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NURSING ETHICS IN CANADA: TWO DECADES

by

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A THESIS

SUBMITTED TO THE FACULTY OF GRADUATE STUDIES AND RESEARCH

IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE

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The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies and Research, for acceptance, a thesis entitled NURSING ETHICS IN CANADA: TWO DECADES submitted by Marianne Lamb in partial fulfillment of the requirements for the degree of Master of Nursing.

Supervisor

Date December 11, 1980

ABSTRACT

This study was directed toward an examination of the ethical dimension of nursing over time. The study was limited to nursing in Canada during two decades, the 1920's and the 1970's. Specific concepts under study were "nursing ethics" as a system of beliefs, the context of those beliefs, as well as the relationship between the two. The research approach was that of descriptive-comparative social analysis using current and historical data. The major source of data for this study was the Canadian nursing literature.

The ethical beliefs of nurses and the contexts of those beliefs are described in terms of the major ethical themes of each decade. These themes were selected following a review of the literature of each time period, and they related to broad aspects of nursing ethics rather than single ethical issues. The description of nursing ethics of the 1920's focuses on the service ideal, duty to the community, and the "spirit" of nursing. Nursing ethics of the 1970's is described in relation to the themes of person-centered care, patient rights, and quality of care.

The two decades of nursing in Canada were compared in terms of the similarities and differences in ethical beliefs and in terms of the contextual factors that seemed to influence or be influenced by the ethical beliefs of nurses. On the basis of these comparisons, several changing and unchanging aspects of nursing ethics are described. Nurses of the twenties tended to focus on the sort of person the nurse ought to be, nurses of the seventies on the behaviours that nurses ought to demonstrate. The broad moral principles that nurses

of both time periods identified as those guiding nursing conduct seemed to be fairly stable over time. Many of the specific moral obligations or qualities described by nurses of both decades changed within and between the two time periods. Changes in these more specific moral rules were generally associated with changes in the social context of nursing.

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CHAPTER I

INTRODUCTION

Contemporary nursing literature reflects considerable interest in and concern about the ethical dimension of nursing. The literature indicates that many authors seek to clarify the ethical dimension in their discussions of specific moral issues and related moral concepts, ethical implications of recent changes in nursing practice and ways and means of promoting ethical conduct. This study is directed toward an examination of nursing ethics over time.

A frequently emphasized point in the health care literature is that scientific and technological advances have brought about unprecedented changes in health care, creating new ethical challenges for health professionals. In addition, it is often underlined that ethical decisions must be made in a modern social climate of moral uncertainty and pluralism (Curtin, 1977). The "newness" of ethical problems and changes in the context of nursing seem to have directed attention away from the past. Of the few historical references made to nursing ethics, most carry the implication that it was once mainly a matter of etiquette and social conformity (Crowder, 1974). Those authors who have reviewed early codes of nursing ethics generally support such a contention (Carroll & Humphrey, 1978). While it would appear that the system of beliefs known as nursing ethics has changed, as have the contexts of those beliefs, there is a paucity of systematic research on those topics.

The literature of the past ten years would indicate that nurses frequently experience conflicts and confusion in relation to

the ethical aspects of nursing practice (Tate, 1977). In response to ethical problems, several authors have proposed changes for the nursing profession. These changes include new approaches to the nurse-patient relationship (Carper, 1979), the revision of nurse practice acts (Curtin, 1978), and the introduction of new ethics courses in nursing curricula (Aroskar & Veatch, 1977). Current uncertainty about the ethical dimension of nursing and the search for creative solutions to ethical problems are indications that the concepts and contexts of nursing ethics merit study.

Objectives

The major objectives in this study are to describe and analyze nursing ethics over time. The major questions underlying the research are: Have beliefs about nursing ethics changed over time? How have ethical beliefs changed? What is the relationship between ethical beliefs in nursing and the context of those beliefs? The specific concepts under study are those of "nursing ethics" and the "context" of those beliefs, as is the relationship between the two.

The Approach

The research approach used in this study is that of a descriptive-comparative social analysis using current and historical data. The major source of data for this study was the Canadian nursing literature of two decades; the 1920's and the 1970's. The 1920's were chosen because this decade represents the earliest time period in which nursing could be considered a profession (Stinson, 1969). The 1970's were chosen for study as this most recent decade was

characterized by discussions of nursing ethics that are of greatest relevance to current-day nursing.

As mentioned above, the major focus of this study is nursing ethics as defined and described in the nursing literature. "Nursing ethics" refers to beliefs about the moral values, ideals, virtues, obligations and principles identified by nurses as important ones during the two decades under study. Several factors constitute the context of nursing ethics. These include the mode of nursing practice, the organized nursing profession, the health care system, and Canadian social conditions. Storch's (1977) analysis of consumer rights and nursing indicates that changes in such contextual factors have had ethical implications for the profession.

In this study, the description of nursing ethics is based on major ethical themes selected following a review of the literature of each decade. The use of themes was considered to be the best method of describing the concepts and context of nursing ethics for a beginning "macroanalysis." These themes were selected as major ones as they received greatest attention and emphasis in the content of the nursing literature of each decade; they relate to the largest, i.e., "modal" group of nursing practitioners of each decade; and they involve broad aspects of nursing ethics rather than single ethical issues.

On the basis of the descriptive portion of this study, the two decades of nursing ethics are compared; similarities and differences in the concepts of nursing ethics are examined. The comparison of contexts is focused on the similarities and differences in the social factors influencing or influenced by ethical beliefs during the

two decades.

Limitations

The description and analysis of nursing ethics is confined to the Canadian setting and to two points in time, thus generalizations cannot be made to nursing in Canada between those points in time nor can generalizations be made to nursing in other countries. The data base for this study is current and historical literature, much of which was written by nursing leaders and educators. The beliefs and views expressed in that literature do not necessarily reflect those of the majority of practicing nurses. Further, as only the major ethical themes of each decade are described, not all aspects of nursing ethics are examined. For reasons such as these, this study should be regarded only as a beginning analysis of nursing ethics over time.

Sequence of Analysis

The focus in Chapter II is upon describing the concepts and context of nursing ethics in the 1920's. The discussion of ethical themes follows an introductory section on the "status quo" of nursing ethics and practice at the beginning of the decade. Chapter III describes nursing ethics of the 1970's and is organized in a similar manner. Chapter IV constitutes the comparative analysis of the 1920's and 1970's and this chapter also contains concluding comments.

CHAPTER II

NURSING ETHICS: THE TWENTIES

In order to both establish a starting point and provide some background for the subsequent discussion of ethical themes, a brief description of nursing practice, prevailing ethical beliefs, and major social factors related to nursing at the beginning of the decade are first outlined.

Nursing Ethics and Practice; 1920

By 1920, most graduate nursing services in Canada were provided by private duty nurses. These women gave nursing care in the home or hospital for a daily rate of approximately five dollars for 12 or 24-hour duty (Cashman, 1966; Weir, 1932). Most of these women were dues-paying members of registries set up to accept calls from physicians, hospitals, or patients and to dispatch nurses on cases. Most registries were operated by the nurse-members and the organization usually set fee rates in accordance with the recommendations of the provincial nursing association (Robinson, n.d.; Weir, 1932).

In the early twenties, an individual who was ill was generally cared for at home by a private physician and, if advised by the physician or requested by the family, by a private nurse. If hospitalization was necessary, the patient could hire a private nurse for "special" duty. Those who could not afford special nurses were cared for by student nurses. The major proportion of nursing services in Canadian hospitals was provided by students, even in small hospitals (Ellis, 1927a; Weir, 1932).

The nursing literature of the post-World War I period indicates that the beliefs that Canadian nurses held about nursing ethics remained largely unchanged from those articulated by Florence Nightingale, years earlier. However, there are indications that traditional beliefs were sometimes strengthened or sometimes weakened by the events and social currents of the period.

Nursing had an ethical component as surely as it had a knowledge-skill component. As Potts (1921) explained, "the profession originated for the good of humanity" and was founded on Christian principles (p. 223). Although it was true that the trained nurse must have special knowledge and skill, the theoretical and practical sides of nursing were deemed insufficient by themselves:

> The third side is not less important. It may be called the moral side or the ethical side, but I prefer to call it the Spirit of Nursing. It is that attitude or feeling which the true nurse has for her work, which provides the motive power, the ideals of service, the inspiration and the morale, which are so vital to all good nursing. (Stewart, 1918, p. 1394)

The notion of service embodied an altruistic ideal calling for self-sacrifice on the part of the nurse. As stated by one nurse, "If nurses shrink from self-sacrifice and devotion, called for in private duty nursing, then they should not take up this branch of nursing" (Browne, 19-1, p. 626).

Nursing was a particularly human service that "had to do not only with the bodies of suffering mankind but with the spirit as well" (Scovil, 1917, p. 463). The nurse was to devote her abilities to the individual in her care. She was to win the confidence of her patient,

learn and adapt to his likes and dislikes, and be attentive to detail in meeting the physical and mental needs of the individual (Clint, 1914; Scovil, 1917). As the victim of disease, the patient lacked strength, energy, and oftentimes reasoning ability. For these reasons, the nurse was justified, even obligated, to take a protective, motherly attitude with respect to the patient:

> In her relation to the patient the nurse must shield her from all adverse influence and anxiety, standing between her and relatives, if necessary, and must see that all details are run smoothly for her advantage, at the same time studying her characteristics so as to determine when to yield and when to be firm in executing orders disagreeable to her. (Clint, 1914, pp. 645-646)

Such an attitude did not imply any lack of respect but rather an intention to act in the best interests of the individual, as an "attitude of authority" was believed to give the patient a feeling of security and confidence (Byers, 1922). Although firmness was sometimes necessary, a good nurse was kind and tactful, yet not overly "familiar" with the patient (Robb, 1916). Tact was a quality highly praised by physicians, and nurses agreed that it was essential in private duty practice.

From her obligations to the patient stemmed those duties the nurse "owed" to the physician. As members of the two key professions in the field of sickness care, the nurse and the physician worked toward the same goal and both worked in the interests of the patient. Together they formed a team in the battle against disease and death (Byers, 1922). The physician was "captain of the team" and the nurse's role on the team was to observe the patient, carry out the physician's

orders, ensure that the patient was as comfortable and contented as possible, and report her observations and concerns to the physician when he visited. Any discord in this team was viewed as not being in the best interests of the patient. His recovery would be jeopardized by any lack of confidence in the nurse or physician (Scovil, 1917).

Several factors appear to have strengthened the notion of nursing as a public service and sense of professional pride and commitment that formed part of the traditional nursing ethic. World War I, the Halifax explosion of 1917, and the Spanish flu epidemic of 1918-1919 were well-known examples of disastrous events that had called for public service and courage on the part of Canadian nurses. Members of the profession were aware of the numbers of nurses who had lost their lives in "the line of duty" (Editorial, 1918a, 1918b; Graham, 1918). Beamish (1970), who was a student nurse during the flu epidemic, recalls: "You could not go through such an experience without developing more stamina and character. Your code of nursing ethics was developed by the day" (p. 31).

During the post-war years, Canada was in the midst of a moral and social reform movement (Allen, 1971). The social reform spirit fostered the development of public health nursing as a special branch of the profession. A public health section of the Canadian National Association of Trained Nurses (CNATN) was formed in 1919, and nursing leaders expressed considerable pride and optimism about the contribution that the profession would be making to the health of Canadian citizens:

> Canada has, inevitably, a great industrial future, but you cannot have a great industrial future

> without a healthy people; and inevitably nurses must have a big share, a large and important and deep-seated share, in the maintenance of the health of the people, wherever they are; nothing is more certain than that. (Nutting, 1918, p. 1354)

Women's groups had long been active in Canada, but the war years had brought more women into the labour force and greater political activity by women (Thompson, 1975). In the eyes of many, women had sacrificed equally with men during the war, and the 2,000 nurses overseas were public examples of the contribution that the "gentler sex" had made to the nation during the war effort. It was the belief of some citizens that the influence of recently-enfranchised women would bring a stronger moral tone to the life of the nation (Thompson, 1975). The moral qualities and finer sensibilities of women made nursing a "natural vocation" for females (Cameron, 1922, p. 641). Nurse authors stressed the importance of "character" in nursing, and among the requisite qualities for the membership in the profession were honesty, loyalty, diligence, trustworthiness, unselfishness, and self-discipline. Among the most desirable characteristics were those of tactfulness, adaptability, patience, endurance, courage, respect for authority, dignity in demeanor, cheerfulness, a sense of honour, and a sense of pride in her profession (Robb, 1916; Scovil, 1917).

Discontent among Canadians that had been submerged during the war effort resurfaced amid the inflation accompanying the post-war boom (Morton, 1967). Unrest among labourers and strike activity increased after the Armistice, culminating in the Winnipeg General Strike of 1919 (Robin, 1968). Concern with working conditions in nursing was reflected in a movement for the eight-hour day by private

duty nurses. This movement was noted at the 1919 annual convention of the Canadian National Association of Trained Nurses:

> We are having some difficulty locally in Toronto with the nurses on special duty wishing to establish an 8-hour day, and while at the present time this is only a local condition it is the sort of thing that may rapidly spread to other communities. (CNATN, 1919, p. 25)

During that discussion, members (most of whom were superintendents of nurses in hospitals) pointed out that patients would have to hire more nurses and that the costs would be prohibitive. They believed that the patient should be considered first, that "it would be too bad if it [the 8-hour day] became general," and that "we should act as a profession and not place ourselves on the level with common labor" (p. 26). Nursing educators (who were usually superintendents of nurses) had long hoped for reforms in nursing schools, but these had not yet been achieved:

> I think we are losing sight of the main point. While we approve of the 8-hour day for pupil nurses on account of the educational features of the matter, we would not take the graduate nurse into consideration in the same way, because they have not that same mental strain, preparing their class work. I would like to move that we disapprove of the 8-hour day for graduate nurses special duty in hospitals. (p. 26)

The motion of disapproval was carried, but one member suggested that the association should take a positive stand on hours as some special nurses were providing 24-hour duty and having difficulty getting time off to rest. Although some believed this matter could be "left to the superintendents" without going on record, a motion was carried

recommending that special duty in hospitals not exceed 12 consecutive hours (CNATN, 1919, p. 27).

The Service Ideal

One of the major perceived threats to the nursing ethic at the beginning of the 1920's was that of "materialism." According to some social critics of the day, the spirit of materialism was so widespread in Canadian society that traditional values, religion, and family life were threatened (Allen, 1971; Fairley, 1923). Although nurses had long professed a belief in the need for self-sacrifice and altruism in nursing, during the early twenties, some implied that contemporary life was so characterized by a concern with money and goods that ethics and the altruistic ideal could become a thing of the past within the profession (Canadian Association of Nursing Education (CANE), 1924). The movement by private duty nurses to shorten their hours of duty while maintaining their daily fee rate generated fears that nursing was becoming commercialized. To some onlookers, such a movement was evidence that nurses were becoming materialistic and less ethical in their attitude. Those holding such a belief emphasized that as a professional, and a participant in the healing art, one was supposed to be above "mere money getting" (Field, 1923).

In 1919, the Graduate Nurses Association of Ontario (GNAO) formed a private duty section following a request from the Central Registry in Toronto for representation (Carruthers, 1923). A private duty nurse representative from GNAO, Mrs. Gaskell, attended the 1920 CNATN convention. At this convention, part of the discussion centered on private duty nurses, and Mrs. Gaskell was appointed national

convenor of a committee to organize private duty nurses in all provincial associations. In the past, these nurses had rarely participated in professional associations as "it was very difficult for the Private Nurses to get together for organization, on account of their duties being continuous" (CNATN, 1920, p. 2). Private duty nurses hoped that they could achieve their goal of shortened hours by organizing as a group and gaining official nursing support within professional organizations. They considered their demands to be justified but they were aware that they were being criticized for being unfair to the public. One nurse reported such criticism in Sherbrooke:

> It seems to the public [sic] why we should ask for shorter hours, and a fee of $25 a week. A number of the nurses live outside the city, and consequently cannot do 24 hours duty and feel they are giving their patient justice. The Medical Profession seems to think we are asking for too much, in asking for this fee and shorter hours. (CNATN, 1920, p. 2)

These nurses acknowledged the problem of citizens who could not afford their services, but they could offer no solution: "People need our services and we would like to be able to give it to them, but we cannot afford to do it without payment" (CNATN, 1920, p. 2).

