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University of Alberta

Advancing an Integrated Ethic for Nursing

by

Donna Leigh Hoopfer 

A thesis submitted to the Faculty of Graduate Studies and Research in partial fulfillment of the requirements for the degree of Doctor of Philosophy

in

Philosophy of Education

Department of Educational Policy Studies

Edmonton, Alberta

Fall 1998

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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 **Advancing an Integrated Ethic for Nursing** submitted by Donna Leigh Hoopfer in partial fulfillment of the requirements for the degree of Doctor of Philosophy in Philosophy of Education.

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ABSTRACT

The overarching aim of this project is to develop a philosophically defensible ethic for the practices of nursing and nursing education. The currently influential claim that nursing is properly based on an ethic of care is critically assessed and found wanting. First, an ethic of care does not sufficiently accommodate the complex moral character of nursing. Second, it fails to acknowledge that nurses have a moral responsibility to respect others and treat them justly whether or not the specific moral connection of care develops with any given patient. Third, nurses who attempt to operate from an ethic of care are placed at considerable risk of oppression and exploitation.

The theories of Jean Watson, Sally Gadow, and Nel Noddings are explored in detail as examples of the strengths and limitations of care as a moral concept for nursing. An alternative ethic is proposed that has similarities to the three previous cited ethics. The main difference is that justice and caring are integrated as mutually supportive modes of moral responsiveness. It is also argued that both justice and caring must be understood in the context of an objectivist account of human good.

I argue that the integrated ethic makes it possible for nurses to address the abuse of medical authority in established institutions. Finally, I argue that nursing education must move to integrate ethics into pre-service,

in-service, and continuing educational programs. This means that all nursing educators must be active in creating an educational environment that enables progressive, continual development of their own and students' moral responsiveness in nursing.

ACKNOWLEDGEMENTS

I will always cherish having had this opportunity to take this rewarding journey. It really has been a gift - given to me by so many people who have touched my life in so many significant ways.

I limit my deepest appreciation to those having the most direct influence on this part of my life.

First, and foremost, my best friend and sweetheart - my husband Ken Anweiler, for believing in me and being a tireless supporter.

All the nurses, patients, physicians, families, and friends who stimulated and enriched the research by sharing their experiences.
Dr. Eamonn Callan, my supervisor, for requiring a level of scholarship that has been challenging and rewarding, and for his unwavering support and commitment to the research. Thank you!

Fellow graduate students Anne Chinnery, Daniel Dalton, Kathryn Byrne, and Susan James -- for their lively spirits, critiques, ideas, thoughtfulness, and mutual support. You will always be my colleagues.

Dr. John Dossetor for his continuous support of the importance of the research for nursing and other health practices, and for the resources provided through the newly dedicated Dr. John Dossetor Health Ethics Centre.

The John Dossetor Health Ethics Centre and the Faculty of Nursing for making it possible to do studies with Dr. Sara Fry, attend workshops conducted by Dr. Jean Watson, and seminars by Dr. Sally Gadow.

Dr. Allen Pearson for being an artful mentor in our team teaching of ethics.

Marguerite Schumacher who instilled the vision of career-long learning and the importance of openly questioning practices and resisting unscrutinised traditions. You have continued to be a source of inspiration in my nursing career.

And finally, my family who have been supportive while being denied some of our precious time together.

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CHAPTER I

INTRODUCTION

When I began my nursing career it seemed correct for Mayeroff's book *On Caring* to be part of the pre-service curriculum (1971). The moral necessity of having a caring attitude toward patients was accepted without question by almost everyone in nursing. But it was also assumed that a nursing relationship did not require the development of a "closeness" to patients of the sort that might be found in intimate, emotionally charged relationships.

As my career continued, it was upsetting to see nurses exhibit indifference or disrespect to patients, especially as the Canadian Nurses Association Code of Ethics for Nursing cited care and respect as necessary elements of ethical practice (1991, revised 1997). Yet, I also began questioning what it meant for the profession of nursing to hold caring as a moral responsibility. I interpreted the Code to mean nurses have a moral responsibility to meet the needs of patients and interact with others in a "caring way". But I thought of this "caring way" as concern for the good of patients and respect for their dignity; I did not think of it as sharing much common ground with the more emotionally profound caring attachments. Nevertheless, a ground-swell of nursing literature seemed to support Madeleine Leininger's claim that an affectively demanding

ideal of care is the essence of nursing (1981, 1984). Prominent nursing scholars - e.g., Sara Fry (1988), Jean Watson (1988), Sally Gadow (1980), Patricia Benner (in Benner & Wrubel 1989) - were beginning to elaborate this ideal.

I started to question my whole understanding of nursing. Could all of these scholars be mistaken? What arrogance for me to even ask that question. I sought out many nurses to discuss their ideas on caring and what they considered ethical practice. The conversations and my master's research helped me regain confidence for pursuing greater understanding of the importance of ethics in nursing and to begin another quest. Gilligan's book *In a Different Voice* and Noddings's book *Caring* were but two of the valuable sources that informed my quest. My investigations into ethics, philosophy, and nursing were helping to uncover what seemed to be a gap between nursing scholars views on nursing and what many nurses experienced in their practice.

