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Review article

Specifics of nursing ethics

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ABSTRACT

The classic division of the tasks of doctors and nurses to ''cure'' and ''care'' is no longer valid. Nevertheless, medical ethics, more oriented towards treatment, has a long-term tradition and is more theoretically elaborated. The reason can be seen in the traditional dominance in the medical field, but a bigger factor is obviously the difficulty to grasp the theoretical concept of the word ''care''. In the game there are at least two players who can equally fail. Not only their attitudes but also their real activities are accented. An important part of the care is the relationship; a phenomenon that also cannot be described by simple definitions.

To approach the understanding of the concept of care, a possibility is through the theoretical resolution of different paths of the moral development of man, elaborated by Carol Gilligan. It is possible to use the existential analysis of the ''stay'' of a human by Martin Heidegger, especially his concept of ''coexistence'' and his definition of worry or care about another person. It is possible to apply the definition of care according to Berenice Fisher and Joan Tronto and its consequences in the moral sphere. Deborah Fingfeld-Connett elaborated her own concept of nursing care, which is not based on abstract definitions or concepts, but it is a ''meta-synthesis'' of available qualitative studies that deal with the issue of care conceptualization in nursing. Nursing care depends not only on what the nurse does, but also on her personality. Therefore it is not possible to avoid the ethics of virtues, inspired either by the classic in this area – Aristotle, or by contemporary authors, such as the Australian philosopher Stan van Hooft.

The elaboration of ethics of care should help nurses to be more successful in their demanding profession. Also, adequate understanding of what I am doing leads to personal growth and to greater life satisfaction. Executives and managers will find an incentive for equipment and the organization of health facilities so that good care will be feasible.

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Introduction

The oldest, and therefore to the greatest breadth and depth of sophisticated moral concepts in health care is medical ethics, the tradition of which dates back to ancient times. The classic example of an early interest of ancient doctors in morality is the well-known Hippocratic Oath from the fourth century BC. Even later, in the Middle Ages [1], as well as in modern times [2], doctors fostered their reputation and ethics was always taught in medical schools. In the 1970s a new era of medical ethics was introduced [3]. A rapid development of medicine at that time not only rendered new opportunities but also new moral problems. It was necessary to redefine the relationship between doctor and patient and even in theory to solve the dilemmas that gradually emerged. Therefore, medical ethics became the basis for the theory and practice of morality of the new era in health care.

A part of the radical transformation of medicine in the second half of the twentieth century was the gradual decline of the originally almost absolute dominance of doctors in medicine. A series of new health professions were developing at that time, each of which gets its own competence and their workers are increasingly perceived as full collaborators in health care. The oldest such peculiar medical profession is nursing. Its roots go back to antiquity, but its modern history derives from the nineteenth century. Together with gradually increasing demands on nurses, changes take place even in their education. From the second half of the twentieth century, higher education of nurses develops fast and nursing itself becomes a university academic discipline [4,5]. Like medicine, nursing care is also associated with high moral standards from the beginning. Its philosophical reflection has not such a long and rich tradition as medical ethics. Only in recent decades are new distinctive concepts of nursing ethics being elaborated. Doctors and nurses care for the same patients and have the same basis for their morality – acting in the best interests of their patients. Therefore, their ethics are not very different and the differences are not fundamental. It is more about different perspectives of the peculiarities of both professions.

Cure vs. care

The most common expression of the difference between medical and nursing ethics is based on the similarity of two English verbs: ''to cure'' and ''to care''. The doctor's duty is primarily to cure, which includes the diagnosis of diseases. Nurses complement the activities of doctors by taking care of the ill. Even if we accept this fundamental distinction as valid, there is no doubt that the two professions overlap significantly, and that part of the doctor's work is care, and in addition to care nurses not only participate in diagnostic and therapeutic processes, but also create their own diagnostic schemes, such as the classification of the needs of patients [6].