In 1921, Mrs. Gaskell reported to the CNATN convention and presented the by-laws for the new "private duty section" of the association. In her address, she stated that long hours of labour were a factor in the failure of private duty nurses to contribute to the solution of problems facing the nursing profession. Although some support for private duty aims was expressed at this meeting, some

nurses did not seem convinced that a move for shorter hours by nurses was justified. Browne (1921) spoke at the 1921 CNATN convention on private duty nursing:

> One of the noblest professions open to women is tending to become a soul-less trade, a purely commercial contract, a simple exchange of goods for money, the goods being their knowledge, skill and bodily powers. For these goods they are out to secure the highest obtainable price at the minimum expenditure of time and trouble. (p. 627)

A military nursing leader, Matron MacDonald, addressed members of the GNAO in 1921, and spoke of "the need of regeneration in the idealism of the nurse of to-day" (Ontario, 1921, p. 111).

Much negative publicity had been generated by a famous American physician, Dr. Charles Mayo of Rochester, Minnesota (Nurses selfish thinks, 1921). He had accused the American nursing profession of "unionism" and of selfishness, and his well-publicized views gained some support in Canada. Dr. Mayo's proposal for a shortened course for nurses was supported by a Dr. Cameron (1922) and the proposal was based on the belief that nurses were overtrained for the job required by most citizens (Hospital Association, 1922). Mayo had accused "overtrained" nurses of putting a prohibitive price on a public service, and he believed that those with less education would be more content with fair wages and conditions (McQuhae, 1922).

Nurses pointed out that physicians could more easily offer free services and a sliding scale of fees when necessary, as they did not provide continuous services and could charge higher fees to wealthier patients. Several Canadian nurses responded to Dr. Mayo's

criticisms (Gaskell, 1922; Gibson, 1922; McQuhae, 1922). McQuhae defended the ethical image of the nurse. She pointed out that nurses would gladly provide free services to those who could not pay, that they were no less charitable than Dr. Mayo, but that they were not in a position to be philanthropic nor had they been able to accumulate, much less give away, $2,000,000 (a reference to Dr. Mayo's recent contribution to the University of Minnesota).

Physicians expressed concern about the inability of their patients to hire a trained nurse during illness. Treatment of pneumonia and other complicated cases required the continued attentiveness and skill of a graduate nurse, as it was believed that recovery might well depend on it (Keeping fit, 1926; Weir, 1932). Dunlop (1925) told student "staff" in Calgary that they must remember to consider the viewpoints of those in authority and of patients. The nurse "must analyze herself and see that her motives are unselfish. Hers is more or less a life of self-sacrifice" (p. 363).

There were some physicians who supported the shortened day for nurses, and Cameron (1922) even justified his views with a detailed comparison of the work and wages of female teachers and nurses. Although some sympathized with the nurses, they could not support a plan that seemed unfair to the public. Dr. Byers (1922) acknowledged the demands of nurses, and considering that "the average active lifetime of a nurse is about 20 years," he agreed that they needed to be able to save more money for their declining years or lengthen their working years (p. 88). Private duty nurses set the length of a nurse's working life at ten years, due to the "mental and physical

endurance" required (Beers, 1921, p. 628). Byers rejected the solutions of shorter hours and more pay as they would be unfair to the public, but suggested instead that nurses be provided with cheaper accommodations that would allow them to increase the amount they saved.

Nurses and Hospitals

In the early 20's, there was a shortage of applicants for training schools, and many attributed the hours of duty to be a major factor in the reluctance of young women to enter nursing (Carter, 1921; Gaskell, 1921). Some sacrifice however, would always be required in nursing practice (Browne, 1924). Potts (1921) wrote an article on the teaching of nursing ethics and emphasized that:

> The young woman, therefore, who decides to take up nursing should dismiss from her mind that it is merely a pleasant and lucrative form of occupation. If she would succeed, high ideals are absolutely essential. (p. 223)

Some essays by student nurses that were published during the early twenties reflect the teachings of the traditional ethical beliefs of nurses and the importance of the service ideal in nursing. Greenham (1923), a student at the Children's Hospital in Winnipeg, described moral lessons that student nurses had to learn about to become nurses. These included deference, obedience, honour, loyalty, and professionality: "The nurse will early learn, and be told, that it is her bounden duty to be ready to go anywhere, at any time, and to do anything" (p. 290).

Although hospital administrators agreed in principle with the change to an eight-hour day for student nurses, few had implemented

such a policy in the early twenties and few thought these hours applicable to graduate nurses (Carter, 1921; Haywood, 1922). Gaskell (1921) saw no reason why the eight-hour day should not also apply to private duty nurses for they had an "arduous field of labour." She implied that hospitals opposed any improvement in hours of work for private duty nurses. Hospitals were accused of "exploiting" student nurses (Carter, 1921), but according to Haywood (1922), budgets did not allow for increased expenditures on nursing education. It would seem that those who operated hospitals would not favour shorter hours for graduates so long as their students worked 12-hour duty.

Nursing ethics applied to the relationship between the nurse on special duty and hospital authorities (Catton, 1922). Although the nurse was paid by the patient, she was obligated to abide by the regulations of the hospital regarding appearance, demeanor, reporting off and on duty, and nursing tasks. As students, nurses had been taught that they had an obligation to be loyal to the training school and hospital (Aikens, 1925). Considering "the influence that the graduate nurse carries into the municipality where she takes up her work," such an obligation continued after graduation (Armstrong, 1930a, p. 6).

Most hospital boards had to depend on public good will and donations to finance projects (Agnew, 1974); as such, the behaviour of graduates reflected on the hospital (Aikens, 1925; Armstrong, 1930a). Students were taught that any hint of criticism or dissatisfaction could jeopardize the patient's welfare (Dunlop, 1925). Complaints were to be taken to the proper authorities and never to be discussed

with patients or members of the public. An ex-governor of a hospital board deplored the publicity generated by student unrest at a hospital in Guelph (As an ex-governor, 1928). Although the student protest was not about hours, the local Trades and Labour Council passed a resolution advocating an eight hour day for hospital nurses (Provincial inquiry is, 1928). Such support was not solicited; one local citizen noted that the nurses were "recruited from a class which have no sympathy for the ordinary working man" (Council deals with, 1928, p. 3). Graduate nurses seemed reluctant to alter the status quo until they had the support of their professional organization and they indicated that as professionals, they would never use tactics employed by labour groups (Gaskell, 1922). Public airing of complaints and problems would be inconsistent with nursing ethics.

Private duty nurses seemed to consider it advisable to compromise somewhat and try to gain support for a ten-hour day. At the 1924 biennial convention of the newly renamed Canadian Nurses Association (CNA), the private duty section forwarded the following resolution for a general membership vote:

> (a) That whereas the undue length of the working day of the Private Duty Nurse is either forcing many such nurses into other branches of the profession, or out of the profession altogether, and thus depriving the private duty body of experienced nurses, to the great detriment of the body;
>
> (b) And whereas the length of the working day in any other profession than that of nursing, or in any other branch of the nursing profession, is not as great as is that of the private duty nurse;

> (c) And whereas the continued overweariness due to long hours of the most exacting labour must inevitably result in a much poorer quality of service rendered to the sick;
>
> (d) And whereas the private duty nurse knows that even a ten-hour day is too long for the kind of work she has to perform, yet because she realizes the difficulties under which hospitals carry on, and because her desire is to disturb hospital management as little as possible:
>
> THEREFORE BE IT RESOLVED That the hours of duty for Private Duty Nurses in hospitals be from 8 a.m. to 6 p.m., and 8 p.m. to 6 a.m. The same hours to obtain in private homes where possible, at the discretion of the nurse. (CNA, 1924, p. 17)

During the discussion of the resolution, one superintendent of nurses objected to the specification of hours and preferred this to be left open for negotiation between hospitals and private duty nurses. The convenor of the private duty section agreed that this would be acceptable, as the resolution was intended to emphasize the ten-hour day and not specific hours. The resolution was amended accordingly. A motion to send a copy of the ten-hour day resolution to superintendents of nurses and hospital boards was seconded, but during discussion:

> It was stated that this motion presented to hospital boards would cause considerable criticism, possibly of an adverse nature, but by presenting the resolution to superintendents of nurses the latter could quietly put the experiment into effect. (CNA, 1924, p. 18)

Based on this discussion, the second resolution was amended so that members of hospital boards would not be immediately confronted with the ten-hour day.

Nursing leaders during the 1920's generally held the position of superintendent of nurses in a hospital. This position carried the dual responsibilities of ensuring proper nursing care of patients and the education of student nurses. In accordance with nursing ethics, their duties to patients came before their obligations to students, and the women in these positions experienced many conflicts during their careers (Brown, 1924). They hoped to improve the quality of nursing education and improve such conditions as long hours of duty for students. To some of these nurses, educational reforms were a priority for the profession. Ellis (1927a) noted that most students spent 8,000 hours in hospital duty during their course, with only 300 to 600 hours devoted to "theoretical work." She asked: "Could we offer less and call it education?" (p. 472).

Most superintendents had little or no experience as private duty nurses (CNATN, 1920). They were willing to assist with the development of a private duty section, but they generally did not consider the problems of these nurses to be theirs. Johns (1921) reminded private duty nurses that criticisms of graduate nurses were threatening attempts to improve nursing education. As private nurses began to participate in professional organizations, there seemed to be greater sympathy for the group (CNATN, 1921) and the degree of support that nursing leaders gave private duty nurses increased. Although official support for a shorter day increased, there was still some concern that demands might antagonize hospital boards and affect the progress in improved conditions for students (CNA, 1924).

References to "materialism" or "commercialism" in nursing

seemed to fade by mid-decade when unemployment among graduate nurses became a widely-recognized problem (Unemployment among nurses, 1925). Less often was it implied that private duty nurses were lacking in ideals and unethical. It was thought that alternate approaches to the high cost of nursing services should be studied, and the Canadian Medical Association (CMA) expressed an interest (Cameron, 1927; Supplement, 1926). Subsequent joint activity by the CNA and CMA led to a "scientific study" of nursing practice and nursing education. The study lasted several years, and the final report entitled, Survey of Nursing Education in Canada, was released in 1932. (The "Nursing Survey" will be used to denote subsequent references to this study.)

Despite the decrease in the criticism about the motives of nurses and the growing sympathy for their economic problems, few nursing leaders or physicians could justify any increase in costs to patients. Private duty nurses justified their demands by questioning the quality of care given to patients during long hours, by comparing their fees to other women and other nurses, by pointing out their duty to provide for their old age, and by implying that few would be attracted to a profession that offered such unattractive working conditions (Gaskell, 1922). They professed a desire to be of service to the public, but did not see any way around the problem of fees given prevailing economic conditions. The private duty section of the Canadian Nurses Association presented resolutions advocating the ten-hour day at the conventions of 1926, 1928, and 1930 (CNA, 1926; 1928; 1930). There was a limit to their obligation to serve; they offered a professional, not a charitable service. There was a noticeable decline

in the number of references in the literature relating to the importance of self-sacrifice in nursing.

Duty to the Public

It was widely acknowledged by 1920 that many Canadians did not have ready access to the services of a trained nurse during illness (Clint, 1914; CNATN, 1919; Johns, 1921). Those thought to suffer most were middle income earners and their families. These Canadians could not afford private duty nurses for any length of time beyond perhaps a few days; even a few days could constitute a financial hardship (Perry, 1929). It would seem that private duty nursing was available only to the wealthier citizens of the country. The "middle income group" was never clearly defined in the nursing literature in terms of annual income, but it seemed to include anyone who could not easily afford private hospital rooms and private duty nurses, and anyone who worked for a living and was not indigent or poor. In terms of hospital care costs, middle income earners were considered to be unjustly burdened by a daily rate established to offset the costs of non-paying patients (Armstrong, 1930b; Johns, 1921).

At the annual meeting of the CNATN in 1920, Ethel Johns raised the issue of nursing care for middle income people in an address entitled, "The Challenge of the Future." That challenge was clearly directed to the private duty nurses. While she acknowledged the difficult life and economic problems facing these nurses, she pointed out that they had failed in their duty to the community:

> My quarrel with the private duty nurses is this: As a group they are usually inarticulate, unless it is a question of raising fees or reducing hours. Not that they should be blamed for doing either, or both, when it becomes just and necessary; but, in addition, they should take their part in formulating a constructive programme which will help solve the burning question of how people of moderate means are to be cared for when they are ill. (p. 7)

In the opinion of Johns, nurses were not meeting their obligations to the Canadian public. She implied that private duty nurses were content to work below the level of their skill caring for the wealthy when their talents could be put to better use in society. In her speech, Johns suggested conferences with physicians and women's groups, communication with the public, investigation of insurance plans or government-sponsored plans, and trained attendants for routine nursing care.

Members of the CNATN had acknowledged the nursing shortage and the need for trained attendants at the 1919 annual meeting. They believed that attendants could offer domestic services and simple nursing care in times of illness (CNATN, 1919). These nurses agreed that the development of such a category of worker was in the public interest, but to ensure that the public was protected, attendants should be licensed, carefully taught, and supervised by trained nurses. An attempt by the nursing profession in Manitoba to gain legislative jurisdiction over trained attendants had failed (Johns, 1921). Courses were established in Saskatchewan, Alberta, Ontario, and Quebec during the early part of the decade (Brown, 1924; CNA, 1924; Smith, 1921).

Although some nursing leaders and physicians supported the development of a category of worker to supplement graduate nursing

services, private duty nurses did not heartily endorse such plans. They were concerned that "subsidiary nurses" would be taking cases that rightfully belonged to graduate nurses. Registered and supervised trained attendants were acceptable, but legislation was necessary to ensure that these workers were properly regulated. The public often did not know the difference between a trained nurse and a non-graduate "nurse" (Gibson, 1922). At the 1922 CNATN convention, the private duty section proposed a resolution disapproving of the "sub-nurse" as they considered such a worker "inimical to the best interests of both the Public and the Nursing Profession." This resolution was withdrawn however, presumably due to pressure from other members. A resolution was passed however, condemning hospitals that assigned students to private nursing care and collected a fee for the service (CNATN, 1922).

While trained attendants or housekeepers were acceptable, "practical nurses" were not (CNA, 1924). For several years, Dr. Mayo had been calling for shortened courses for nurses and the development of a group of practical nurses (Hospital Association, 1922; McQuhae, 1922). He condemned the nursing profession for resisting the development of courses for practical nurses in the United States and his comments were published in Canada. Mayo raised questions that challenged the ethical basis of nursing. How could nurses claim to be a service that met the needs of the public? McQuhae (1922) publicly contested Dr. Mayo's solution to the cost of nursing services by attacking the idea of a lower standard of nursing care for Canadian citizens with moderate incomes:

> Everything seems to be fair except the results, and they undoubtedly would be very unfair to the sick patients. And this from Dr. Mayo, a man famed for retrieving patients from the 'gray menace of the shadows.' He may still retrieve the rich, because they apparently will have proper care, but, if he continues this mad and reckless scheme of thrusting the people of moderate circumstances into the hands of the half-trained and inexperienced, he will soon be known as a good ally of the undertaker. (p. 227)

If justice was to be served, all Canadians should have access to professional nursing care. Some nurses had suggested government-subsidized nursing services during the war years (Kennedy, 1916). Johns (1921) had considered government-sponsored plans for care of the sick a possibility worth investigating in 1920. McQuhae (1922) proposed a similar plan as an alternative to practical nurses:

> Each city or community should maintain a staff of graduate nurses, to be paid for by taxation. These nurses should be paid a reasonable salary and given reasonable hours, and, when the man of moderate means is ill, he should have the care of a qualified graduate nurse hourly, daily, or twenty-four hourly, as indicated by the condition of the patient. (p. 228)

Despite such suggestions, tax-supported nursing services had little appeal in the early 1920's. Most nurses did not seem to consider the possibility of state intervention and the development of courses for trained attendants or housekeepers was more frequently proposed as a solution.