Many scholars outside of nursing were finding that care was an insufficient concept for addressing the full moral complexity of human life (Houston 1989, p. 24, 1990, pp. 115-119; Friedman 1993, p. 156; Callan 1992, p. 434; Nelson 1992, p. 9; Flanagan 1991, pp. 243-246; Blustein 1991, pp. 19-22; Card 1990, p. 102; Puka 1990, p. 74; Hoagland 1990, pp. 109-115; Kymlicka 1990, p. 279; Calhoun 1988, p. 459). Nursing scholars did acknowledge the concept of care was

being used vaguely and ambiguously in nursing (Leininger 1981; Gaut 1983, Griffin 1983; Fry 1991). But it was assumed that further research would dispel the vagueness and ambiguity, and so many continue to support care as the moral ideal for nursing. Among exponents of the ideal it is often taken for granted that not caring is the same as being uncaring and that only through caring for a patient could a nurse engage in morally sensitive nursing (Carper 1979; Leininger 1981; Gardner & Wheeler 1981a; Swanson-Kauffman 1986; Watson 1985, 1987, 1988, 1994; Gadow 1980, 1995a; Benner 1984, 1991, 1994a; Benner & Wrubel 1989).

As my investigation continued, I came to realize that much of the appeal of the emerging ideal of care depended on the false claim that its only alternative was a crude and legalistic conception of justice. The critics had been blinded to a richer conception of justice that escapes the hazards of "absurd moral abstraction" and "emotional disengagement" which sometimes beset discourse about justice in the Kantian tradition (Callan 1992, pp. 435-436; See also Dancy 1992, p. 453; and Pelligrino & Thomasma 1996, pp. 14-15). Therefore, the criticisms only served to support rejection of a specific conception of justice and were insufficient for a wholesale rejection of the concept. Moreover, I was coming to believe that even if there were sufficient arguments to reject justice as central in nursing practice, this could not provide the necessary support for

accepting care as a sufficient alternative. Somewhere along the line, Boyle's insightful understanding that caring "is not" the totality of nursing was being forgotten (1981, p. 40).

These issues had become more than matters of theoretical interest to me. Nurses are being urged to accept the "feminine" moral voice of care as a morally authoritative voice for their practice (Watson 1989a, 1990; Gadow 1988, 1995b; Benner 1991). Care is being claimed as the differentiating factor between the practices of nursing and medicine (Gadow 1985, 1988) and nursing is being referred to as a "caring practice" (Benner 1994a, p. 43; Benner & Gordon 1996; Bishop & Scudder 1996, p. 1). If these claims are based on false and misleading moral theory, real harm may be expected to follow from their implementation.

Some nursing scholars suggest that justice does have some place within the parameters of an ethic of care (e.g., Cooper 1988; Davis 1995; Fry 1985, 1988, 1989a, 1989b, 1991). However, they have not addressed the matter of how to incorporate justice and care in nursing practice. Those who have said something specific about the role have assigned justice to a marginal supportive role (e.g., Benner & Wrubel 1989, p. 368).

I wanted to understand the basic moral values that should guide the practice of nursing, and I wanted to keep

an open mind about how care and justice might be related in those basic values. But I asked myself, did this research have to be done by me? I was somewhat hesitant to pursue such an investigation since Vezeau had just claimed that to be against caring as the moral ideal for nursing was "tantamount to being against apple pie and motherhood" (1992, p. 18). Yet, I had to determine whose views on ethical practice were correct. I needed to be sure what practising nursing ethically really entailed. So, I embarked on a journey that has led me to the arguments that are presented in the following chapters.

This document is presented in the spirit of participating in an enterprise of critical inquiry, aimed at advancing our understanding of the significance of ethics in nursing, education and the health system. Like life itself, this is a work that will need to remain in progress.

The Research

The research undertaken in this project has addressed two questions. First, can the concept of care provide a sufficient basis for the moral life, and more specifically for guiding the practice of nursing? Second, does the inclusion of justice and care in an ethic provide a richer moral life for nurses, and those in relation with nurses, than justice or care can provide alone?

The research has been conducted through philosophical

inquiry with some use of qualitative data (Benner 1991, 1994b; Morse 1995). Scholarly works from philosophy, nursing, medicine, women's studies and education pertaining to moral theory and ethics comprise the theoretical research data. The subjective research data includes nursing-students', nurses,' physicians', and patients' experiences as presented in the literature and personally to me throughout my nursing career. During the project, personal observations and discussions with nurses and patients residing in Canada, France, New Zealand, Australia, Switzerland, Germany, and China provided an enriching context for the research.

In Chapter 2, I argue that misunderstandings regarding the significance of care in nursing have stemmed from the word "care" being used to refer to discrete elements of care rather than what I call "the moral sense of care". I detail why care is an insufficient concept on which to base an ethic, especially an ethic for nursing. Yet, an ethic for nursing needs to integrate the concept of care with the concepts of respect and justice. The integration I argue for is based on caring and justice being two different modes of moral responsiveness each stemming from different moral connections that are compatible within the same relationship. However, while the moral connection of respect for person is necessary to the moral life in all relations and encounters, the moral connection of care is

not but can, and often does, develop in some relations.

