that we can address this constant tension between presentation and representation in nursing? We need to be attentive to the tension that this interwoven-ness of presentable and unrepresentable elements generates in our midst and that practicing nurses and the nurses of the world embody. Turning our attention to the unrepresentable is a vital part of our ethical stance. We need to refurbish our discourse and take it to originary ground. We must question the representedness of our theoretical discourse as we deal with individuals, families, communities, global areas where the unrepresentable in its utmost forms of expression resists our current categories of thought.

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Graceful Competent Care: Exploring a concept

Graceful Competent Care (Graceful CC) fuses art (aesthetics) and science in wise healthcare practice. Campbell (1964) identified gracefulness in healthcare workers. I added competency as not only a parallel aspect of Graceful CC but as a synergistic partner within Graceful CC in which all aspects are necessary and where each one is multi-factorial internally. Central to this fusion is Aristotle's notion of practical wisdom which includes authenticity of thought combined with skilfulness in choosing appropriate ways and means (strategies) for action. Aesthetics refers to practical wisdom demonstrated in implicit and explicit imaginative choices made to respond competently to the contextual needs of a situation. In GCC, the practitioner appreciates skilled coupling of the virtues of excellence with theoretical and technical expertise in artistically, scientifically, competent practice. In contrast, unskilled practitioners may learn, for example, to excel at the fine art of effective communication or at technical competencies, but fail to fuse the two in practice. The global theoretical research framework for my research into clarifying the concept is the artistic/holistic paradigm proposed by Fish (1998). This promotes a critical appreciation of artistry in healthcare practice. The paradigm allows for philosophical reflection and encourages the use of research methodologies which delve into the affective dimensions of healthcare practice.

Graceful has many definitions as does competency and care. In this paper, I briefly mention some pertinent understandings which 'graceful' and 'competent' touch on and then concentrate on the ethical component which overlaps and perhaps is the fusing factor for the three major aspects of Graceful CC. I touch upon authenticity or genuineness in healthcare practice as a basic requisite for Graceful CC. The importance of mood in interactions between healthcare personnel and recipients will be briefly addressed. Empirical examples provide substance to highlight the relational ethical aspect of for Graceful CC .

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Nursing Practice and Moral Theory: Is the Content Boundary of Moral Theory for Nursing Too Narrow?

Much of the nursing ethics literature focuses on the nurse-patient relationship. One can argue that this is as it should be, however, I take the position that this focus is too narrow. It is important for nurses to have a broader and deeper view of nursing ethics than that limited to a one to one relationship as important as this is. I argue in this presentation that nurses need to think ethically about the larger policy issues that influence local, regional, national, and international health status on populations including hospital patients and those who do not and cannot become patients. Nursing students may learn principle based ethics, caring ethics, feminist ethics or some combination of these moral theories, however, the notion of nursing practice, as used in this conference title, might suggest a clinical focus only. If nurses are to be involved in policy issues at hospital, local, regional, national, international levels, they need to raise their sights above and beyond the nurse-patient relationship while keeping that relationship at the center of their clinical ethics. What should the content boundary of moral theory be to prepare nurses to deal with policy issues?

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A consideration of the issues around truth for community specialist practitioners.

Abstract: Truth...in...Practice.....--what does this mean?

This paper is seeking to examine some of the issues that concern community specialist practitioners working across agencies in the UK DOH (2002). The emphasis on community participation and developing partnerships highlights a necessary need to build trusting relationships, Seligman (1997), Putnam R (2000). This paper looks to tease out questions about how this can be supported and encouraged and suggests that encouraging the development of the reflexive practitioner can provide skills to develop ethical thinking that can sustain honesty in all forms of dialogue. The critiques around this are evidenced by the increasing value of sharing stories and knowledge and developing practitioner's awareness of self, Maldonado et al (2003).

It questions the assumption that truth issues should not be directly addressed and that no one agency could hold the definitive truth. This obviously links into the areas of knowledge, risk management and social capital. It is suggested that community specialist practitioners from all disciplines with additional skills have a key function in community development.