Courses for practical nurses and nursing housekeepers continued to develop during the first half of the decade, and the private duty section provided grudging support at the 1924 CNA convention by acknowledging that "practical and housekeeping nurses should

have a definite place in the profession" (p. 1324), but they should in no way replace the graduate nurse. By 1925, however, unemployment was an acknowledged problem in nursing and such conditions did not foster a kindly attitude to potential competitors. Admittedly, it was a tragedy that many nurses sat waiting for a call from the registry while many citizens went without needed nursing care. The editor of the Canadian Nurse supported private duty nurses by insisting that students not be used for private duty service, that visiting nursing services not compete with private duty nurses and offer services below cost to those well able to pay, and that doctors not engage the services of untrained women when skilled nursing care was required (Unemployment among nurses, 1925).

Courses for subsidiary nurses or trained attendants did not seem to expand during the decade, and the one that had started in Saskatchewan in 1920 was discontinued in 1926. Several reasons were given for failure of the course. According to Robinson (n.d.), citizens still preferred to manage with family and friends, registered nurses were unsupportive, and nursing housekeepers frequently left practice to enter nurse's training.

Group and Hourly Nursing

By the middle of the 1920's, there were reports of new methods to deal with the problem of providing nursing care to the middle income group. One approach used for hospital care was called group nursing. A graduate nurse would provide care for two patients and the patients would share the cost. In the system described by Sister Domitilla (1925), nurses alternated day and night duty monthly,

and worked a 12-hour shift.

> The nurses receive five dollars a day and their meals. The patient pays the hospital $6.75 a day for the nursing service and the nurse's meals, and the hospital in turn pays the nurses. (p. 586)

Such a service provided nurses with steady employment, but Domitilla noted that the service had to be located in one suitably-designed section of the hospital, that administrators had to ...te patients so that one nurse would not have two acutely ill patients and that nurses must be chosen who were capable of caring for two patients and who were "fired with the spirit of service and good will."

Such a service had been introduced on a limited, experimental basis during the first half of the decade, but interest in the scheme grew (CANE, 1924). By the late 1920's, more members of the public were willing to enter hospitals during illness, and private duty nurses were employed less often in the home and more frequently in hospitals (Carruthers, 1927). Agnew (1930a) noted greater public confidence in hospitals, a tremendous hospital building campaign, and a growing discontent about the costs of hospital services. Most observers viewed the development of group nursing systems necessary as skilled nursing care was imperative in the care of patients undergoing new and complex surgery (Agnew, 1930b; Cameron, 1927).

One private duty nurse (Carruthers, 1927) agreed that physicians preferred an experienced nurse for the first few days following surgery, and she believed that once the critical post-operative period was over, students could take over from special nurses. However, group nursing was a controversial issue according to

Agnew (1930b), and Weir (1932) reported that an active campaign against group nursing had been waged by private duty nurses in Ontario. Some private duty nurses indicated that they feared such schemes would increase unemployment, that the least ill patient would get less care although he paid half the cost, and that seriously ill patients would not get sufficient care when a nurse was shared (Weir, 1932). These nurses seemed to think in terms of their obligation to provide attentive and devoted care to an individual patient rather than their obligation to Canadian society.

There were several indications that private duty nurses resisted the idea of working for hospitals. As an independent professional, the nurse was free to "use her own initiative" and "make her own arrangements with the family" (de Nully Fraser, 1925, p. 22). Private duty nurses also enjoyed the freedom that private practice offered (Clint, 1914; Private duty section, 1929). Carruthers (1927) considered the ability to choose one's field and to change it when desired just two of the advantages of private duty practice. As special duty increased, some of the usual freedom was restricted by hospital rules. In 1921, a superintendent of nurses told her audience that "the special nurse has everything to gain, and nothing to lose by her work in the hospital" (Catton, 1922, p. 288). In 1928, Jamieson presented a private duty nurse's view when discussing hours of duty for special nurses:

> Yet there are superintendents and hospital officials who are still trying to hold us down to these hours, even when our patients are convalescent—enjoying a book or newspaper—not co-operating with us but

> laying down rules and regulations, etc., without any consideration with us: treating professional women as probationers. (p. 197)

The desire for independence and antipathy toward hospital control suggest that opposition to group nursing schemes during the twenties was not all due to fears about unemployment.

The greatest problem did not seem to be nurses however, but lack of an appropriate administrative structure. Hospital administrators only began to express an interest in group nursing towards the end of the decade. A hospital administrator (Armstrong, 1930b) told members of the Registered Nurses Association of Ontario (RNAO):

> We have a fine group of nurses to work with but the general organisation principle by which they are employed in the hospital is wrong. Working towards efficient service of the graduate nurse in the hospital, the first feature seems to be a policy of adjustment whereby all special nurses would be engaged by the hospital and this institution held responsible for the efficiency of the service....Under such a general arrangement it would be quite an easy matter for the hospital to spread the service of the group-nurse over two, and possibly three, patients. (p. 348)

Of those surveyed across Canada, most nurses professed no strong views on group nursing and indicated a willingness to test out such a system. Most nurses seemed to be awaiting the results of the Nursing Survey. Browne (1929) told a meeting of Ontario nurses that initial results of the Nursing Survey indicated the practical value of group nursing in hospitals, and she emphasized that nurses must make an "honest, cooperative attempt" to solve the problems of their profession (p. 124).

Despite the increasing popularity of hospitalization, most care of patients took place in the home (Agnew, 1930b). In 1926, 17.8% of births took place in hospitals, and by 1930 the percentage had only risen to 26.6 (Urquhart & Buckley, 1965). According to physician estimates contained in the Nursing Survey, more than 60% of cases of average acute illness were nursed by untrained "nurses", maids, or family members (Weir, 1932). Hourly nursing offered a solution to some of the economic problems for the middle income group. This system offered a patient the services of a graduate nurse who would visit the home, provide the amount of care necessary, advise a member of the household about care, and charge for the amount of time spent in the home before going on to the next case (Cameron, 1927; Moag, 1929). Registries in Toronto and Montreal began to offer hourly services on a small scale early in the twenties (Cameron, 1922; CANE, 1924), but the services had not expanded to the same extent in Canada as they had in the United States (Moag, 1929). Registries offering these services reported few requests by physicians or the public for hourly nursing, but MacIntosh (1930) attributed the low demand to lack of publicity on the part of registries, and poor organization. She thought that perhaps it would not be unethical to advertise such services, as there seemed to be a public need for them.

In 1929, private duty nurses attending the Congress of the International Council of Nurses (ICN) in Montreal discussed the need for collective efforts to establish nursing as a community service. Ideally, such a service would be regulated by new legislation designed to ensure quality and protect the public (Private duty section, 1929).

Nurses at this conference asserted that individualism must give way to collective action if the public interest was to be served. Moag (1929), a VON superintendent, considered the organization of hourly nursing services in Canada to be the moral duty of nurses:

> Is it not our responsibility as nurses to provide, so far as in our power, satisfactory nursing care; and if we fail in our duty are we not liable to be censored [sic] as a group, because we are not meeting the nursing needs of our people? (p. 141)

Private duty nurses registered greater support for hourly nursing services than for group nursing (Weir, 1932), but it would seem that the logistics involved in organizing such a service plus the inertia of members of the registries, prevented any large-scale development of this system during the decade.

The literature would indicate that most private duty nurses focused more on their obligations to patients who engaged their services than on their obligations to society (Kay, 1926; Keeping fit, 1926; McIntyre, 1925). They had been trained to serve individuals, not to organize services, and new forms of service were quite foreign to their idea of graduate practice. Some expressed quite a pessimistic attitude to the middle income problem (Jamieson, 1928). Others expressed optimism about new hourly and group nursing services, and they urged nurses to engage in collective and unified effort (Private duty section, 1929). MacIntosh (1930) affirmed that "for the future we have faith in the further growth of the principle of our organization for higher and better service" (p. 357).

The Spirit of Nursing

The spirit of nursing was a term associated with the "art" of nursing and the ethical aspects of professional practice (Stewart, 1918). The spirit denoted the human concern that the nurse demonstrated and the ethical principles that guided her conduct in the practice of her profession. Christian love of one's neighbour and humanitarian ideals were to be manifested in the nurse-patient relationship (Aikens, 1925; Potts, 1921). Such a spirit directed the art and science components of nursing and inspired the nurse in her efforts to promote the total welfare of the patient (Stewart, 1926). During the twenties, concerns were expressed that the traditional spirit of nursing was being weakened by changes in societal values, nursing education and methods of caring for the sick.

Nursing Education

Most nursing leaders hoped to raise educational standards by offering students programmes that had more hours of theoretical content in medical science as well as courses in psychology and sociology (Gibbon & Mathewson, 1947). Given the traditional emphasis on the mental as well as the physical aspects of nursing care and the development of public health nursing, such curriculum changes were considered to promote a higher standard of nursing service for society (Brown, 1924). Graduate nurses also sought courses to keep them up to date with developments in these fields, and they generally agreed that such information was necessary in modern practice (Gaskell, 1922; Weir, 1932).

Some considered greater scientific knowledge unnecessary for nurses and implied that such changes were more in the interests of the nursing profession than in the interests of society (Hospital Association, 1922). The Rockefeller Foundation had sponsored an investigation of American nursing education, and the study committee's recommendation to upgrade curriculum content was rejected by a British physician:

> As a curriculum for a woman doctor it is inadequate, for a nurse it is excessive and superfluous. The Committee appears to look upon a nurse as a person to be trained to become a sort of doctor's assistant. This is not her function. Her duty is to carry out accurately the instructions of the doctor as to the nursing of the patient. (Eason, 1925, p. 82)

He seemed to agree with Dr. Haywood (1922) who had warned nursing educators "to guard against our curriculum becoming too much theory and too little practice" (p. 73).

The CNA president, Jean Browne (1925), wrote a response to Dr. Eason's critique of the Rockefeller Report and described the Canadian medical and nursing opinion as one halfway between that of the American report and the British physician. She objected to the Rockefeller Report on the grounds that it failed to acknowledge the presence and importance of the service ideal in nursing. Browne also objected to Dr. Eason's interpretation of the role and requisite qualities of the nurse:

> It would appear that his idea of a nurse is a thoroughly trained automaton whose only lode-star is obedience. It is a characteristic feature of the modern young woman in this country. . . if she chooses nursing as her profession, she does

> not see any necessity for suspending her processes of thought . . . Be very sure that this young woman does not consider that she is working for the doctor. She has very definite ideas that she is working for sick people. She is endeavoring to give to the physician intelligent co-operation rather than blind obedience. (p. 83)

There seemed to be some fear that scientific knowledge would interfere with the traditional humanistic approach in nursing and build a barrier between nurses and patients. Nurses were reminded of their traditionally close relationship with families and individuals in times of illness (Carter, 1921; Eberts, 1925). Johns (1921) reported that critics of nursing believed that higher education made nurses unwilling to do the ordinary duties required in the care of patients. Dr. Craig (1923) noted the development of nursing specialties and that increasingly, "the nurse has been delving into the field of science until the term 'nurse' no longer holds its old-time meaning, applying to one who has to do directly with the care of the sick" (p. 657). While Dr. Carter (1921) supported the changes in nursing education and the training of specialists through higher education, he did not foresee the private duty nurse ever being replaced at the bedside. Private duty nurses would always have for their task, "the interpretation to the people of the true spirit of the nursing profession" (p. 149).

Nursing leaders stressed the importance of the spirit of nursing and were aware of the criticism that the newer graduates did not compare well with earlier graduates (Haywood, 1922). At the 1923 convention of the American Medical Association, the CNATN President, stated:

> While our efforts in Canada have been directed to giving the student nurse a more scientific training than used to be thought possible, the superintendents of our training schools have been vigilant in safeguarding the art of nursing. We don't want our Canadian nurses to lose that essential quality of devotion to the interests of the patient. (Brown, 1924, p. 783)

Private duty nurses also emphasized the importance of teaching the spirit of nursing as most complaints about graduates involved character rather than skill. According to Jamieson (1928):

> Very often the problems are largely a matter of ethics rather than skill or good nursing technique. So look to schools to study the whole question of ethics, and instill in students that they must realize their responsibilities in personal obligation. (p. 196)

Although nursing educators and private duty nurses agreed on the need for nurses to learn their duty of devotion to the patient, the methods of instilling ethical teachings and of promoting ethical conduct were disputed. Traditionalists emphasized the importance of obedience to rules and strict discipline in the formation of moral habits (Aikens, 1925). Those who thought harsh discipline inhibited the initiative necessary in nursing stressed the value of ethical discussions and student government in nursing schools (Sidelights upon professional, 1926; Talley, 1929).

Most nurses agreed that students should be carefully selected for nursing on the basis of character, that ethical teachings should begin early in the probationary period, and that teachings should be continued during the three year course (Aikens, 1925; Potts, 1921; Talley, 1929). There was less agreement on other methods of fostering

the spirit of nursing and promoting ethical conduct in nursing. Fraser (1925) represented the modern view:

> If we could throw greater emphasis on respecting the sensibilities of the patient, on the giving of expert scientific care with better cheer, could we gather our courage to fling some of our vaunted professional etiquette to the winds? Might we even stand aside and let the shades of the old military discipline pass? (p. 641)

Throughout the country there were superintendents of nurses who believed that the best way to ensure ethical practice was to protect students from outside influences, maintain strict discipline, and emphasize loyalty and obedience during hospital training. According to Wakeling (1930):

> The success of the training school depends largely upon the personal interview with the applicant and the acceptance of students not living in the city, or in the immediate vicinity of the hospital. The ignoring of this factor frequently gives rise to disturbance between the families of the pupil nurses and is liable to upset the morale of the training school. (p. 25)

An ex-governor of a hospital board wrote that ignoring the practice of accepting only young women from outside the hospital locale had been one of the "root causes" of an unprofessional walk-out by students at a hospital in Guelph (As an ex-Governor, 1928, p. 178). According to the local newspaper account, the students had walked out (leaving minimum student staffing) in support of colleagues who had been subjected to "severe discipline" (30 Nurses are, 1928). The clash between generations also erupted in Alberta early in the decade when a superintendent of nurses banned bobbed hair for students

(Cashman, 1966).

Nursing leaders from around the world discussed "professional ethics" at the 1925 Congress of the International Council of Nurses. They presented a mixture of traditional and modern opinions on the ethics of nursing and the teaching of ethics (Sidelights, 1926). Following a round table discussion, members concluded:

> The young generation cannot and will not submit to authority. Young people prefer to gain wisdom by personal experience and to use their own judgement. It is for us to set a good example and to help them to arrive at the highest solution. (p. 28)

These nurses seemed to agree with Brown (1924) that an ethical spirit in nursing could be promoted, but that educators could not change the character of a student. According to Brown, any decrease in the humanitarian ideals of the modern nurse was a reflection of a similar decrease in society as a whole.

Nursing Practice

Although nurses professed a belief in the importance of the ethical aspects of nursing as well as the knowledge and skill components, graduate nurses were most often criticized for ethical failures, and many critics noted a decline in the spirit of the profession. Nurses were said to be "high-handed" (Perry, 1929) and rather than being helpful, they needed "waiting on" (Humbly, 1921). Laywomen told nurses that most of the complaints about private duty nurses involved the attitude, efficiency, and economy of the nurse in the private home. McWilliams (1921) reported that some nurses had a "too professional" air and lacked a tactful approach. It was almost a maxim

that "a maid walked out when a nurse walked in" (Johns, 1921). Plumptre (1930) called for cooperation between the nurse and members of the public over issues such as domestic chores and meal hours.

These matters were traditionally governed by nursing ethics and discussed by authors of ethics books for nurses (Aikens, 1926; Robb, 1916). Nurses had generally been taught to use their judgement about taking on household duties in the home. If housework was in the best interests of the patient, the nurse should do it willingly (de Nully Fraser, 1925). However, the nurse was trained and hired for professional abilities and therefore, in wealthier homes, she should not feel obligated to do domestic chores when help could be hired for these purposes (Carruthers, 1927; Robb, 1916). Nurses were to be kind, tactful and adaptable. If they could not "fit in" to a home, they were to resign from the case if they could arrange for a replacement (Kay, 1926).