Despite the fact that even the work of a doctor contains elements of care, the basic axis of medical ethics is the ethics of the decision-making process. The path to make a diagnosis and to propose a treatment is often complicated. It requires not only knowledge and experience but also repeatedly deciding which way to go. The most famous contemporary theory of medical ethics – principlism [7], is based on two classical principles contained in the Hippocratic tradition: to choose and act in the best interests of the patient (beneficence) and not to harm the patient (nonmaleficence). It added two more principles based on the transformation of medicine in the second half of the twentieth century: respect for the patient's autonomy and justice (in the allocation of scarce resources). In other words: the decision-making process in medicine must be led by the best interests of the patient, but it is the patient who decides on everything that will happen. At the same time it is necessary to respect the lack of resources and social differences between people and seek the most equitable solution.

From the beginning there is no doubt that in addition to diagnosis and treatment implementation, patients need assistance on many things that are directly treatment related. They need a space where they can find peace, a clean environment, food and drink, as well as the company of other people, to find solace in their anxiety and other worries. These things are a natural part of caring for sick people, either in hospitals and shelters, or in their homes. Nevertheless, there was a long time period without any deeper theoretical analysis. There are two possible reasons for this. One of them is the fact that treatment and care are a part of the traditional Christian concept of charity and Christian duty to help the poor and suffering. There were always people who took care of the sick in accordance with this philosophy. Therefore, there was no need for a theoretical approach to the concept of care. The second reason might lay in the difficulty that is brought about by theoretical attempts to handle the concept and development of care. The decision making process can be described by relatively simple algorithms. Neither the questions who and under what circumstances make the decisions easy to make, and the answer is not always clear. Treatment and care are already concepts that set up a variety of problems in setting up their definitions. In the game there are at least two actors (the implementer and the recipient of care) who, even with a full understanding of the definitions, may fail due to their personality traits and inappropriate responses on a psychological and social level. An important part of care is the relationship; a phenomenon that cannot be described by simple definitions.

The moral development of man

In the 1980s, Carol Gilligan tries to explain the reasons why until a short time ago the ethics of care was neglected at a theoretical level [8]. A theoretical elaboration of ethics, whether at a philosophical or psychological level, is based on the categorization of the world. World morality is described in terms of principles and values. A man reaches proper conduct by the evaluation and hierarchisation of the principles and values that are at stake. In the 1970s, Lawrence Kohlberg [9] developed the theory of the moral development of man. The development takes place in three stages, which are further divided into six phases. A simplified scheme is as follows: preconventional morale level (focus on punishment and reward orientation), the conventional level of morality (focus on consensus between people and on law and order) and postconventional morale level (focus on the social contract and the

stage of universal morality). Carol Gilligan noticed that in their development women too often remain in the second, conventional stage. Using qualitative methodology she showed that many women remain in the conventional stage simply because their moral maturation proceeds in a different way. They do not decide on the basis of evaluation and hierarchy of abstract principles and values, their morality is built on relationships. Carol Gilligan consequently developed her own scheme of moral development. Women originally emphasize the approach to themselves, and the basis of their morality lies in self-care (orientation to individual survival). There follows a critical period in which the care of herself begins to appear selfish (the first transition: from selfishness to responsibility). In the second stage the concept of justice appears, and in connection with the maternal morality, good is conceived as care for others (goodness and self-sacrifice). This concept also leads to a crisis in which the woman is aware of the need to balance the care for others with the care for herself (the second transition: from goodness to truth). Therefore, in the third stage the woman is already experiencing tension between her relationship to herself and to others. The basic motif in her decision-making is the rejection of inflicting pain or harm (hurt) and abuse, not only on others, but also on herself (the morality of nonviolence) [10].

Carol Gilligan can be understood as a feminist fighting for the right of women to see the world in their own way. Nevertheless, the results of her work also reveal another discovery, a so far neglected dimension of human moral judgement, which relates to both sexes. The author even admits this possibility in several passages of her work. At a time when even men enter the nursing profession, the second approach is also suitable for nursing ethics.