It is also suggested that truth and the virtues around working ethically across boundaries and within collaborations is qualitatively different to the issues that surround truths about health protection. That wider discourses are required to ensure that over protection does not prevent community development and understanding.

DOH 2002 Keys to Partnership working together to make a difference in people's Lives

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Ethics and priority setting – Doctors` and nurses` concrete patient priorities in Norwegian Intensive Care Practice

Purpose: The purpose of this project is to acquire more knowledge about doctors` and nurses` actual prioritization in concrete patient cases, focussing on ethical considerations of priorities, related to starting, withholding or withdrawing Intensive Care treatment.

This project is based on an assumption that patient prioritizations in an Intensive Care workday restrained by resources inhabit substantial morally complex and ethical difficult choices involving doctors, as well as nurses. Further it is presumed that more knowledge about the clinical priority setting will be an important contribution to the debate about priority setting on the health-political level.

Background: The problem of health care priorities has been highly actualised in the Norwegian Health Care system within the last two decades. Developments within medicine, technology and society, as well as limitation of available medical and economical resources, require legitimate prioritizations of the health care services. The Lønning II committee articulated the recent guidelines for priority setting in Norway, in 1997. Lønning II makes a point of more coherence and openness in priority settings, and also increased knowledge about the rationale behind prioritizations in clinical patient contact. Knowledge of concrete clinical priorities is necessary for developing well-founded and feasible ethical guidelines for prioritization. This project will fulfill one of the main intentions in Lønning II, which is to make decisions about priorities of medical and nursing care in clinical Intensive Care more informed.

Method and discussion: Qualitative method and explorative design will be used. The strength of qualitative method lies in the in - depth understanding of meanings, intentions and values, which is a necessity in this project. I will follow doctors and nurses in concrete patient cases, including starting, withdrawing or withholding Intensive Care treatment. The data collection will consist of observations and half-structured in-depth interviews. The text material will be ordered in themes and analysed from Kvaales three levels of interpretation: *self-understanding*, *common sense* and *theoretical interpretation*. The results will be discussed in the light of different ethical approaches. In the end it will be a discussion of how the actual priorities can contribute to the superior theoretical debate of health care prioritization.

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Nursing Ethics: Resisting the Medical Model of Applied Ethics

Viewing nursing ethics as one disciplinary subset of medical ethics or even biomedical ethics, is problematic for patients and society on several counts. The medical ethics perspective, for the most part, tends toward an interest in dilemmas, avoids seeking the roots of problems in social and societal arrangements, and favors a conception of patients, or potential patients, as autonomous entities separable, for the purposes of ethical debate, from their environment and interpersonal relationships.

Medical ethics is a discipline that has evolved in response to problems emerging out of the application of technological and biomedical advances to the 'treatment' and 'cure' of disease. However, the lens of medical ethics has proved itself to be too acutely focused to adequately address the contemporary complex health needs of individuals and society. While not denying that in some instances biomedical cures are needed to treat discrete disease entities, the majority of health related problems are not susceptible to mere cure by technology. These other health related problems have their fundamental origins in societal values and attitudes as well as in the nature of humans as inseparable from their contexts and relationships.

This paper presents a critique of traditional medical or bioethical approaches to decision-making in health care. The argument is made that Nursing Ethics is rooted in the ideals of a profession responsible for providing services to any in need, or potential need, of its services and with the health of individuals or groups as its main goal. Thus, Nursing Ethics should strive to maintain a perspective that incorporates the complex nature of this goal. The moral and philosophical viewpoints that guide the discipline must include those that permit comprehensive evaluations of clinical practice, practice environments, the prevalent health care arrangements and a conception of persons as inseparable from their contexts.

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The Link Between Habermas' work on Discourse Ethics and Gadow's Conception of Advocacy.

The aim of the paper is to offer a brief description of Habermas' (1987) philosophical perspective on communication and to apply this to Gadow's (1983) perspective of advocacy.