Members of the CNATN (1922) discussed criticism of the private duty nurse and the private duty section decided to establish a committee to investigate complaints. At the 1924 convention of the CNA, the convenor reported that the committee had been inactive. It would seem that most nurses did not consider unethical conduct to be a major problem. Although Catton (1921) had proposed that a "Code of Nursing Ethics and Etiquette" for Canadian nurses be prepared and adopted by the CNATN, the matter was not pursued. Carruthers (1927) and Jamieson (1928), both private nurses, agreed that some complaints were justified but that some members of the public had unrealistic expectations of nurses. In Jamieson's opinion, private duty nurses

did not receive more criticism than other nurses when one considered that they were members of the largest group of nurses.

Private duty practice was changing during the twenties as the percentage of hospital cases increased. Developments in medicine had also brought about changes in hospitals. If Canadians were to benefit from the advances made in medical and social science, organizations and institutions would have to develop efficient methods of providing services to citizens. The model for modern efficiency was to be found in the world of business (Haywo , 1921). Frederick Winslow Taylor's principles of scientific mana were used in industry during the 1920's (Khandwalla, 1977), and such principles were deemed applicable to the provision of health and sickness services. It was thought that efficiency would be promoted through standardized procedures and equipment, effective supervision, and appropriate use of workers carefully selected and trained for their jobs (Agnew, 1930a; Armstrong, 1930b; Brown, 1927). Amid the enthusiasm for scientific medicine and scientific management, some warnings were sounded about overemphasis on technique and science to the exclusion of "humanity" in nursing care, seen as constituting the true spirit of the profession.

The principles of scientific management used in modern industry began to be applied to nursing services in hospitals, and the subject was discussed at the 1927 Interim Conference of the ICN (Brown, 1927; Birkner, 1927). Smellie (1928) from Canada and Clayton (1927) from the United States discussed the advantages of standardization, but they cautioned against rigidity with respect to techniques and routines. Clayton stated that Taylor's main objective had been to

bring about "the greatest well being for all concerned," and told her audience:

> Standardization must not be used when it interferes with the best interests of the patient, either physically, mentally or spiritually, nor must it be used when by so doing it interferes with the well-being of the nurse. (p. 52)

The spirit of nursing was seen as somehow dependent on the closeness of the nurse-patient relationship, and even administrators of hospitals viewed such relationships as important ones. The superintendent of the Kingston General Hospital (Armstrong, 1930a) told nurses that as they were closest to the patient in a hospital, they must convey human concern and avoid "appearing to the patient that we are creatures of an inflexible routine" (p. 60). Fraser (1925) expressed concern that nursing care in hospitals might become very impersonal and centered on efficient routine rather than patients. She advised supervisors about the importance of guiding nurses in the proper spirit of nursing:

> Can she be helped to the consciousness that our first duty to the patient is to make common cause with his essential humanness; that the consideration of his mental welfare and comfort is as important as his physical treatment? (p. 641)

New tests, tasks, and procedures delegated to nurses were partly due to advances in medical science and partly due to new standards of record-keeping (Dobbie, 1926; Ellis, 1927b). Many nurses were aware of the criticism that patients did not receive the attention and service formerly provided by nurses in hospitals (Ellis, 1926;

Reed, 1927). For both the student and graduate, "the demands made upon her time and attention other than in affording actual nursing care to the patients have increased" (Ellis, 1926, p. 633). One nurse (Sharpe, 1927) argued that more staff should be hired as demands on nurses increased. In her opinion, the poor quality of education and the accompanying shortage of staff were responsible for any decline in the nurse's spirit of service.

Private duty nurses expressed a sense of pride in their professional knowledge and the recent establishment of the profession "on a scientific basis" (MacIntosh, 1930, p. 354). They continued to affirm a belief in the service motive and did not consider scientific education to be incompatible with devotion to the patient (Kay, 1926). The disciplines of psychology and sociology offered knowledge about human relationships (Fraser, 1925) that would be valuable to nurses in their work with patients and families. Knowledge of self and a "deeper understanding of life based upon psychology" were applicable to ethics (Sidelights, 1926, p. 27). The distinction between the science and art of nursing seemed to become less clear during the decade. Early textbooks on nursing ethics such as Robb's (1916) included information on "the art of conversation" and nurse-patient relationships. Similar topics in newer curricula were included in courses on psychology and sociology (Fraser, 1925). What one generation considered "tact," another generation considered the application of psychological principles. Empirical knowledge of human life was added to moral knowledge, and both guided the nurse in her relationships with patients.

Attention will now be directed to the concepts and contexts of nursing ethics in the 1970's.

CHAPTER III

NURSING ETHICS: THE SEVENTIES

The first section of this chapter contains background information on nursing practice, nursing ethics, and related social factors of the late 1960's and early 1970's. As in Chapter II, the major ethical themes of the decade are then delineated.

Nursing Ethics and Practice: 1970

In 1970, more than 80% of working nurses were employed by hospitals or other institutions, and the majority of these nurses worked as general duty staff nurses (CNA, 1971). Although not all nurses were members of a union, collective bargaining activity had increased considerably during the sixties (Murray, 1970). Most registered nurses in Canada were graduates of a three-year hospital programme, but increasing numbers of students were enrolling in community college programmes, basic baccalaureate and post-basic baccalaureate nursing programmes (CNA, 1971). Such trends were consistent with the recommendations of the 1964 Royal Commission on Health Services and the Canadian Nurses Association (Kergin, 1969).

In 1954, the CNA adopted the International Code of Nursing Ethics (hereafter called the ICN Code) that had been developed the previous year by the International Council of Nurses (ICN). This code was slightly revised in 1965, and it would seem that most nursing students in Canada were introduced to the tenets of the ICN Code during class discussions of ethical obligations in nursing (Laycock, 1964). Students in nursing schools operated by Roman Catholic orders

were also taught the Moral Code that guided the operation of Catholic hospitals (Godin & O'Hanley, 1959).

Nursing was considered a "service to mankind" organized to meet the needs of people, sick or well (Code, 1965). Changes in the nursing role were to be based on an assessment of the health needs of the Canadian public (Charbonneau, 1966). Although "preservation of life" was an acknowledged principle in nursing (Code), the obligation to promote health was increasingly emphasized by national leaders in nursing and in government (Munro, 1969; Mussallem, 1968) as they began to discuss the future of nursing more frequently in terms of community services than hospital services. The 1969 Task Force Reports on the Cost of Health Services in Canada (hereafter called the Task Force Report) recommended the development of community health care services as alternatives to costly in-hospital care (Department of National Health and Welfare (DNHW), 1969).

The nurse's obligation to the patient in her care was considered to be primary (Pelley, 1964), and the nurse was to give care that was "unrestricted by considerations of nationality, race, creed, colour, politics or social status" (Code, p. 38). Nurses valued and derived satisfaction from the "human" aspects of their role. Murray (1970) noted that nurses were reluctant to add on or delegate duties that would reduce their contact with patients and that they considered "direct care" rather than "direct cure" activities to be their unique contribution to health care.

During the late 1960's and early 1970's, health professionals were acutely aware of criticisms about Canadian health care

services (Health Resources Directorate, 1970; National Conference on, 1973). The demands for changes in the health care system were attributed not only to rising costs, but also to rising expectations about medical science, growth of the consumer movement, increasing public sophistication, and changing social values (Blishen, 1970; Maloney, 1970). One of the major criticisms was that patients were treated in an impersonal manner and given "assembly-line" treatment. The ICN Code affirmed that "the nurse believes in the essential freedoms of mankind" (p. 38). As a personal service to humans, nursing required a non-discriminating attitude, a patient-centered approach to care, and conduct respectful of the dignity and worth of the individual (Rogers & Ballantyne, 1963). By the late 1960's, many nurses were expressing concern about the "dehumanizing" aspects of hospitalization (McMurtry, 1968; Munro, 1969).

Nurses were obligated to provide a high quality of care, and to maintain high standards of knowledge and skill throughout their nursing career (Code). Charbonneau (1966) wrote:

> Nurses consider the quality of their work to be of paramount importance. Both individually and through their professional associations, they strive to establish and maintain high-quality services that assure protection and security to society. (p. 9)

During the late 1960's and early 1970's, examination of the Canadian health care system led to many proposals for changes in the nursing profession. These changes were considered to be necessary if the profession was to keep pace with developments in health care, provide a high quality of nursing care, and meet the needs of Canadians.

Increasingly, it was thought that nurses could and should be prepared to function in an "expanded role" as specialists in acute care facilities (Coombs, 1970) and as nurse practitioners in primary care settings (Mussallem, 1977).

The ICN Code specified the nurse's obligations to physicians. The nurse was to "carry out the physician's orders intelligently and loyally and to refuse to participate in unethical procedures," and to "sustain confidence in the physician and other members of the health team," but alert authorities to incompetent or unethical practice (p. 38). Towards the end of the 1960's, nurses in Canada preferred to refer to their obligations to physicians in terms of co-operation and teamwork (Lindabury, 1967; Wedgery, 1967). Ethically, nurses were not to diagnose or prescribe except in cases of emergency (Code), but as nurses north of the 60th parallel frequently substituted for physicians, some practices that would be considered unethical and illegal in the south were sanctioned in the more isolated areas of Canada (Gascoyne, 1967; Munro, 1969). As greater numbers of medical procedures were being delegated to nurses in all areas of the country, legislative changes or mechanisms were considered necessary (ICN Congress report, 1969; Munro, 1969).

In a departure from the obligatory nature of most statements, one tenet of the ICN Code was: "The nurse is entitled to just remuneration and accepts only such compensation as the contract, actual or implied, provides." Such a statement probably reflected the growth of organizations for collective bargaining in nursing. MacLeod (1966) noted that nurses were becoming less reluctant to accept current

salary levels:

> Prevalent in society today is a great concern for the welfare of the worker. Influenced by this trend, nurses feel strongly that they, too, have a right to better salaries, better hours, better conditions of work. But as a profession we have been inhibited by a guilty feeling that pressing for our rights somehow conflicts with the professional ethic of "putting the patient first." (p. 20)

By the late 1960's, several groups of Canadian nurses had resorted to strike action following unsuccessful negotiations (Lindabury, 1968). There still seemed to be a reluctance to use strike action; some bargaining groups declared that they would not resort to that tactic (Controversy, 1967). A 1946 no-strike resolution by CNA members was still in effect during the late 1960's, but increasing numbers of nurses considered the "withdrawal of services" threat a necessary one. According to Lindabury (1968), withdrawal posed a dilemma as "there is not a nurse in Canada who wishes to be put in the unenviable position of having to resort to strike action" (p. 29).

Person-Centred Nursing Care

Nurses had considered themselves unique among health professionals in that their traditional focus was the "whole person" as an individual, rather than a limited interest in the disease condition or physical status (Murray, 1970; Mussallem, 1968). Therefore, public complaints about impersonal care, especially in hospitals, alarmed many members of the profession. An ex-patient (Rose, 1970) complained that "hospital nurses seem content to deal with patients as physical beings" (p. 32), and unlike public health nurses, they

failed to provide patients with information and psychological support.

In 1970, an article on the topic of individualized care was published in the Canadian Nurse. Poole, a federal nursing consultant, challenged hospital nurses to improve their care by examining practices that were not based on patient needs. She criticized nursing care that was all too often organized around hospital routine, based on ritual and tradition rather than scientific knowledge, and guided by archaic hospital policies rather than nursing judgement. DuMouchel (1970) directed her comments to nursing administrators and advocated the reorganization of hospital nursing services to meet patient rather than personnel needs.

Consumer representatives and government reports confirmed for nurses that patients wanted the profession to retain the "unique focus" of nursing. The nurse's professional knowledge and skill should be directed to meeting the needs of the individual patient (DNHW, 1969). Patients wanted the feeling of knowing "their nurse" (Murray, 1970), and they objected to being treated as clinical cases or disease entities (Frayne, 1973). Speaking on behalf of patients, Dutrisac (1973) told a group of nurses:

> The patient wants to be considered as a whole person with unique personal problems, reactions, temperments, habits of thinking and acting .... Deprived of his abilities, he experiences anxiety because he has to rely entirely on the nursing team. It is the nurse that he sees most often; in order to retain his sense of personal identity he needs her comfort and sympathy. (p. 23)

The expectations of patients seemed clear.

In order to refocus on patient needs, many members of the profession adopted what has been termed the "nursing process" or a "problem-solving approach" to nursing care. The nursing process, a systematic method of assessing, planning, implementing, and evaluating care for an individual patient, was not new in 1970, but during the decade it seemed to develop as the acknowledged method of nursing. Student nurses were taught this approach to care (Geach, 1974), and the patient-centered focus was encouraged in graduate practice as many hospitals introduced nursing care plans and problem-oriented charting methods (Howard & Jessop, 1973; Silverthorn, 1979). Professional organizations encouraged such developments by offering regional workshops on the nursing process (Registered Nurses Association of British Columbia (RNABC), 1973) and organizing new standards of practice in terms of this method of nursing (College of Nurses of Ontario (CON), 1976; Alberta Association of Registered Nurses (AARN), 1978).

Complaints about depersonalized care in hospitals did not disappear during the 1970's (MacLellan, 1976; Marcus, 1975) and often the complaints were lodged by nurses. One nurse (Guth, E. 1973) related her unpleasant experience as a patient undergoing cardiac surgery. She attributed the problem of depersonalization, in part, to understaffing:

> A heart unit should not exist if there is not enough money to staff it properly. There is so much more to nursing than running machines and passing out pills. An overworked nurse is not blessed with the quality of mercy, and her strain affects the patient. (p. 33)

Some nurses agreed that the workload of the staff nurse led to impersonal care that was limited to the basic essentials of safety and prescribed treatment. Understaffing was said to be acute during perids of nursing shortages (Murray, 1970) and government austerity programmes (Miller, 1977).

Not all nurses believed that staffing was the major factor in complaints about nursing care. Nurses wrote letters to the Canadian Nurse during the decade expressing alarm about the lack of human caring in nursing (Greenland, 1973). Some Canadian nurses began to examine "values" in nursing, and wondered if depersonalized care was the result of a modern emphasis on "cure" rather than "care" (Jenny, 1972) or if human values were being lost in an environment that increasingly highlighted scientific progress and technological innovation. An American nursing professor told nurses at the 1973 convention of the Registered Nurses Association of Ontario:

> The most sophisticated technology, the most esoteric science avail us nothing if, in using them, we fail to use the spirit ... of our very imperfect humanity. (RNAO told, 1973, p. 10)

Among those who believed that depersonalized care stemmed from confused values, many considered nursing education to be at fault. Changes in nursing education were either advocated or deplored depending on one's viewpoint. One nurse (RN, Ontario, 1973) believed that the traditional service of orientation was being threatened by changes in the educational system: "In the transition of nursing education from hospitals to colleges, there has been decreasing concern for the patient" (p. 5). Schumacher (1973) proposed that nursing

curricula be based on "person-centered models" of nursing rather than the traditional "medical model" that focused on disease conditions. Increasing numbers of Canadian nursing schools based their curricula on nursing models developed by faculty (Skelton, 1977), or on one of the newer conceptual frameworks developed by American nursing educators (Reidy, 1975). A nursing model was believed to better prepare students to meet the nursing needs of patients and to more accurately reflect the beliefs and values of the nursing profession. Reilly (1979) advocated the explicit teaching of values in the curriculum. She stressed the importance of values relating to human rights in nursing practice and suggested that a past emphasis on science had focused attention almost exclusively on value-free "facts."