The philosophy of care

Anchoring care in the philosophical tradition faces similar problems as the above description from the psychological perspective. Connecting a person as an individual with another person was first introduced by Martin Heidegger thanks to his inclusion in phenomenological philosophy [11]. This philosophy is based strictly on the perspective of ''I''. According to Heidegger, it is seen from the perspective of the being of a human, who cares about his or her own being. Unlike mass bodies or objects in nature, the nature of man is that he or she is not indifferent to where, when and how he or she will live his or her life. Therefore, thanks to their abilities (cognition, abstraction, speech), they understand the world in which they live, they always somehow understand and care about themselves and the people around them. A part of this care is also represented by the schedule of options, which builds on the understanding and experience (in the past), and looks to the future. Of course, the actual implementation of the schedule is possible only in the present [see also 3]. Yet the introductory chapters mention that a human being materially incorporates the existence of others, namely that being is togetherness. Other people also differ from all other types of being in terms of their own being, they somehow understand the world and themselves and they care. Therefore, a person can take care of another person. This caring person has ''two extreme possibilities''. ''He or she can either take away the care from another person and replace him or her in providing care. In other words they fill in for the other person.'' The other ''is shoved aside, recedes into the background, so that eventually they take over what has been done...''. ''As a result, such a caring can lead to addiction and the manipulation of the other person...'' ''However, a caring that does not cover for another person is possible. It rather overtakes his or her existential 'ability to be', not in order to take his or her 'care' away, but in order to render it.'' ''... It helps another person to become transparent and free for his or her care'' [11,p. 148, in Gesamtausgabe p. 163].

These passages from the work of Martin Heidegger are significant to understanding the notion of care, because care is described as one of the essential characteristics of man, as a substantial part of human existence. They also describe two principally different ways of taking care of another person. One way makes the other person controlled and dependent. On the contrary, the other one develops his or her own opportunities to care.

However, it is necessary to point out that in ''Being and Time'' Martin Heidegger primarily solves the difficult age-old philosophical question of being, which cannot be adequately asked nor understood and provisionally answered without proper philosophical education. The philosophy of care is not part of his philosophical schedule.

What is care?

Care, which is an integral part of the medical professions, can be seen as a professionalization of one of the basic human attitudes and actions stemming from it. Therefore, Belgian authors [12] called their text: ''To be is to care''. They understand care as a fundamental part of life that is embedded in biological mechanisms, as well as in ethical appeals. Care is a matter of attitude (a person cares about something), but of activity as well (a person takes care of something, someone), care gives people the meaning to their lives.

In their work [13], Berenice Fisher and Joan Tronto first criticize previous attempts to see the concept of care rooted too much in the world of a rational man and, therefore, it is too motivation-concerned. They are also dissatisfied with the definitions which simplify the concept. To completely understand care as an attitude and activity which can, but does not have to be satisfying enough, the authors set their own definition: care is an ''activity of a genotype which comprises everything we do to preserve, maintain and improve our world, so that we can live in it as well as possible''. This world comprises our bodies, us as people and our surroundings, which we are trying to interconnect in a complex life-supporting net''.

A definition so broad requires specification, so the authors defined four phases of care: ''caring about'' – in Czech this means taking care of someone or something, regarding the recognition of the need for care. ''Caring for'' – nursing someone, the carer takes responsibility for the job done. ''Care giving'' – providing care, doing the job of a carer. ''Care receiving'' is receiving the care, the response to the care provided. Joan Tronto adds an ethical extension to every phase. The first phase requires special ethical properties – attention and recognition of needs. The second phase includes

responsibility, and the third phase requires qualifications for care providing, which is also an ethical appeal. To receive care is not a moral obligation, but everyone involved should question the quality of the process of care [14].