There has been a demonstrable need for advocacy in different societies and this has been apparent when one considers the developments that have occurred, for example, with reference to the treatment and care of patients and clients in the British Health and Social Services. The need for advocacy in the British National Health Service is aptly demonstrated by the case of Graham Pink (Pink 1992). In this case Pink, as a Charge Nurse, having used the normal and accepted management procedures to make known his concerns regarding staffing levels in his clinical area, perceived that this action was insufficient to address the problem. He felt that it was necessary to 'blow the whistle,' by allowing his concerns to be published in the press.

With reference to the occurrence of such incidents in nursing, the paper will discuss how Habermas' (1987) philosophical perspective, for example, of 'System and Lifeworld,' can be applied to Gadow's (1983) work on advocacy, with reference to her conception of the 'Lived and Object' body. During the paper, the application of Habermas' perspective to that of Gadow's should become evident.

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Nursing Ethics is Not Professional Ethics:
Philosophical Problems with the Boundary Paradigm in Nursing

In this concurrent session I wish to examine the moral pitfalls of using a professionalism model of ethics in nursing. Drawing upon the work of Peplau,¹ Muetzel,² and King³ in nursing theory, I argue that a role-based ethic emphasizing boundaries in nurse/patient relationships is not phenomenologically sound. Such a model distorts both (a) the nature of such relationships themselves and (b) the kind of moral obligation towards healing that arises out of such relationships.

Peplau's model of "professional closeness," Muetzel's model of "therapeutic nursing," and King's "goal attainment" model offer three distinct but thematically similar ways of characterizing nurse/patient relationships. A common theme running through all three, I argue, is the shared hermeneutic nature of the healing relationship between nurse and patient. The significance of recovering, creating, and re-building meaning following the illness/injury experience is one of the central components of the kind holistic care than can be offered by nurses.

The current emphasis on nursing as a profession—while achieving laudable goals for the discipline in the politics of healthcare—has encouraged ethical models that mirror those in other professions. Indeed, in the American Nursing literature, patients have become "clients", and nurses have become "healthcare professionals". This terminology shift has also followed from the tendency in American philosophical bioethics to simply replace the "medical" in "medical ethics" with "nursing," implying that nurses and other allied health practitioners have moral obligations that mirror those of physicians. Such a movement, I argue, not only fails to adequately capture the moral significance of nurse/patient relationships, but actively distorts that significance by leaning too heavily on a boundary paradigm. As an alternative, I propose a relationship-based paradigm that arises out of the shared hermeneutic developed between nurses and their patients. This is not a shift from principlism to an ethic of care. Rather, it is a philosophical exploration of the hermeneutic process that can occur when nurses and patients engage in a process of co-meaning making, a central part—I argue—of healing. Moral analysis of such relationships needs to take as its starting point a phenomenologically faithful representation of nurse/patient interactions.

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¹ H. Peplau, "Professional Closeness," *Nursing Forum* 8, no. 4 (1969): 342-360.

² Plaxy-Anita Muetzel, "Therapeutic Nursing," in Alan Pearson, ed., *Primary Nursing: Nursing in the Burford and Oxford Nursing Development Units* (New York: Croom Helm, 1988), 89-116.

³ Imogene King, *The Theory for Nursing: Systems, Concepts, Process*, (New York: John Wiley & Sons, 1981). ³ Bruner, J. (1995) *A Narrative Model of Self Construction* Paper given at the New York Academy of Sciences 20th March 1995

³ Newton, A.Z. (1995) *Narrative Ethics* Cambridge: Harvard University Press

Joan McCarthy

Nursing Ethics, an eclectic view

My thesis is that the task of nursing ethics is an eclectic one: to develop a pluralist moral vision. In defending my claim, I sketch and reject, two perspectives of nursing ethics that are currently debated in the literature – the Traditional View and the Theory View.

On the Traditional View, it is argued that nurses, like other health professionals, must draw insight from ethical frameworks such as utilitarianism or principlism in order to negotiate the ethical challenges they meet with in the course of their work.

On the Theory View, nurse ethicists, concerned that traditional frameworks fail to address issues specific to nurses, argue in favour of the development of an independent and comprehensive theory of nursing ethics. Such a theory, it is argued, must either be grounded in a nursing philosophical framework, or, appeal to an ethical framework such as virtue ethics which is seen as particularly compatible with nursing interests. A comprehensive theory of ethics developed along these lines is considered to hold out the promise of capturing and articulating a, specifically, nursing ethical focus.