Respect for the values and beliefs of the patient and maintaining a non-judgemental attitude were encouraged. According to one physician (Dennison, 1972), health workers and hospitals were notorious for their judgemental treatment of drug addicts, alcoholics, or anyone who held values that differed from those of the middle class. Nurses who worked "on the street" with transient youth described this tendancy, and they also emphasized the obligation to respect the values of others (Ruiterman & Biette, 1973). In sum, the theme emerged that one's own values and beliefs were not to interfere with the provision of professional care. This concern about personal and professional values was not confined to Canada. Bergman (1973) reported that the International Code of Nursing Ethics had been revised in response to complaints by student and graduate nurses. According to Bergman:

> Their statements imply that they are not ready to accept a code of ethics which protects doctors and nurses at the expense of the patient .... They refuse to follow established customs or official policies which are out of tune with the times and their philosophy. (p. 140)

The revised International Code, changed in format and in substance, was adopted by CNA (ICN, 1973). Changes included an explicit statement on the primacy of the nurse's responsibility to the patient, the obligation to respect the "beliefs, values, and customs of the individual" (p. 9), and deletion of specific reference to physicians. To all health workers, the nurse owed co-operative effort. The one remaining reference to personal conduct now carried the modifier, "when acting in a professional capacity." Respect for life and the dignity and rights of man remained basic principles of the revised code.

The Concept of Caring

The word care, as in nursing care, had always been used by nurses, but during the seventies, this word seemed to take on special meaning. The words care or caring formed part of the title of several nursing conferences during the decade, and were used to denote key conference themes (A call to, 1970; Motto for year, 1979; Nurses' function should, 1971; RNAO delegates examine, 1976). Although not clearly defined by all who used the word, caring seemed to signify a humanistic philosophy of nursing, and the term conveyed a concern for the individual person, commitment to the welfare of the patient, empathy and sensitivity to the patient's emotional state, human compassion, and a respect for human worth and dignity. As expressed

by various nurses, caring was a capacity (Poole, 1973), an attitude (Christo, 1979); a quality in nursing (Flaherty, 1977), and a natural human quality (Roach, 1975). The new sense of caring meant caring "about" not just caring "for" patients (Besel, 1973). Educators emphasized the importance of nurturing caring attitudes in nursing students (DuGas, 1973; Mesolella, 1974).

Caring was described most frequently in relation to those patients who seemed most vulnerable to dehumanization, those most avoided by others, and those seemingly rejected by soceity. Kubler-Ross's 1969 book, On Death and Dying, had sensitized the nursing profession to the isolating treatment given to terminally-ill patients. Such patients seemed to epitomize the need of individuals for personalized, human care. McElroy (1975) described nursing care for infants who were untreated and "allowed to die":

> You cannot hope to save an incurable child with love and comfort, but you can soothe his fear, reach out and touch his loneliness for a little while. This child is not just an incurable disease or another untreated meningocele or mongoloid with a bowel obstruction. He is still just a baby, with the same needs as all babies. He is still a human being and he deserves to die with respect and dignity. (p. 30)

McElroy insisted that the untreated infant was not to be subjected to painful tests, nor was the infant to be isolated in an incubator away from the mainstream of nursing activity.

It became increasingly acknowledged that certain groups of patients were likely to be avoided, forgotten, or dehumanized if nurses found care of these patients frustrating, if nurses lacked the

knowledge and skill necessary to care for these patients, and if nurses only valued those who seemed likely to recover, improve, or behave normally. Nurses who seemed to view depersonalized care as a consequence of insufficient nursing knowledge wrote articles that sensitized nurses to the needs of special patients and the importance of increasing their knowledge about the care of such patients. Articles on special groups of patients included nursing care of the elderly (McIver, 1978), retarded children (Peer, 1979), psychotic patients (Berezowsky, 1977), and Canadian natives (Steiman, 1978).

Some nurses seemed to imply that failure to demonstrate caring stemmed not so much from lack of knowledge, but from a lack of some quality in the nurse. A student nurse deplored the treatment of chronically-ill patients that she had observed:

> As a student nurse I understand that I still have years in front of me to really learn how to cope with patients in every situation. But surely love is not learned; it is innate. (Camolinos, 1979, p. 34)

Poole (1973) predicted that in the future, the capacity to care would be measurable, and that applicants to nursing schools would be screened for such a capacity. Christo (1979) urged nurses to "take a good long look at yourself" to see if they approached nursing "in a compassionate humanistic manner" (p. 7). Some nurses expressed guilt about depersonalized care and their failure to act in a caring manner. An intensive care nurse (Sklar-Mathie, 1978) described a period in her career during which she gave competent physical care, but uninvolved care: "And there it was. I no longer cared about the person and his

feelings, just his condition and the expected outcome" (p. 34). Disturbed about her own attitude, she re-examined her values and eventually reconfirmed for herself that "people" were the focus of her nursing care.

Caring to some nurses was the ability to empathize with others, the courage to share experiences, and the willingness to become involved with the problems experienced by patients. In this sense, caring was related to psychological support, communication skills, and "therapeutic use of self" (Alberta Advanced Education and Manpower, 1975; Birrell, 1976). Willetts-Schroeder (1979) described her experience with a dying patient and noted:

> My feeling of exhaustion made me aware too that caring involves a kind of budgeting of inner resources, just as one would do with time or money. If I find I am unable to meet someone's needs then I must find someone else who can, or help the person to help himself. (p. 40)

During the seventies, several individuals advocated support systems for nurses who were beginning practice or working in stressful areas. Kramer (1974) had investigated the phenomenon called "reality shock" in nursing in the United States and had described the conflict new graduates experienced when their ideals clashed with the realities of the working world. Canadian graduates seemed to agree: "No one has told us it is physically impossible to do what we are taught and feel is our responsibility to do, and at the same time please our supervisor and keep our job" (Harper, 1976, p. 31).

The stressful environment of acute care and other special hospital units led some researchers to emphasize the need for some

system of support for nurses working in such areas (Freebury, 1972; Vachon, 1976). The tendancy to give impersonal care and to detach oneself from involvement with patients was described as a common defense in times of stress. At least one unit for the care of terminally-ill patients in Canada adopted methods of providing support to their personnel (O'Neill, 1978).

Some nurses believed that more was expected from nurses in hospitals than the average workload would ever permit. They knew that they became "hardened" over a period of years and that they were failing to live up to the ideal of caring. Jack (1979) wrote:

> Nurses are expected to be both caring and technically competent and yet they are persistently obstructed in these aims. The staff nurse usually has a patient assignment of such size that to give basic physical care requires the full shift .... An individual really in need of special attention to his emotional state often becomes a source of frustration, guilt, and ultimately, anger. (p. 34)

Jack believed that most nurses treated patients with respect and gave reasonable care, but that "although the literature spurs them on" (p. 35), they could not involve themselves with most patients. Some nurses reported that insufficient time to meet patient needs, workloads and staff shortages, and frustrating job routines led them to quit nursing or to become more "controlled" in their manner over time (Allan, 1979). Several expressed concern over changes in their capacity to be caring and compassionate.

Although not everyone agreed on the major causes of depersonalized care, nurses did consider such care to be a violation of the obligation to respect the worth and dignity of the individual.

The concept of caring and the problem-solving approach to nursing seemed to be the two ideas or approaches most widely emphasized by nurses as counters to depersonalized care. Nurses using the nursing process would focus on patients, not tasks. This method of nursing care was consistent with the traditional belief that nursing was a service concerned with more than the patient's physical condition. The concept of caring seemed to signify the ethos, motive, or intent of nurses, and the widespread use of the word would indicate that the concept was central to nursing ideology.

Patient Rights

Interest in the rights of individuals in society was not new in Canada by the seventies, but growth of the consumer movement together with increased public financing and costs of health care focused attention on the rights of the individual in relation to health services (Storch, 1977). Public confidence in professionals was considered to be at an all-time low during the seventies, and provincial government reviews of statutes regulating professions were cited as an indication of lowered public esteem (Slayton & Trebilcock, 1978). The stormy introduction of medicare in Quebec in 1970 revealed a distrust of the medical profession by some members of the public as a coalition of unions protested against the privilèges intolérables of physicians (Taylor, 1978). Frayne (1973) told a conference of nurses that public attitudes were changing: "Consumers will realize health professionals (particularly physicians and surgeons) are not to be held in awe, as gods at an elevated shrine" (p. 19).

In 1973, the American Hospital Association's Statement on a Patient's Bill of Rights was described in several American nursing journals (Storch, 1977) and debated in the popular press (Gaylin, 1973). In 1974, the Consumers' Association of Canada (CAC) published a statement on Consumer Rights in Health Care (Consumer rights in, 1974). This latter document described four rights: the right to be informed, the right to be respected as the individual with the major responsibility for his own health care, the right to participate in decisions affecting his health, and the right to equal access to health care. Such publications underscored a past failure by health professionals to respect the most basic rights of patients.

If the first half of the decade was marked by an interest in the fundamental rights of patients; the latter half of the decade was characterized by concern about the rights of particular groups of patients, patients in special circumstances, and situations in which rights and obligations seemed unclear. Developments in the transplantation of human organs and genetic manipulation had increased interest in medical ethics in the late sixties and early seventies (Ramsey, 1970; Siminovitch, 1973), but by mid-decade, dramatic events such as the Karen-Anne Quinlan case had focused public attention on the ethical complexities of some medical situations (Branson, 1976). Traditionally, health professionals had turned to the law for answers about their duties; increasingly, they turned to moral philosophy. Rights of research subjects (Medical Research Council, 1978), dying patients (Suzuki, 1975), and the mentally handicapped (Greenland, 1975) were studied and debated. In Canada, philosophers, lawyers,

nurses, and physicians began meeting at conferences to discuss bioethical issues (Papers and proceedings, 1975; Davis, Hoffmaster & Shorten, 1977). During the seventies, bioethics institutes were established in various parts of the country (Katz, 1980), and a federal Law Reform Commission was appointed to investigate and recommend legislation on such issues as euthanasia and the definition of death (Baudouin, 1977).

Patient Autonomy and Advocacy

The ICN Code contained statements emphasizing the fundamental rights and freedoms of individuals, respect for the dignity and worth of the individual, respect of the patient's right to privacy, competent care and protection from unethical or incompetent practitioners (Code, 1965; ICN, 1973). Although the patient's right to information and to autonomous decision-making would logically stem from the principles embodied in nursing codes, such rights had not been delineated in the past by nursing educators or practitioners. The legendary nursing remark, "You'll have to ask your doctor," reflected the common belief that information-giving was the physician's responsibility, not the nurse's. The dispensing of information was viewed by many as the physician's privilege in accordance with the doctrine of the inviolable doctor-patient relationship (Jenny, 1979).

During the seventies, nurses began to emphasize the patient teaching aspect of their role; such content as teaching-learning principles was increasingly emphasized in curricula (Redman, 1976; Jenny, 1978). Many articles described how hospital nurses developed and/or participated in new teaching programs for patients with

diabetes (Leahey, Logan & McArthur, 1975), cardiac conditions (Stockwell & Tada, 1976), and chronic lung disease (Pasch & Jamieson, 1975). Information to patients about health habits and fitness was encouraged by professional associations issuing policy statements on the role of nurses in health promotion (CNA, 1976; RNABC, 1977).

The right of patients to participate in decisions about care was emphasized by some members of the profession, and "contractual models" of care were described, particularly by nurses who worked in psychiatric settings (Ujhely, 1973). Using such a model, patients and nurses together planned care and agreed on goals, methods, and the responsibilities of each party to the contract (Orovan, 1972; MacDonald, 1977). The notion that patients were to be full partners with health professionals or members of the health team was consistent with several of the "theories" or "conceptual models" of nursing that had emerged in the United States during the late sixties and early seventies (Orem, 1971; Roy, 1976). According to such models, nurses must validate information and observations with the patient and set mutually-agreeable goals. Nurses were involved in programs that taught patients to give themselves hemodialysis treatments at home (Schaffer, 1973) or assisted paraplegics to learn how to function independently (Hansen, 1976). Nurses were to ensure that they respected the autonomy and dignity of patients by giving the patient the necessary information and the time to learn and practice self-care activities. They were to avoid promoting dependence, and to refrain from doing too many things for patients that they could learn to do for themselves, given time and patience (Erikson, 1975; Hansen, 1976).

In some instances, the emphasis on informing patients and patient education led nurses into conflict with others. Some nursing administrators complained that hospital administration was "cool" towards teaching programmes and not supportive of the teaching role of the nurse (Harrison, 1975). Conflicts arose when the nurse believed that the physician had fulfilled the obligation to inform the patient about diagnosis or treatment. For example, a nurse who knew that the patient had a life-threatening illness felt extremely uncomfortable when uninformed patients would ask about their diagnosis. Kubler-Ross (Four-day work, 1975) advised nurses to honestly tell patients that such information must come from the physician.

The issue of informed consent to treatment arose most frequently in relation to surgical procedures. The surgeon was legally responsible for discussing the risks and benefits of the procedure as well as alternatives prior to obtaining a written consent (Linden, 1975). In some areas of Canada, hospital nurses were responsible for obtaining a patient's signature on a consent form, and although the nurse was merely witnessing a signature, it was expected that information about the surgery would be reviewed and the patient's understanding would be assessed at this time. Some nurses were confused about the legal aspects of consent and did not realize they were merely witnessing a signature. Many health professionals seemed to make the faulty assumption that a signature on a form was proof of informed consent (Panel, 1975). An expert in health law (National OR nurses, 1974) addressed a group of operating room nurses and affirmed that it was the physician's responsibility to give the patient information about

surgery. The Registered Nurses Association of British Columbia (1980) issued a policy statement on informed consent that clarified the legal position of the nurse as a witness to a signature, but also emphasized the nurse's moral obligation to assess the patient's understanding and to report any misunderstandings.

Public complaints about the abuse of patient rights in health care settings began to generate new laws, codes, policies, and job descriptions, all designed to protect the rights of health care recipients. Following the CAC's statement on patient rights, CNA members asked for a policy statement from their association (Resolutions chart new, 1976), and RNABC members endorsed a statement on consumer rights at their 1976 annual meeting (Delegates pass eight, 1976). Although some Canadian hospitals distributed "rights information" to patients and appointed patient representatives (Some hospitals, 1978), the ombudsman or advocate position in hospitals was adopted more frequently in American hospitals (Storch, 1977). American nursing literature on the role of the nurse as "client advocate" had grown during the early 1970's during the widespread discussions of patient rights.

Traditionally, nurses had considered patient protection to be their ethical obligation (Code, 1965; ICN, 1973), and many Canadian nurses affirmed their belief in such a duty when discussing the issue of reporting fellow nurses for medication errors (Readers criticize article, 1974). Adoption of the advocate role was viewed by some Canadian nurses as a natural extension of the traditional ethical obligation to protect patients from incompetent or unethical practice (Sklar, 1979a). The RNAO (1978) developed a statement on patient

advocacy in nursing that seemed to incorporate several tenets of the 1973 code and the CAC's statement on rights. The RNAO presented the advocate role as one in which the nurse informed patients of their rights and alternatives in health care.

Although some nurses interpreted the advocate role as an affirmation of traditional protective duties, other individuals considered that the role required a more active and assertive stance in view of the growth, rigidity, and complexity of health care bureaucracies (Prepared to care, 1978). As the only health professionals providing direct, continuous care in institutions, nurses were considered by some to be the logical persons to carry out advocacy functions. For this reason, some believed that patient representatives were unnecessary if nurses were doing their job properly (Jenny, 1979).

Not all nurses agreed that adversarial functions could be performed successfully by nurses providing patient care (Sklar, 1979). Storch (1977) doubted that the majority of practitioners had adopted the advocate role, and urged nurses to accept the patient representative as a new category of worker in hospitals (Prepared to care, 1978). Debate about the client advocate role for nurses continued during the seventies as authors questioned whether or not the nurse was in a suitable position, had the required knowledge and skill, and sufficient power, or was independent enough of the employer to effectively fill such a role. In Jenny's opinion:

> Advocacy appeals to nurses at the present time as a philosophical and social statement of nursing commitment to human ideals. Traditional role implementation has failed both patients and nurses.