The concept of care was also questioned by Deborah Fingfeld-Connett [15]. She did not work with abstract definitions and concepts, but she worked out a ''metasynthesis'' of available qualitative studies dealing with the conceptualization of care in nursing. The author understands metasynthesis as the ''reinterpretation and recreation of existing findings of qualitative studies''. Her goal is to ''interpret a certain phenomenon or process of evidence-based methodology and continue to understand it conceptually and theoretically''. The author used 534 qualitative studies and conceptual analyses, and, according to the nine set criteria, she chose 49 studies and 6 conceptual analyses to work with. The result is an understandable scheme capturing the basic characteristics of nursing.

According to Fingfeld-Connett, care is an interpersonal process characterized by professional nursing, interpersonal sensitivity and close relationships. The receiver must be in need of care and open to it. The conditions for providing care are a professional maturity and ethical basis. The professional maturity comprises professional qualifications and the ability to deal with the psychological and physical demands of the profession. Ethical basis includes the effort to act in the interest of the treated in a conscientious and responsible way. A necessary condition is also the working place, which would make quality care possible. It is necessary for heads of staffs to appreciate the care provided, and see that there are enough material resources and time. The result is that patients experience peace of mind and body. Nurses see their better peace of mind as personal satisfaction, mental revival and personal growth.

The more we try to understand care as one of the important foundations of nursing, the more we can see it is not only what nurses do, but also what they are like. If care claims interpersonal sensitivity, professional maturity and ethical basis, we cannot ignore the fact that a nurse is a human being who has a certain attitude. So we have reached the ethics of virtues. This concept meets the same problem as the concept of care. It is a complex phenomenon defying a simple definition. The philosophical basis goes back to Aristotle [16]. In his Nicomachean Ethics, he does not offer simple definitions. The introduction states: ''So we have to be satisfied with the fact that the truth can be expressed only in an outline... it is for scholars to seek in every field just as much precision the nature of things allows them'' (1094b 19–24). For us, it is important that ''in ethics, behaviour is not just or appropriate if it has a property, but only if who acts, acts knowingly, according to their own judgement where the judging is focused on ethical behaviour, and, thirdly, if they are firm and constant in the acting'' (1105a 28–34).

The basis of virtue is a conscious act aimed at a good thing, not executed randomly or only at times. The contemporary concept of virtue was described by the Australian philosopher Stan van Hooft: ''Virtue is the ethical orientation of self towards the world. It is not only in the behaviour of virtuous people, it is also part of their inner lives. It comprises our emotions and motivations, as well as our thinking. It is an expression or orientation of our inner lives as a whole, whether they are emotional, rational or concerning our intentional actions. I see virtue as an ethical form of a dynamical orientation towards the world and people, an orientation to actions which the society would mark as good or right'' [17].

Nursing care appears as a complicated phenomenon defying simple definitions. Nothing remains but to accept the dynamics of the concept and think about its aspects over and over again, knowing the fact that we always cover only a part of the issue and that time will always open new and practical views.

To treat or to care?

The nursing profession, as well as nursing ethics, comprises both the treatment and the process of decision-making and nursing. In practice, it is not easy to fulfil all mentioned ethical demands while nursing a patient.

Theoretical elaborations can help a nurse orientate in a difficult situation, but also to accept the fact that it is impossible to satisfy often competing demands. It is good to have an elaborated ideal of a good nurse, but it is proper to seek ways to approximate to it. Aristotle offers eudaimonism (bliss, satisfaction) as part of the search. It is the search for compromise among different extremes, and, when a person is successful in it, the result is a good feeling. Deborah Fingfeld-Connett also found that good nursing can lead to peace of mind, satisfaction and a feeling of mental revival and personal growth in nurses.

Theoretical elaborations of the nursing phenomenon also bring an appeal to head members of staffs. Without their support and with a lack of material resources and time, it is impossible to demand quality care and it is impossible to expect the nurses to be fulfilled and satisfied. The responsibility of the managers of health institutions is not smaller than the responsibility of the others; it can even be bigger. They too should work on their ideal head of staff and seek ways to accomplish it.

Conflict of interest

The author has no conflict of interest to disclose.

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