My paper takes issue with both of these views of nursing ethics. While I agree that traditional ethical frameworks are limited, I also suggest that the search for a more comprehensive theory of nursing ethics ought to be abandoned. My alternative, inspired by feminist and postmodernist approaches to nursing, is the Eclectic View which acknowledges the heterogeneous nature of nursing practice and attaches significance to the socio-cultural context within which that practice takes place. On this view, neither moral truth, certainty nor a unique moral perspective are achievable, but meaning, and living with uncertainty and diversity are. I conclude by indicating a set of learning objectives that a nursing ethics syllabus, based on this view, might adopt

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Mike McNamee,

Subjective Guilt and the virtuous nurse

It might be thought that a nurse who properly felt guilt at some action had therefore done wrong. We naturally relate the two concepts of wrongdoing and guilt, often adding a third – blame – for good measure. Might there be cases, however, where a nurse properly feels guilt without having performed a wrongful or blameworthy act? It strikes me that this emotion is precisely what nurses feel when by commission they remove feeding tubes from patients who have ordered advanced directives or when, by omission, they follow through on an order not to resuscitate. Perhaps most commonly, nurses in palliative care may feel guilt at the proper administration of pharmacological treatment to alleviate pain which in so doing brings about the termination of life.

A rationalist response from a colleague might well take the form of an order for a cold shower. Less prosaically, another philosophical response might be to invite the nurse better to order their understanding of conceptual relations between the act/omission and their moral responsibility. As Rawls (1972) has written, guilt felt in relation to things one is not responsible for is an irrational response. In contrast to these positions, and illustrative of the greater sensibility of virtue ethics, I argue for the praiseworthiness of the felt guilt. First, I defend an account, after Greenspan (1995), of subjective guilt. Secondly, I offer an account of the normative value of such guilt within nursing. I argue that in feeling the emotion, nurses typically demonstrate their sensitivity to, and empathy with, the well-being of the patient's significant others specifically and the moral loss at the end of life more generally speaking. Feeling guilty under such circumstances may then be seen rather more as virtuous than irrational.

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Moral implications of theoretical perspectives on children and childhood...

What we believe about childhood, and how we understand children in relation to adults is a subject of ongoing debate. Within the spectrum of views about children we can find many instances in which they are portrayed as innocent, vulnerable beings, in need of adult protection. In contrast, in certain quarters, children are portrayed as “not yet human” -- beings that must be disciplined and educated toward the goal of becoming reasonable, productive adults. For example, liberal perspectives, as the foundation of contemporary democratic systems, focus on the development of children to become rational and autonomous citizens. In contrast, rights theorists, while sustaining a view of children as autonomous beings, have endeavored to shift the focus away from children as “becoming”, toward children as “being”, as holders of particular human rights. Some authors have suggested an ethic of care as response to this problem, endeavoring to move our views of children out of the stronghold of liberal views and toward a more relational understanding of our responsibilities toward children. Whichever stance is taken, how children are theoretically understood has a profound influence on the nature and quality of children’s lives, with children’s experiences of health care delivery and nursing care as no exception. While rarely made explicit, particular views of who children are and what they need underpin nurses’ interactions with children and their actions on behalf of children. These views are manifest in nursing practice with individual children, health care policies developed to shape services to children, and the approach to research with and for children. In this presentation, I engage in an analysis of our practice with and for children, examining ways in which various understandings of children and childhood influence our nursing practice, health care policy and research, and questioning whether, within contemporary Western societies, there are ways of thinking about children that are more morally defensible than others.