> .... Whether it becomes a viable model for the nurse's role or remains a philosophical ideal will largely depend on nurse's determination to escape from traditional bondage and the desire for greater power and accountability. (1979, p. 181)

Ethical Dilemmas and Decision-Making

Perhaps the first moral issue of the decade to affect a large number of nurses was that of abortion. This issue surfaced in 1969 following federal amendment of the Canadian criminal code. The abortion issue was refueled by recommendations to liberalize the law in the 1970 Report on the Status of Women in Canada. The morality of abortion was hotly debated in letters to the editor of the Canadian Nurse during the seventies, especially following articles for and against abortion (Adamkiewicz, 1976; Ehrleich & Holdren, 1972). Although the articles debating the morality of abortions were not written by nurses, letters to the editor indicated that nurses were as firmly divided as the general public with regard to their views. Unlike the general public however, nurses were health professionals with a specific interest in health services, assisted in the performance of abortion procedures, and cared for women following the abortion.

The CNA board passed a resolution stating that women having abortions had the right to the best possible health care (CNA board discusses, 1970). Some members indicated that they would like CNA to take a firm stand on the removal of abortion laws from the criminal code. In 1971, the CNA board issued a statement that presented this position, and sent the statement to provincial associations for endorsement. Following provincial association debates that year, only

four of the ten member associations endorsed CNA's statement; most of the associations preferred not to take a stand on the issue (CNA board rescinds, 1971).

Some nurses reported that their jobs were threatened when they refused to assist in abortion procedures. At the 1972 CNA annual meeting and convention, the following resolution was carried:

> Be it resolved that CNA take the necessary steps to encourage the inclusion in the Code of Nursing Ethics of each province, the following statement: "Each nurse has the right to refrain from participating in any procedure that conflicts with her moral or religious convictions, within legal limits, without prejudice." (Resolutions posed at, 1972, p. 31)

The 1972 resolution was consistent with the findings of an American nursing journal's survey on nursing ethics. More than 700 Canadian nurses responded to this survey, and although the investigators cautioned that those responding did not necessarily represent all nurses, they reported that Canadian nurses were more likely to condone another nurse's refusal to care for post-operative abortion patients than American nurses (Nursing ethics, 1974a). A large majority of respondents would not refuse to give care themselves.

During the abortion debate some nurses expressed the opinion that personal beliefs should not interfere with the provision of nursing care and that the denial of nursing care to abortion patients was an example of nurses imposing their values and beliefs on patients. One nurse wrote a letter to the Canadian Nurse that expressed such a view:

> Surely nurses must respect the rights and beliefs of all creeds and not maintain that their own view about an issue is "right" and all other views are wrong .... Let all nurses accept and care for patients as they are and not presume to judge their actions as right or wrong. (Poole, 1973, p. 4)

In cases of emergency, nurses were to provide care despite their personal beliefs, and some nurses suggested that those who objected to abortion should transfer from areas of the hospital where they would not encounter such procedures. A 1972 CNA statement on family planning included a policy on the personal beliefs of nurses:

> When health care procedures conflict with the personal beliefs of any health worker, provision for service appropriate to the needs and welfare of the patient must take precedence. (CNA, 1972, p. 11)

The issue of the right of the nurse to refuse to participate in abortions resurfaced at the 1974 meeting of the CNA, but a proposed resolution was ruled out of order because it was a repeat of one passed in 1972. The CNA requested provincial associations to forward any cases of discriminatory treatment of nurses who refused to participate in abortions. No documented evidence was forwarded (CNA directors meet, 1974). It seems probable that nurses objecting to abortions avoided working in hospitals or areas where they were performed or made suitable arrangements with their employers as the issue faded towards the end of the seventies. Rozovsky (1980) pointed out that unlike physicians, nurses were hospital employees, and once hired, the nurse "can be required to perform any nursing task within the scope of her particular job" (p. 89).

Following the preparation of ethical guidelines for nursing research (Ethics of nursing, 1972), members of CNA's special committee on nursing research asked nurses to submit examples of ethical problems and promised a report on the dilemmas that Canadian nurses encountered in practice. Despite several published requests, only 22 responses were received from a population of more than 100,000 subscribers. Based on these replies, Allen (1974) published a report in the Canadian Nurse. The categories of problems were: uncertainty about to whom the nurse was responsible, difficulty in doing what one knows should be done, and unsatisfactory quality of care. DuMouchel (1977) had also noted a small response when the Order of Nurses of Quebec (ONQ) asked members to respond to proposals for the new provincial code. The Canadian response to the Nursing '74 ethics survey (6% of total respondents) did suggest however, a more extensive interest in ethical issues (Nursing ethics, 1974a, 1974b).

Some nurses described their role not as moral decision-makers for others but as providers of supportive care to patients during or after moral decision-making. McElroy (1975) emphasized the obligation to respect human dignity when giving care once the decision not to treat "defective" infants had been made. Rudd and Youson (1976) described the nurse's role in a genetic screening programme, and emphasized the need of couples for information and support at a time of difficult decision-making. O'Neill (1978) described the Palliative Care Service established in 1975 at the Royal Victoria Hospital where nursing personnel must have "a warm, sensitive, non-judgemental attitude" (p. 3). Nurses working in such special programmes would

quite probably have examined the ethical aspects of their role and agreed with the philosophy of these services. Most nurses, however, worked in areas that presented a variety of ethical dilemmas and on units that had no formal or explicit guiding philosophy.

During the latter half of the seventies, nurses seemed particularly concerned about the rights of dying patients and their families and the nurse's obligations with respect to such rights. Winter (1976) described her conflict with medical personnel when she and her family requested that their mother receive no further life-prolonging treatment. She affirmed her belief in the importance of "death with dignity," a belief frequently expressed by nurses. Members of CNA's executive committee discussed the ethical aspects of life-sustaining treatment at joint committee meetings with members of the Canadian Medical Association (CMA) and the Canadian Hospital Association (CHA). Nurses attending CNA's 1976 annual meeting and convention listened to a debate on the ethical issue of preservation of life versus termination of life-support equipment (CNA annual meeting, 1976).

In 1978, the CNA annual meeting was based on the theme, "Ethical issues in nursing." Roy, a bioethicist, addressed the convention and discussed several conflicts described to him by nurses. Several of the examples from nurses involved patients who were terminally ill, and most of the examples described conflict between health professionals over treatment goals and decisions (Convention, 1978). The major concerns of nurses, as disclosed at this conference, were conflicts between and among duties to patients, physicians, and

employers; confusion about the nurse's role and responsibility in ethical decision-making; the need for knowledge and guidelines for moral deliberation.

A greater sense of moral doubt and confusion by nurses was reflected in an ICN publication on nursing ethics (Tate, 1977). This book contained examples of ethical conflicts submitted by nurses from around the world. During the late seventies, some nurses in Canada formed committees to discuss ethical issues (RNAO delegates examine, 1976), attended seminars or lectures on nursing ethics (DuMouchel, 1977), and, in a rare article, analyzed ethical problems (Aroskar, Flaherty & Smith, 1977). Nurses began to express a need for more guidance in the face of moral uncertainties. Several recommendations concerning guidance were forwarded at the 1978 CNA convention by nurses and ethicists (Convention '78). Speakers advocated on-going seminars for health professionals, improved ethics teaching in basic curricula, consultation with ethicists, and the preparation of nurse-ethicists. At this convention, an earlier proposal from the board of directors that a Canadian code of ethics be developed was proposed and adopted as a convention resolution. In 1979, Sister Roach, the newly-appointed director of the code of ethics project, appealed to CNA members to participate in the development of the code by forwarding comments and recommendations (Roach, 1979). The College of Nurses of Ontario issued a similar appeal to its members during 1979 as a committee studied principles for inclusion in that province's new code (Your input, 1979).

Quality of Care

According to traditional nursing ethics and the ICN Code, nurses were obligated to provide a high standard of care and to maintain a high level of professional knowledge and skill (Code, 1965). In addition, nurses were obliged to protect individuals from incompetent care provided by other health care workers. During the decade, concern about the quality of nursing care raised questions about the extent to which nurses accepted personal responsibility for their practice, whether or not the nurse's knowledge and skill improved or even kept pace with the developments in health care, and the extent to which the public was protected from incompetent practitioners.

Although the quality of nursing care had been safeguarded or monitored in terms of nursing education standards and requirements for admission to practice as a registered nurse, less attention had been given to the continuing competence of graduates and standards of care in professional practice (Murray, 1970). As Grafftey (1973) noted: "There is a general failure to establish standards and criteria, including criteria for determining good patient care" (p. 70). The authors of the Task Force Report recommended that standards for nursing care in hospitals be developed as well as methods of measuring the quality of care and nursing performance (DNHW, 1969).

The development of nursing research, nursing specialties, and practice standards were viewed as methods of promoting a high standard of nursing care to society (Coombs, 1970; DNHW, 1969; Report of the Committee, 1970). However, the quality of care a nurse provided also depended upon the willingness of the nurse to assume

responsibility for practice and the ability of the nurse to make decisions about care. Several nurses, physicians, and non-medical authors advocated greater authority and autonomy for nurses (Baumgart, 1972; Grafftey, 1973; Rudnick, 1972). The Task Force Report had recommended that nurses in hospitals be given greater authority for decision-making about patient care, and that the categories and levels of supervisory personnel be reduced (DNHW, 1969). Over supervision, paranoia about "overstepping bounds," lack of authority, rigid policies, and the professional jealousy of physicians were just some of the reasons cited for the reluctance of nurses to make professional judgements and to be accountable for their decisions.

Nursing Competence and Knowledge

Although the provision of a high standard of nursing care had long been viewed as an ethical obligation of nurses, during the seventies nurses undertook responsibility for defining standards. According to the ICN Code of 1973, "The nurse plays the major role in determining and implementing desirable standards of nursing practice and nursing education" (Code, 1973, p. 166). In some provinces, new nursing statutes required or provided for professional organizations to develop practice standards (General assembly of, 1975; Health Discipline Act proclaimed, 1975), but most provincial nursing associations formed committees to develop standards whether or not that was required by legislation.

Competence was a central concept in the development of standards, for whether defined levels were basic ones (CON, 1979) or general (AARN, 1978), they described the requisite abilities of

registered nurses. In many cases, practice standards were part of or associated with quality assurance programmes, safety-to-practice programmes, discipline procedures, and continuing education programmes (AARN, 1978; Quality assurance off, 1977; Safety to practice, 1980).

The focus on nursing competence led to the examination of the traditional practice of automatic renewal of a nurse's registration upon receipt of an annual fee. Although nurses collectively defined standards of nursing practice, maintaining competence was a personal responsibility and the 1973 ICN Code specified the nurse's obligation of "maintaining competence by continual learning" (p. 166). The extent to which Canadian nurses engaged in ongoing education was not known (Flaherty, 1975), but MacDougall (1974) detected a "lackadaisical attitude toward continuing education" (p. 19). Many debated the topic of mandatory versus voluntary continuing education (Flaherty, 1975; Goringe, 1977). Most authors did not favour mandatory schemes "at this time," as there seemed to be little evidence that mandatory education improved competence or that well-planned and effective programmes were available (Kay & Kergin, 1977). Authors pointed out that much continual learning was informal, but Kay and Kergin considered this type of learning to be insufficient:

> We will continue to learn as long as we live, but can we be relied upon to learn what is required in order to fulfill our professional obligations to Canadian society? (p. 91)

Most authors recommended the development of new programmes and methods of encouraging nurses to engage in continuing education programmes voluntarily.

According to the ICN Code, nurses were obligated to protect individuals from the unethical or incompetent practice of other nurses, and as members of the profession, nurses shared a responsibility to protect the public. Nursing acts and/or professional by-laws outlined grounds for disciplinary action and discipline procedures. In general, grounds for discipline were incompetent practice and unethical conduct (Newfoundland Registered Nurses, 1970; Health Disciplines Act, 1975; An act respecting, 1978). The degree to which professional associations could discipline members ranged from written warnings to revocation of registration. Members disciplined by the association could appeal decisions in higher courts.

Although incompetent practice was unethical according to the ICN Code, incompetent practice seemed to be a special case of unethical behaviour, or of a different order. Nurses could use new standards of practice as a yardstick for evaluating their own care and that of other nurses. Most provincial nursing associations had adopted the ICN Code as a standard of ethical conduct, although Quebec developed a provincial code of ethics during the seventies, and Ontario initiated work on one (Code of ethics, 1976; Your input, 1978). Some provincial nursing acts contained a reference to, or defined "professional misconduct." This term seemed to refer to unethical conduct as distinguished from "professional incompetence." Kay and Kergin (1977) wrote:

> Not only may codes of ethics be used to describe appropriate behavior under various conditions, they also may be used to develop definitions of deviant behavior, such as behavior that represents professional misconduct. (p. 89)

The nursing section of Ontario's Health Disciplines Act (1976) contained a list of behaviours that constituted professional misconduct. This list included "misappropriating property, participating in advertising, failure to report inability to perform a duty without supervision to one's employer, and abandoning a patient (p. 28).

Not all nurses thought basic competency was sufficient. Clarke (1978) implied that the guidelines used to determine the need for disciplinary action were not in line with current definitions of quality nursing care. According to such definitions, all nurses were supposed to promote health and prevent illness, not just nurses working in community settings. One could question the extent to which health promotion and illness prevention were part of nursing care in acute care settings:

> When this occurs, should we be disciplining the nurse because care is incomplete and the nurse's conduct is contrary to the ethical standards of the profession of nursing? .... I believe that when these qualities of care are not provided, disciplinary action of some sort is necessary. (p. 17)

The rapid growth of specialty units in hospitals brought about the development of new hospital, community college, and university postgraduate courses in clinical specialties (Grant helps to, 1971; Post-diploma programs, 1971). Traditionally, nurses working in specialty units received on-the-job training and developed expertise through experience rather than formal programmes. Despite some growth in the number of specialty courses, many of the staff positions in specialty units had to be filled by nurses without specialized training.

Hospitals often compensated by providing longer orientation periods and ongoing inservice education programmes (Youngblut 1971).

One of the concerns about "expanded role" nursing related to protection of the public, competence, and the legality of delegating "special procedures" to nurses. For example, nurses in cardiac units diagnosed ventricular fibrillation and defibrillated patients in the absence of a physician, although legally, diagnosis and treatment were duties limited to qualified physicians (Nurses who study, 1972). Many provincial associations developed guidelines on the delegation of medical acts in co-operation with provincial medical and hospital associations (RNABC, 1971), to ensure that nurses performing such duties were adequately prepared. The ICN Code no longer included a statement prohibiting such acts when revisions were made in 1973.

The CNA responded to the proposals for nursing specialties and in 1973, issued a position statement on specialization in nursing:

> In keeping with its goal of the promotion of the highest possible standards of nursing care, the association recommends recognition of degrees or levels of specialization within the profession. (CNA, 1973, p. 11)

In this statement, CNA recommended recognition of specialization at both the non-degree and master's degree level. The statement was non-specific on the question of areas of specialization, except to indicate that specialization in health maintenance and primary care should eventually be at the master's level.

In order to improve the quality of nursing care in hospitals, the authors of the Task Force Report had recommended the introduction of the clinical nurse specialist (CNS) role (DNHW, 1969). A CNS was

a nurse with expertise in clinical nursing and advanced preparation in the behavioural sciences, biological sciences, and research (Boone & Kikuchi, 1977). Although advanced preparation in the humanities was not generally included in discussions of the educational requirements for the CNS role, a recommendation that graduate students in nursing take courses in ethics was made during a panel discussion at the 1978 CNA convention (Convention, 1978). During the seventies, several Canadian universities developed or revised a master's in nursing programme to prepare nurses that could function as a CNS (Kerr, 1978).

A list of special interest groups organized in Canada would seem to be an indication of considerable specialized practice among Canadian nurses (Fitzpatrick, 1979). Some of these interest groups were affiliated with nursing associations but as standards were just developing for general nursing practice, there were no officially established standards for specialized practice nor were members officially recognized as specialists. Kay and Kergin (1977) acknowledged the many forms of nursing being practiced and raised the question of how specialists could maintain competence in general nursing. In their opinion, the profession would soon have to consider the concept of restricted or limited registration in nursing.