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NARRATIVE ETHICS IN NURSING FOR PERSONS WITH LEARNING DISABILITIES

Both in the Netherlands and in Britain practices of 'life story work' have emerged in nursing for persons with learning disabilities. The narrative approach in care and support may at the same time be considered as an attempt to compensate for the 'disabled authorship' of many persons with learning disabilities and a sign of controversy with standard practices of diagnosis and treatment that tend to neglect the personal identities of both clients and care givers, their particular historical and relational contexts and their spiritual needs. This paper argues that narrative ethics offers an appropriate moral framework for practices of life story work, and moreover that these practices are themselves a narrative ethic in action. Starting with an account of the concept of life story work as it has been introduced in nursing practices in the field of learning disability, the paper explains its relationship with key characteristics of narrative ethics. The teleological dimension in narrative ethics and in practices of life story work sparks off a dialectic process of understanding the client and self-understanding of the care giver. It also invites to respecting life in its openness toward the future and presupposes an openness toward other possible versions of the life narrative. The phenomenological and hermeneutic-interpretative methodologies in narrative ethics aim at a 'sudden moment of intimacy' in relationships of nurses and clients. However, the 'epiphany' of this essential moment of recognition, insight and engagement cannot be enforced by methodology.

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'MAKING MUSIC TOGETHER' CARING ETHICS AS CARING PRESENCE

The paper is about caring ethics in theory and practice. 'Caring ethics' is conceived as a theoretical position with moral obligations to nursing practice. The research question is: What conceptions of caring ethics do psychiatric nurses have, what ethical situations do they experience and how do they deliberate and make decisions about their actions? The study is a pilot study with two psychiatric nurses as participants. The research paradigm is qualitative using a phenomenological methodological approach. First a conception of caring ethics is presented grounded in traditional ethical and contemporary feminist and caring theories. In the second part data from qualitative interviews about daily work experiences of caring ethics and ethical choice situations are presented. The analysis reveal five 'essences' of caring ethics, namely 'ethics and morals', 'a good nurse', 'caring', 'ethical choice' and 'suffering and co-suffering'. Thirdly the findings are elaborated and discussed. The findings indicate that conceptions of caring ethics are twofold and that moral actions are grounded in multiple ethical traditions and theories. Outstanding moral components, which situate the essences, are the 'dignity' of the human being, the 'being-with' in caring presence, the 'responsibility' in the caring relation, the impact of 'ethical conscience' and the use of 'practical reason'. The findings are preliminary and demand further investigation in similar and other contexts to strengthen the knowledge base of caring ethics.

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The Problematic Nature of Existential Advocacy

Advocacy is an important ethical principle that has been valiantly promoted within nursing. Debate continues regarding the precise definition and nature of advocacy. 'Existential advocacy' is one view within nursing, first developed by Sally Gadow. According to Gadow, existential advocacy 'is based upon the principle that freedom of self-determination is the most fundamental and valuable human right. In negative terms, this implies that the right of self-determination ought not to be infringed upon even in the interest of health.' This view of advocacy has practical implications for nurses who are then obliged to act 'on the basis that only the patient can define his or her best interests' (Ellis). Practical examples will be presented of how this view of advocacy has been used both to promote alternative therapies regardless of their evidence base and to justify ethically controversial practices such as assisted suicide and euthanasia.

Existential advocacy is based upon a moral theory which make patient autonomy the primary ethical value. Yet this aspect is rarely mentioned, nor is a moral theory based on autonomy and self-determination defended. This approach to ethics flows from a broader acceptance of post-modern relativism which claims that people determine for themselves what it means to be healthy and how best to pursue health.

Post-modernism in general, and existential advocacy in particular, are open to critique. While denying objective standards, they lay down their own standards. Existential advocacy is a reaction against paternalism, yet it is paternalistic in itself in the way it assumes that someone's best interests are achieved through self-determination. This assumption will be examined and critiqued. This presentation will propose an alternative view of advocacy that promotes patient well-being while holding advocates accountable to ethical and professional standards. Such an approach seeks to balance the importance of allowing patients to reach their own decisions without promoting the idea that all decisions are equally valid, from either an ethical or a healthcare perspective.

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Moral Responsibilities and 'Substandard Practice'

Professional self regulation is commonly considered a crucial aspect – perhaps the defining characteristic – of professions. However, within nursing, there have been few empirical studies of how the professional regulation of practice quality actually occurs, nor has the problem of 'substandard practice' been given much theoretical attention.

To the limited extent that these problems have been taken up within nursing, two dichotomies seem to persistently arise. First, substandard practice is often characterized as an error either of technical expertise or of moral judgment. Secondly, there is a focus either on the moral responsibilities and actions of individual nurses, or on the surrounding institutions, the systems that enable and constrain nursing practice. The relationship within either of these pairs is seldom explored. In part, this is due to the ways in which professional practice is theorized as 'application of theory', to the poor fit between conventional models of professionalism and the highly institutionalized context of nursing practice, and to the general inattention to social structures within nursing research.

The result of this dichotomizing – between individuals and institutions, and between moral and technical dimensions of practice – is that it is difficult to see these elements as intertwined, and to explore how – in practice – individuals and institutions negotiate the challenges and ambiguities of 'quality care.'

I will briefly describe several theoretical tools – including negotiated order, 'vocabularies of motive', and a Wittgensteinian approach to rule-following – that can help to open up an analytic 'third space' in which to explore the regulation of nursing practice. These tools would allow us to see individual nurses as contextualized moral agents, acting within and on institutions, both taking up and resisting various available discourses, and negotiating with others the complex moral and practical landscape of everyday nursing care.

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The Participatory Paradigm: A Resource for Ethical Inquiry in Nursing Practice

Empirical and philosophical inquiry in nursing over the past two decades and more have articulated the difficulties that nurses experience enacting their moral agency. In particular, we have come to better understand the constraints nurses encounter in the social, political, and economic contexts of their practice. Although we have a body of work explaining the constraints on nurses' moral agency, we have little work providing direction about what to do about such constraints, or how to strengthen nurses' enactment of their moral agency.

It is the author's contention that the participatory paradigm (as articulated by the theorist Peter Reason) offers significant promise here. In supporting her argument, the author will draw on the design, conduct, and preliminary findings from a study, *Ethics in Action: Strengthening Nurses' Enactment of Their Moral Agency Within the Cultural Context of Health Care Delivery*. This is a three year study funded by the Social Sciences and Health Research Council of Canada, and is taking place in an acute medical/oncology unit and a busy suburban emergency department. The author and the team of investigators and graduate students she is working with will be entering the third year of the study at the time of this presentation.

During her presentation, the author will address the ontology, epistemology, and methodology of the participatory paradigm. This will include a discussion of the key features of participatory action research, as well as a discussion of the challenges and promises the team has encountered in the *Ethics in Action* study. The author will conclude by suggesting how more participatory inquiry might benefit nursing and other health care professions.

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Questioning the Language of Autonomy

A model of decision-making that emphasizes respect for patient autonomy has become the dominant discourse in clinical practice in recent years. Among nurses, the concept of autonomy has been integrated into our practice via the idea of patient advocacy. This emphasis has been an important corrective to the paternalistic and manipulative ways patients were (and still are) treated in health care institutions. However, there are an increasing number of critiques of autonomy as a guiding principle, particularly its acceptability to multiple communities, and in its effectiveness in achieving the goal of minimizing the power differentials between health care professionals and patients and families.

The recent challenges to autonomy come, in part, from the recognition that it is no longer clear what we mean by it. The term is asked to serve multiple purposes, and is deployed in ways that its champions never envisioned or intended. Additionally, it is not clear how autonomy is appropriately balanced with other social values. For example, the troubling relationship between the core nursing values of advocacy and caring has not been adequately theorized. Finally, the ability of most interpretive methodologies to examine the experience of autonomy is limited by their very structure. Because they presume an autonomous individual, these methodologies often fail to address the embeddedness of people within social, historical, and linguistic contexts

People's choices about their health care and their lives cannot be adequately explained by a model that constructs them solely as autonomous actors. A more complex model that acknowledges the importance of personal agency, but also accounts for the backdrop of discursive constraints and possibilities, would be more useful in negotiating health care in our pluralistic societies.

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Towards an Understanding of Nursing as a response to Human Vulnerability.
Or . All people are vulnerable but some people are more vulnerable than others.