In order to improve the quality of nursing care, nursing practices would have to be subjected to systematic study. According to Thibaudeau (1979):

> There is, on the whole, general agreement on the goal of nursing practice; it is the use of health-focussed strategies to activate, develop or enhance

> a care recipient's achievement of well-being.... It is in this area that research in nursing must be pursued. (p. 29)

Although not all nurses could be prepared to engage in formal nursing research, members of the profession were obligated to promote the development of nursing knowledge. The 1973 ICN Code specified this obligation: "The nurse is active in developing a core of professional knowledge" (Code, 1973, p. 166).

Stinson (1977) pointed out that the improvement of nursing care through research depended upon the availability of nurse-researchers to investigate nursing problems, the dissemination of research findings, and the ability of nurses in clinical practice to utilize or implement research findings. A 1976 resolution by CNA members led to a national seminar on doctoral preparation for Canadian nurses in 1979. At this seminar, participants reached a consensus on the need for the development of a Canadian Ph.D. (Nursing) programme or programmes (Zilm, Larose, & Stinson, 1979).

Nursing Autonomy and Accountability

In the Task Force Report it was noted that the highest turnover rate within the nursing department of hospitals was to be found in the general duty nurse group, those providing direct nursing care (DNHW, 1969). One recommendation to reduce turnover rates was to give these nurses "an opportunity to use their knowledge and judgement," the authors noting that "the registered nurse cannot practice as a professional nurse" (p. 92). A growing demand for nursing autonomy, seemingly influenced by the women's movement (Webb, 1975), was accompanied by a growing emphasis on accountability in nursing.

There is evidence that nurses were concerned about the quality of patient care in hospitals even before new legislation and the widespread emphasis on accountability. In 1968, an advocate of collective bargaining for nurses told her audience that nurses were interested in having input into policies about patient care as well as salaries (Montreal nurse [illegible], 1968). She viewed collective bargaining as a way of ensuring that standards of care did not decline as salaries increased.

In 1970, an article in the Canadian Nurse described a 1969 British Columbia court case in which nurses had been judged negligent with respect to the care of a patient in the recovery room of a hospital (Negligence in the, 1970). Injury to the patient occurred when a nurse went for coffee leaving the one remaining nurse to care for incoming patients. Although they could have anticipated the number of arriving patients, the nurses did not request additional staffing. This court case seemed to underscore for nurses the importance of their responsibilities and of safe levels of staffing (Hudson, 1970).

In 1970, three Sudbury nurses working in an acute care unit complained for several days about inadequate staffing. After several days they threatened to leave in mid-shift if the "nursing office" did not provide more staff. Although they did not carry out their threat, the hospital dismissed them the next day. Because they did not have a bargaining unit, they asked the RNAO for assistance. Thirteen months later they were compensated after conducting a campaign to win an arbitration board hearing (Three Sudbury nurses, 1971). In 1971,

a Saskatchewan nurse was fired by her employer for taking swabs from a kitchenette area and sending them to the provincial lab for analysis. Following a walk-out protesting her dismissal and an arbitration board hearing, she was reinstated in her job (Nurse fired at, 1972).

Introduction of federal government anti-inflation policies in October of 1975 not only set limits on wage levels, but also brought provincial cut-backs in health care spending, bed closures, and hiring freezes (Belt-tightening hits, 1976). Nurses working in hospitals began to protest against budget cut-backs, expressed anger over increased workloads, and reported concerns about a decline in the quality of care (Nowlin, 1976). In Ontario, the Ontario Nurse Association (ONA) asked members to document unsafe incidents, and the reports were submitted to the provincial government (Ontario nurses document, 1977). In May of 1976, the journal Nursing '76 conducted a survey of nurses' opinions on the quality of health care (Funkhouser & Nursing '77). Although the number of Canadian respondents was not reported, the investigators noted that, "Canadian nurses have strong feelings about their government's recent across-the-board cuts" (p. 36). Of all nurses responding, 38% considered inadequate budget to be "very often responsible" for poor patient care, but taking the Canadian nurses alone, 60% responded with this answer. Some nurses expressed their concern individually (Campbell, 1978), and some wrote letters to their local members of parliament and ministers of health (Enderton, 1976). Miller (1977) wrote a letter to the editor of the Canadian Nurse:

> During the past year nursing staff in this province [B.C.] as indeed in most other provinces has been greatly reduced. This situation has caused much concern as on several occasions it has literally forced us to run -- not for the sake of fire or hemorrhage -- but in order to keep up with workload. I could give many examples of situations which were potentially hazardous, although, so far, not fatal. (p. 6)

Nursing leaders reminded nurses of their ethical obligation to provide a high quality of care and their personal responsibility for maintaining competence (Flaherty, 1975; Taylor, 1978). Poulin (1977) addressed nurses in Newfoundland on the topic of accountability in nursing. She described standards of practice and codes of ethics as "contracts" with patients and with society. When new legislation was introduced in Quebec and Ontario, nursing associations held workshops and interpretive sessions to ensure that members understood their responsibilities and those of the regulatory body (DuMouchel, 1975; Proposals reach back, 1979). According to Ontario's new Health Disciplines Act, the nurse was required to report to the employer any inability to perform assigned duties competently or without supervision (Health Disciplines Act, 1976).

In 1977, "accountability" became the ICN "watchword" for the subsequent quadrennium (ICN, 1977). Labelle (1978) addressed the ICN Congress that year and discussed accountability for ethical and practice standards as one factor associated with nursing authority. According to Labelle, nursing authority would only be strengthened as nurses increased accountability, continued the development of a scientific knowledge base, improved methods of measuring nursing effectiveness, made a commitment to peer review, and organized continuing education for nurses.

There is evidence that nurses working in hospitals were aware of practice standards and moral obligations. However, as employees, nurses also had legal obligations under labour contracts, for which they were accountable to the employer. In 1976, nurses working the 12-hour shift in the intensive care unit of Toronto's Mount Sinai Hospital refused to accept responsibility for the admission and care of a new patient. They based their refusal on their opinions that an additional patient would jeopardize the safety of those patients already in their care (Sklar, 1979b). Three of the nurses who had been suspended for insubordination following this incident asked ONA to bring their case before a three-member board of arbitration. According to Wahn (1979) this case was of particular interest as it was the first health care arbitration case in which a grievor used the two exceptions of the "obey now, grieve later" rule as a defense.

After an examination of the facts of the case, a two-to-one decision by the board upheld the hospital's disciplinary action in 1978. The board's application of the rule was upheld by the Divisional Court of the Supreme Court of Ontario during appeal. Sklar (1979c) noted that "the award in this case has left many nurses feeling angry," but she suggested that nurses learn from the case for future decisions in practice. In Sklar's opinion, "The result demands that nurses conduct themselves professionally, yet it does little to resolve the dilemma facing the professional nurse: obey first, grieve later" (p. 21).

Although the Mount Sinai controversy was known to nurses in many parts of Canada, appeals were not completed until 1979. In the meantime, a well-publicized nursing dispute at Canada's largest

hospital raged for more than a year. According to RNABC officials, individual nurses concerned about inadequate conditions for the provision of quality care at the Vancouver General Hospital (VGH) began to report their concerns to RNABC in late summer of 1977 (Trying to change, 1978). They were told to document incidents, and over a two-month period, sixty documented incidents were submitted to RNABC:

> There were three major areas of concern: (1) not enough staff to deliver safe care, (2) inappropriate staff allocation resulting in lack of continuity of care, and (3) an apparent inability of VGH nursing leaders, despite their best attempts, to deal with problems like these. (Nurses fight for, 1978, p. 3)

The nurses asked for better staffing, but they also demanded greater input into administrative decision-making in the future (Update, 1978). A recent change in administrative structure was viewed as a setback for the nursing department as it increased the distance between the nursing department and top-level administration. Staff nurses protested what seemed to them to be "administrative indifference" and called for a reorganization of the administrative structure so that the nursing department would have a vice-president reporting directly to the president.

At an RNABC meeting, President Rothwell (1978) seemed to be describing the Mount Sinai incident when she gave members examples of inadequate staffing. She considered the nursing unrest as the "tip of the iceberg," and said: "It is a frightening situation when our professional association tells us we must be competent or face disciplinary action, and yet practice settings do not allow for competence" (p. 30). The protracted dispute involved firings of

several senior nursing administrators, inquiries into the firings, some reinstatements, an RNABC campaign to gain public support for the nurses, reorganization of VGH administrative structure, dismissal of the board of trustees, appointment of a public administrator by the Minister of Health, and changes in administration based on the public administrator's report approximately one year after the initial report of problems to RNABC (Major changes at, 1978). One year after the changes, nurses reported that an uneasy calm prevailed as a newly-appointed vice-president of nursing assumed her duties (Going back to, 1979).

It would seem that nurses were concerned about the quality of nursing care during the 1970's, and that the emphasis on personal responsibility, accountability, competence, and professional decision-making had an effect on practicing nurses. A concern about legal liability was no doubt an important factor underlying complaints about workload and staffing patterns, but even apart from legal aspects, nurses expressed frustration about the lack of time to give psychological support as well as concern about unsafe conditions. In short, the ethical obligation to provide a high standard of care went beyond the legal obligation to meet minimum or average practice standards.

CHAPTER IV

COMPARATIVE ANALYSIS OF NURSING ETHICS: 1920's AND 1970's

Two aspects of nursing ethics are examined in this chapter. In the first section, nursing ethics is examined as a system of beliefs. The two decades of the twenties and seventies are compared and contrasted in terms of the moral concepts, rules, notions, and principles that comprised nursing ethics. In the second section, nursing ethics is examined in relation to the contexts of the beliefs. Throughout, comparisons are made in terms of major factors that seemed to influence or be influenced by ethical beliefs in nursing.

Nursing Ethics: Concepts

Nurses of both decades expressed the belief that there was a moral dimension to nursing and that moral considerations were important ones in nursing practice. According to Bergman (1973):

> Nursing as a health profession is faced with ethical issues on two levels; on the policy level where nursing, together with other groups must face issues and participate in the decision-making for guidelines or laws; and in daily practice on a one-to-one relationship that has to be resolved in the 'here and now'. (p. 140)

The description of the major themes in Chapters I and II illustrate ethical considerations at both of the levels identified by Bergman.

Nursing ethics of the twenties differed from the seventies in that moral judgements in the earlier decade were more often ones of moral value. Frankena (1973) refers to such a view of morality as

the "ethics of virtue." Nurses in the twenties frequently described the ethical nurse in terms of motives, virtues, or qualities. Unselfishness, tactfulness, devotion, and kindness were characteristics of the good nurse. Moral conduct in nursing was considered to be largely dependent on character and the disposition to act in a certain manner. Within this view of morality, ideals were central concepts. The Christian ideal, the service ideal, and humanitarian ideals provided models that defined the sort of person that the nurse should aspire to be.

In contrast, during the 1970's, the approach to nursing ethics corresponded more closely to the "ethics of duty" (Frankena, 1973), involving judgements of moral obligation. Discussions of ethics were more likely to centre on actions and duties than on traits and virtues, the focus on doing rather than being. The ethical nurse of the seventies was one who informed patients about treatment and care, maintained competence through continuing education, and acted as a patient advocate.

Although one or the other predominant view of nursing ethics seemed to be reflected in the literature of each decade, elements common to both approaches are evident in both decades. For example, authors of the twenties indicated that nurses ought to act in organizing nursing services and authors of the seventies indicated that nurses ought to be caring persons. Frankena points out that the two views constitute "two complementary aspects of the same morality" (p. 65), as both virtues and duties are derived from moral principles.

In the literature of both decades, moral principles were not always identified explicitly, but it seems fair to state that a major principle of both decades of nursing was one involving the promotion of good. Promotion of the good in nursing meant aiding or promoting human health, life, and well being. The obligation to promote the patient's welfare was expressed as the primary one by nurses of the twenties and seventies, the patient's welfare encompassing psychological, physical, and social aspects of well-being. Nurses were also obliged to promote the welfare of society; at the policy level, a duty to improve nursing services generated concerns about the accessibility of services in the twenties and the quality of services in the seventies.

Certain principles or notions relating to the way in which humans ought always to be treated were discussed frequently in relation to the nurse's obligation to individual patients. Within the nurse-patient relationship of the twenties, the "Golden Rule" was to guide the nurse's behaviour; in the seventies, the guide was respect for human dignity and autonomy. Any conflict between the good of individuals and the good of society as a whole was seemingly to be resolved in the favour of individuals. For example, during the seventies, the first guidelines for Canadian nursing research indicated that any benefits that might accrue to society from nursing research were not to be pursued to the detriment of individuals who might participate as subjects (Ethics of nursing, 1972). Similarly, the standardization of procedures and routines introduced during the twenties to improve services was not to disadvantage individual

patients.

The promotion of good also required consideration of the prevention of harm. During both decades, patients were viewed as vulnerable and therefore nurses seemed to concur that they had special obligations to protect patients from harm. Loss of power, ability or loss of autonomy were often consequences of illness or lack of knowledge; the specific sources of harm and therefore the consequent obligations differed somewhat between the decades. During the twenties, members of the public were at risk when they unknowingly hired untrained women as nurses. The failure of a graduate nurse to be attentive, devoted, and unselfish would also jeopardize the patient's welfare. The importance of tact during the twenties was, in part, due to the obligation of the nurse to protect the patient from the well-meaning interference of family and friends. A tactful nurse could also ensure that even unpleasant, but necessary treatments ordered by the physician were carried out.

During the seventies, clinical incompetence of the nurse seemed to be perceived as posing a greater threat to patient well-being than lack of devotion. The nurse's individual responsibility to maintain competence and participate in ongoing education were stressed during the decade. As a member of the profession, a nurse shared a responsibility with other members to protect the public from incompetent or unethical practitioners. As the patient was vulnerable to human rights violations, the nurse had an obligation to promote and protect such rights. The emphasis on person-centred care during the early part of the 1970's was indicative of the concern about how

nurses respected patient dignity, but the later emphasis on patient advocacy reflected concern about how the nurse could protect the patient's rights regarding violations by others within the health care system.

During the twenties, the only mention of "rights" was made in reference to the issues of shorter hours for nurses and services for the middle income group. When discussing these issues, nurses referred to the principle of justice and to the moral rights and obligations of nurses; legal obligations were not a consideration in the moral debates of the twenties. Although references to justice were not generally explicit in the nursing literature of the seventies, the obligation of nurses to provide non-discriminatory care would seem to have been derived from such a moral principle. In order to ensure non-discriminatory nursing care, nurses were obligated to respect the values, beliefs, and customs of patients and the importance of non-judgemental attitudes was emphasized during the early seventies.

Although the nurse's central obligations to promote the patient's welfare and the welfare of society did not seem to change during either decade, how a nurse fulfilled such an obligation or what secondary obligations and virtues derived from those central ones did change. Statements about moral obligations in nursing generally reflected a broad principle, but the behaviour or virtue described by the statement was often quite specific. The principle inherent in a specific moral rule was most obvious to those who were practicing when the statement was developed or endorsed by the

profession. Although many moral rules could be considered "generally good guides" for nursing practice, they were often good in an instrumental sense, and therefore changed as conditions changed.

Changes in statements about the obligations of nurses often seemed to reflect a change in belief about what promoted the welfare of patients and society. Some of these changes appeared to follow conflicts between nurses and other groups or the emergence of issues involving conflicting obligations. At the beginning of both decades, obligations to the physician were specified as obeying or carrying out medical orders. During the twenties nurses altered the obligation of obedience to an obligation of co-operation. During the seventies, nurses stopped referring to the carrying out of medical orders as a moral obligation, dropped any specific reference to physicians from the ICN Code, and inserted an obligation to co-operate with all health care professionals. During the twenties, loyalty to one's hospital or training school was considered an obligation by many as such an attitude promoted the welfare of the community. Nurses of the seventies did not discuss moral obligations to an employing hospital and even legal obligations to employers sometimes seemed to conflict with actions that nurses considered to be their moral duty. Some nurses seemed to view obligations expressed in statements as absolute duties rather than as guides to decision-making about conduct. Within this view of nursing ethics, it would seem that an obligation such as carrying out the orders of physicians or the duty to preserve life precluded decision-making. The wording or interpretation of obligations such as these ones sometimes changed following

the emergence of conflicts, suggesting that the reasoning behind ethical statements was not always clear, or that the reasoning had changed.