To describe an individual (or a group) as vulnerable is to say nothing more than 'people are vulnerable'; for it is a necessary truth that to be human is to be vulnerable. This is a condition we share with all other living species and no amount of thinking otherwise will change our essential human frailty. Yet for all this we continue to describe particular patients or groups of patients as vulnerable in the attempt to say something more than merely that these individuals share our common vulnerabilities. In describing people as vulnerable what we really mean is that they are particularly vulnerable to something, something moreover that is harmful to them and against which they have a reduced or an absent capacity to protect themselves. This may well be a common professional understanding but even so it is an extended use of the word (extended, that is, from everyday meanings) and hence is used in a technical or at least a semi-technical sense. As such it needs explaining. This paper is presented as an attempt to clarify what it means to be vulnerable. In doing so it will become apparent that the use of 'vulnerable' as a adjective to describe certain individuals and groups in receipt of nursing practice is imprecise and ambiguous. Our ordinary everyday vulnerability is distinguished from the extra vulnerability that comes with being a patient or a client; hence it is argued that all patients are vulnerable in ways that go beyond ordinary everyday vulnerability. Thus clients are more-than-ordinarily-vulnerable and on this account a legitimate function of nursing as an institution and of nurses as individuals is to offer protection from avoidable harms. Such protection is necessary for patients to flourish as human beings and it is to be differentiated from mere paternalism.

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Academic Freedom in Nurse Education

This paper explores the notion of academic freedom within nurse education. We suggest that a tension may exist between opposing influences, both justifiable on moral grounds. First is the idea that student nurses should be free, and indeed encouraged to express and therefore explore a full range of moral opinions and values, including those which lie outside nursing's accepted moral values and the Code of Professional Conduct (CPC). This can be justified on the grounds that this sort of academic freedom is a 'good' in itself; but also that certain unpalatable opinions are better articulated and therefore challenged.

Second is the requirement within Nursing and Midwifery Council (NMC) documentation that the CPC should be 'internalised' in pre-registration courses. Part of this process of internalisation is that students agree with and accept the CPC, not least because failure to do so, in certain cases could result in being removed from the register when qualified. It is suggested that this could lead to discussions in difficult subject areas being regarded as taboo. One way in which this form of 'censorship' could be revealed is by markers penalising academic assignments which contain certain morally contentious statements.

Whether penalising written work in this way is justified is a normative question. We have argued elsewhere that academic freedom for students should be encouraged. However a fuller exploration of this tension also requires empirical evidence. This paper presents preliminary results of a study of nurse academics at the University of the West of England. Do academics penalise work in this way? Are some opinions more likely to be penalised than others? And given that assessment guidelines which reward analysis rather than moral values appear not to allow penalty, what justification might be used to defend the practice?

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International trends in ethics within nursing

Taking the first, second, tenth and eleventh years of publication (Volumes 1, 2, 10, 11) of *Nursing Ethics* as the starting point for analysis, I will show that significant trends are emerging of where ethics in nursing is going. The main trend is a kind of protest at nurses and nursing being devalued. While this is expressed negatively, the positive aspects are that nurses are taking their professional life into their own hand much more vigorously and daringly now than ten or eleven years ago.

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The Healing Act as a Moral Act: an analysis

Building on ancient Greek philosophy this paper asks, what are the similarities between the healing act and the moral act. Uniquely human actions require knowledge and use reason to discern among options. Freedom is this ability to choose an action. Virtue or human excellence is in discernment and the ability to do the good action. In this one comes to see the moral act is an excellent human act. Sokolowski describes the moral act as my good for you as my good. What I do that is good for you is, in fact, good for me. This good is my human fulfillment.

There is much in health care that clears the way for nature to heal or maintains business aspects. However, there are also specifically human interactions that heal. In these interactions the healing agent is the person who gives of themselves to the patient. They act for the good of the patient as their good. It brings their fulfillment as health care professional. The kind of professional they are allows the patient to be a client of their specific discipline. In this way, the healing act parallels the moral act. This insight carries significant implications for understanding effective health care interventions as moral actions requiring the human practitioner to be virtuously disposed to see the principles and particulars in a situation requiring intervention and, thus, to act with virtue.

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