The abortion issue of the seventies seemed to reveal some confusion about the nurse's role in moral decision-making, legal considerations in decision-making, and just whom or what was to be judged from a moral standpoint. Nurses who refused to participate in abortion procedures were considered by some to be unethical as they were "judging" patients and not respecting the beliefs of patients. Nurses who decided not to participate in abortion procedures indicated that they were making judgements about their own behaviour. These nurses referred to the principle of respect for human life rather than the principle of justice. Regardless of their opinion on abortion, some nurses believed that a nurse should not be censured by the profession or employer for such a decision as long as the woman's welfare was ensured. The patient's legal right to an abortion and the nurse's legal obligation to carry out the directives of the employer were introduced during the discussions of this issue. Although the abortion debate subsided somewhat, resolution of the conflict seemed to come about as nurses and employers made alternate arrangements rather than from any clarification of the moral aspects of the issue.

The scope of nursing ethics seemed to change within and between the two decades. The first change occurred during the twenties as topics once considered solely to be matters of nursing ethics, began to be discussed as topics of psychology and sociology.

Such disciplines provided knowledge that nurses could apply to their relationships with others in addition to the knowledge traditionally transmitted in ethics teachings. By the seventies, knowledge and skill derived from the biological and social sciences and applied within the nurse-patient relationship was supplemented by knowledge of the formal ethical code. During the seventies, however, knowledge of the statements in the code seemed to comprise an insufficient basis for decisions relating to dilemmas that nurses were facing in practice, and nurses proposed improved ethics teaching in nursing schools as well as a new code for the profession.

A second difference in scope that is evident between the literature of the twenties and that of the seventies, is the degree to which nurses distinguished between personal and professional obligations, ethics, and conduct. During the twenties, nurses were expected to demonstrate exemplary personal conduct that reflected credit on the profession. During the seventies, nurses did not generally refer to conduct outside of the professional role, and references to such conduct or to personal ethics were removed from the ICN Code. Such differences in the scope of nursing ethics would seem to be consistent with the relative emphasis given to virtues vis-à-vis duties during the two time periods. As virtues define the person, nursing ethics transcended personal and professional roles during the twenties. During the seventies, nurses emphasized moral duties or obligations rather than virtues, and nursing ethics involved the nurse's behaviour within the professional role more than the characteristics of the nurse.

Nurses encountered conflicts with both approaches to nursing ethics. In the twenties, nurses had difficulty maintaining the position that they were unselfish, altruistic persons (as nurses were to be according to nursing ethics) when they sought support for shorter hours. They referred to personal obligations to provide for their old age, thus introducing a separation of personal and professional duties that was unusual during this period. During the seventies, nurses generally focused on duties within the nursing role, but the abortion debate was viewed as one involving a conflict between personal obligations and professional ones. Withdrawal from units where abortion was performed, or withdrawal from private duty nursing seemed to be the methods of dealing with these conflicts, but the relationship between personal and professional obligations did not seem to be clarified during either decade.

For most of the twenties, nurses referred to all obligations as ethical ones but they began to use the term "professional obligation" more frequently in reference to the duty to meet community needs for nursing services. During the seventies, nurses referred to legal obligations, ethical obligations, and professional obligations. In most instances, the use of the term professional obligation seemed to refer to an ethical obligation and similarly, professional misconduct seemed to refer to what nurses of the twenties termed unethical conduct. Although legal obligations were distinguished from ethical ones during the latter decade, it was not always clear if professional obligations could be distinguished from ethical ones.

Some uses of the term "professional" in relation to obligations, conduct, and ethics seemed to reflect the focus on behaviour within the professional role as opposed to conduct outside of the role. For example, stealing from a patient or employer constituted professional misconduct, an action also considered unethical by lay persons in any setting. A professional obligation might also refer to duties a nurse owed fellow nurses, such as support for better working conditions. In some instances a professional obligation seemed to be one requiring group action such as the development of practice standards.

Nurses of the twenties seemed to express greater assurance about the ethical dimension of nursing. They did not generally report uncertainties about their decisions, their role in decision-making, or their understanding of moral obligations. Even when they encountered conflicts at the policy level, nurses did not seem to be unsure of their judgements. Nurses of the seventies reported more conflicts in the practice situation and less certainty about moral decisions. The differing degree of assurance about nursing ethics in both decades might account for the fact that Canadian nurses sought a code of ethics in the seventies, but ignored a proposal for a code in the twenties.

Nursing Ethics: Contexts

The context of nursing ethics refers to "environmental" factors that seemed to influence or be influenced by the moral beliefs of each decade. Some of the obligations identified by nurses seemed to be emphasized, altered, or introduced as changes occurred in

nursing roles, the organized nursing profession, the health care system, and Canadian social life. Similarly, changing nursing beliefs seemed to influence some of these contextual factors.

Private duty nurses were employed to care for a patient on a "continuous" basis in the patient's own home and there were few concerns expressed about depersonalized care or failure to respect the beliefs or customs of the patient and family. Such a system seemed to be conducive to person-centred care based on knowledge of the individual patient. The emphasis of nursing ethics was on the adaptability of the nurse, for if she was to be a "force for good" in the home, she would have to adjust to various home settings. Although this mode of practice did not generally seem to lead to the violation of an individual patient's rights, such a method of providing nursing services limited a citizen's access to care on the basis of income. Many members of the profession, particularly nursing leaders, viewed such unequal access as unjust and therefore as a major ethical problem that nurses ought to address.

General duty nursing in hospitals was the predominate mode of nursing practice in the seventies, and this form of practice was more specialized than in the twenties as hospital units were organized on the basis of medical specialties and/or severity of illness. Nurses emphasized the obligation to maintain competence and no longer referred to the adaptability of the nurse. Relatively speaking, the importance of competence and accountability in nursing seemed to be assumed rather than stressed during the twenties. When giving care in the home, private nurses organized their duties and made nursing decisions

quite independently; they did not generally share a responsibility for nursing care with others. As more than one nurse cared for a hospitalized patient during the seventies and as a nursing department assumed responsibility for nursing care, there seemed to be a concern on the part of the profession that individual nurses might feel less accountable as individuals.

The degree of nursing independence or autonomy was an issue related to patient and social welfare for nurses of both decades. The desire for freedom from constraints on professional decision-making or for control over practice was, by some, viewed negatively as "individualism" in the twenties and positively, as a responsible attitude, in the seventies. Nurses of both decades seemed to resent being limited by hospital rules or policies.

In the seventies, most staff nurses cared for a group of patients and they indicated that they did not always meet their obligations to provide person-centered care, live up to the ideal of caring in their relationships with patients, and give patients the attention they required. During periods of staff shortages, concerns for patient safety were voiced and nurses indicated that safety was the rock-bottom criterion of acceptable conditions. Nurses of the twenties never suggested that they had difficulty meeting their moral obligations or being devoted to patients, although they indicated that they could never be the "paragon of perfection" that some people expected them to be. Although private duty nurses cited long hours of duty as detrimental to the quality of nursing care given, they did not suggest that patient safety was threatened.

During the late twenties, nurses began to perform new tasks, tests, and procedures in hospitals and uniformity of routines, equipment, and supervision was being advocated to improve hospital efficiency. For the most part, these changes were viewed as beneficial in terms of meeting the needs of patients and improving services to the community. Nurses expressed some concerns that such changes might divert attention from the goal of patient welfare. In the early seventies, similar concerns were expressed by nurses and patient-centered care was re-emphasized. Based on beliefs about what promoted the welfare of individuals, hospital policies on visiting hours, staffing patterns, and teaching programmes changed considerably.

The nursing profession changed the nature of and emphasis on obligations as new roles developed within the profession. During the twenties, the increase in the number of public health nurses was accompanied by a greater emphasis on, and perhaps awareness of, the number of Canadians who could not afford nursing care. Public health nurses required higher education, initiative, and leadership ability. If members of the profession were to meet their obligations to the public, all nurses would need these qualities, skills, and educational opportunities. During the early seventies, the "expanded role of the nurse" began to develop in both hospital and community settings. As nurses in these roles acquired new knowledge, skills, and responsibilities, nursing accountability and autonomy were emphasized.

The major ethical issues at the policy level of the nursing profession involved the quantity or distribution of nursing services in the twenties and quality of services in the seventies. The

influence of the medical profession and hospital administrators was considerable in such debates of the twenties while that of governments was more notable in the seventies. These differing influences were reflected in the groups to whom nurses were obligated. In the twenties, the nursing and medical professions co-sponsored the Nursing Survey, while in the seventies the nursing profession co-sponsored conferences with and contributed to reports of the federal and provincial governments.

During both decades, members of the profession indicated that they had an obligation to provide a high quality of care, and various duties and virtues were related to such an obligation. Nurses who were educators tended to emphasize improvements and changes in nursing education to elevate the standard of nursing care; for the same reason, nurses who were clinicians tended to emphasize improvements in working conditions. In the twenties, the idea that nurses should change working conditions to elevate the quality of care was a new one, but by the seventies obligations to continue learning and promote conditions for quality care were both part of nursing ethics.

Nurses who were concerned about working conditions indicated that hours, workload, and the system of organizing nursing services affected the quality of care, but quantity of care was not an entirely separate problem. During the twenties, some nurses were concerned about justice to the patient in a system of group nursing. Nurses of the seventies reported declining standards of care with increased workloads, and their comments indicated that patients were

not receiving nursing care to which they were entitled. In a sense, just distribution of nursing care was an ethical concern in both decades. Such a concern led to recommendations for the reorganization of nursing services.

In the twenties, changes in the mode of nursing practice and development of more efficient methods of organizing nursing services were advocated as solutions to the problem of unequal access to nursing care. Such changes in terms of hospital care, involved relinquishing responsibility for organizing nursing services to hospital authorities, and it was implied that nurses who failed to give up their independent ways were not meeting their duty to society. In the seventies, changes in hospital policies and in the organization of nursing services were proposed as methods of countering the problem of depersonalized care. Some of these changes were designed to increase the nurse's authority and responsibility for decision-making. It would seem that during both decades, the beliefs nurses expressed about their obligations influenced the organizational context of nursing practice.

Several aspects of Canadian society seemed to be important factors relating to nursing ethics of the decade. During the twenties the spirit of social reform and social progress seemed to be reflected in the nursing profession's focus on obligations to society. Emphasis on the rights of individuals and specific groups during the seventies was reflected in the obligation to respect the beliefs and customs of others, to protect and promote patient rights, and the importance of a non-judgemental attitude in the nurse. Recommended changes in the

nursing role such as advocacy, and emphasis on patient teaching accompanied the emphasis on patient autonomy.

Discussions of nursing ethics during the twenties were filled with references to duty; during the seventies with references to rights. Such language differences would seem to reflect prevailing social approaches to moral questions. Some contemporary authors who have written about bioethical issues consider the "rights approach" to foster a legalistic interpretation of issues (Ladd, 1977). Perhaps the language of the two decades is evidence of the relative importance of the church and the law as sources of moral authority and influence. Davis and Aroskar (1978) point out that the notion of rights is not a clear one and that rights seem to be "entwined" in social and legal systems. During both decades, there seemed to be a blurring of ethical issues with political, social, economic and legal issues.

The fact that "progress" was a key social theme during the twenties seemed to affect the kinds of qualities emphasized for the upcoming generation of nurses. Initiative and intellectual ability somewhat replaced obedience and tact as important requirements in a nurse. During the seventies, there were doubts about scientific progress, and concern about the potential side effects of man-induced changes in the world. Many members of the nursing profession called for a "clarification of values," and emphasized the importance of caring qualities in the nurse.

During both decades, economic conditions seemed to influence the ethical issues that arose within the nursing profession. In the twenties, economic conditions set moral constraints on the movement

for a shortened working day, and the service ideal was seemingly threatened. During the seventies, constraints on hospital budgets with accompanying increased workloads conflicted with the increasing emphasis on the quality of nursing care and individual responsibility for the standard of care. Such constraints raised questions about the limits to the obligations of nurses, at least on the part of nurses.

Perhaps because they were women and trained as nurses within the "hospital family," nurses of the twenties were reluctant to approach the public and/or government about nursing problems. In the seventies, it was socially acceptable for women to protest publicly, nursing unions existed, and as many nurses were no longer graduates of hospital schools, the relationship to the employing hospital had changed. No breach of loyalty was involved, and unlike the conflict of the twenties, such protests were justified by the ethics of the profession rather than deemed contrary to traditional values and beliefs. Nurses of the twenties did indicate that long hours negatively affected the quality of care, but their main argument was that of justice for nurses. Given the plight of the average Canadian during illness, and that nursing involved a degree of sacrifice, that argument did not seem so compelling to others.

Returning to the Research Questions

There have been changing and unchanging aspects of nursing ethics over time in Canada. The view that nursing ethics involved a certain spirit that inspired moral behaviour and a certain character that "ensured" it, changed. By the 1970's, spirit and character were not as central to nursing ethics as the concepts of rights and

obligation.

Three principles of moral behaviour in nursing pervaded the literature of the periods under study. These principles involved the promotion of good and prevention of harm, justice, and a notion of how human persons ought always to be treated; a principle that might be called "respect for persons." In nursing, promoting the good meant promoting human welfare, and welfare included physical, psychological, and social aspects of well-being.

Although there were several general moral notions or guiding principles that seem to have been fairly stable ones, these principles were less explicit and less emphasized than were the specific obligations of each decade. Most often, principles were assumed or implicit in discussions of more specific obligations and issues. The nursing literature indicated that patient welfare was always to be the primary consideration; other obligations were not generally ranked in terms of importance. It would seem, however, that many of the moral obligations or rules comprising nursing ethics during each decade related to the means of promoting either patient welfare or society's welfare. As "better" means became evident, as rules no longer seemed reasonable for promoting welfare, or as rules conflicted, changes in nursing ethics seemed to occur. To some extent, the focus on means and the assumption of principles created a view of nursing ethics as the application of rules rather than the exercise of reason in nursing practice, and such a view appears to have led to conflicts.

Of the issues discussed as ethical ones in nursing, those involving a conflict between the nurse's duties outside of the nursing

role and those duties as a member of the profession seemed to involve the most protracted discussions. In the resolution of these debates, the professional duty to patient and public welfare was viewed as the primary one, at least in terms of an immediate resolution. By the seventies, legal considerations became more important in such issues, and the resolution of conflict often involved labour negotiations. Solutions generally resulted in the clarification of legal obligations rather than moral ones.

Beliefs about what nurses ought to do were influenced by contextual factors; conditions affected the obligations that nurses identified as those of members of the profession. These obligations generally related to the means of promoting the "good," and they were delineated as the level of nursing education changed, as economic conditions changed, or as new nursing roles were introduced. Contextual factors were important considerations in ethical decision-making in nursing, and such factors as legislation, administration and organization of nursing services, and the control of nursing education were variously viewed as constraints on or facilitators of ethical conduct.

The beliefs that nurses held about their moral obligations seemed to influence changes in contextual factors. The methods of organizing nursing services, the nature of the nursing role, the availability of health care services, and nursing education changed as beliefs about nursing ethics changed. The practice of nursing was not determined solely by the concepts or contexts of nursing ethics; taken together, however, these aspects did seem to shape the profession over time.

NOTE ON SOURCES

The major source of literature for this study was The Canadian Nurse. This journal was first published as a quarterly in 1905 with a physician, Dr. Helen McMurchy, chosen as editor on a part-time basis. Although sponsored by the Toronto General Hospital alumnae association, the publication was billed as a journal for the nursing profession in Canada. By the time monthly publication began in 1907, a nurse served as part-time editor and a committee of nurses from various regions of the country had replaced the alumnae association. In 1916, the Canadian National Association of Trained Nurses purchased the publication rights. Nurses continued to serve as editors, the first full-time editor, Ethel Johns, being appointed in 1933. The journal contained articles in the French language as early as the 1940's, but the first issue of the French language edition, L'infirmiere canadienne, was published in 1959. The publication was called a journal for the nurses of Canada until 1977, when it was termed the "official journal of the Canadian Nurses Association."

The archives of the Canadian Nurses Association contains the records of that national nursing association, copies of all the above journals, and other materials that were valuable in this study.

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