The integration of caring and justice maintains the integrity of each concept. An understanding of human flourishing is presented as the necessary context for any ethic that successfully integrates the concepts. It is argued for any action to be deemed just or caring it must be in accordance with an objectivist understanding of human flourishing.

In the second part of Chapter 2 I adumbrate the proposed integrated ethic. The proposed ethic addresses Fry's claim that nurses should not be expected to place themselves at unreasonable risk in order to meet the needs of patients (1985). It is argued the integrated ethic enables nurses to be simultaneously responsible to themselves and others. This involves always being respectful of the self and others while also being generally open to care for the self and others without necessarily caring. Additionally, it is argued there are circumstances when nurses can be excused from being open to care.

In Chapter 3, I critique Noddings's ethic of care for the purpose of determining its appropriateness for nursing. Gilligan is acknowledged and acclaimed for bringing the moral perspective of caring to the forefront of ethics. However, it is Noddings's ethic of care that has influenced many nursing scholars in their pursuit of an ethic for nursing. Fry claims Noddings's ethic of care is a viable

framework for the nurse-patient relationship (1989b, p. 94). She also claims the "ethic of transpersonal caring" that Jean Watson (1988) is proposing for nursing embodies important aspects of Noddings's ethic (Fry 1991). Additionally, Watson claims aspects of her ethic are implicit in the "ethic of advocacy" that Sally Gadow is proposing for nursing (Watson 1988, p. 64; Watson 1997, p. 49; Gadow & Schroeder 1996). I argue that Noddings's ethic is limited by its subjectivist foundation, its undeveloped conception of justice, and the narrow scope of moral responsibility it entails.

Chapter 4 begins an inquiry into the separate ethics Sally Gadow and Jean Watson are proposing for nursing. I argue that the two ethics are similar to Noddings's, as all three ethics include an unacknowledged and underdeveloped sense of respect for persons and justice. This discovery lends additional support to my claim that caring and justice need to be part of an ethic for nursing. Additionally, it is argued the ethics of Watson and Gadow suffer from the same subjectivism that mars Noddings's work.

In Chapter 5, I argue that ethics is not fully integrated in the health system since "science" - in the form of medical science - is often construed in a way that subverts moral authority. Examples are given to illuminate how suppressing ethics impedes nurses from speaking out against unethical practices directed toward themselves and

patients. I argue that the scientistic approach to medical practice works effectively to silence and oppress nurses and to insulate morally irresponsible medical authorities from legitimate criticism. I concur with Tronto (1993) and Blustein (1993) that the moral poverty of the health system is a "political" issue that requires collective sustained action.

I argue that the appropriate basis of such action is the integrated ethic with its distinctive amalgam of justice and care. Personal experiences are used to illustrate how the integrated ethic enables nurses to address moral wrongdoing and avert "moral blunting" and other harmful outcomes that abound in the health system under current conditions.

Finally, in Chapter 6, I propose an approach to integrating ethics throughout nursing educational programs. It is argued this approach enables the pervasiveness of ethics in the practices of nursing and education to become more visible and be more completely addressed by educators and students. Arguments are presented for educators having a responsibility to create an environment that supports ethical nursing, and having a responsibility to engage in ethical practice as nurses and educators. The integrated education schema is based on ethical practice being a central aim of nursing education, and the basis for assessing whether a student is sufficiently educated to

warrant graduating. The proposed schema involves adjusting the predominant classroom course-based approach to ethics education, to a practice-orientated approach that systemically assists students to develop morally. Support is offered for accepting Noddings's four methods of ethics education - i.e., modelling, dialogue, practice, and confirmation (1984, 1988, 1992), but only if they are combined with Schon's reflection-in-action method (1991).

Chapter II

QUESTIONING AN ETHIC OF CARE FOR NURSING

Over the past two decades many contemporary scholars have embraced caring as the moral ideal. Carol Gilligan and Nel Noddings have been influential in this refocusing of ethics away from traditional theories, such as utilitarianism and Kantian deontology.[1] On the other hand, there are those who claim caring and justice are both important moral concepts that need to be included in an ethic for guiding people to live a morally enriched life (Callan 1992; Greene 1990; Bartlett 1992). Like scholars from other disciplines, nursing scholars remain divided on whether justice and care are to be part of an ethic for nursing, and are uncertain exactly how both concepts could be included in an ethic.[2]

In this Chapter I will address the question whether care is a sufficient moral ideal for the complex moral character of nursing, or, if justice is also necessary. In addressing this issue, a thorough investigation into the concept of care is needed.[3] This is especially necessary since the use of the word "care" has become habitual in talking about nursing, to the extent that "caring" is often substituted for "nursing" - implying that "caring" is synonymous with "nursing" (Tschudin 1994, p. ix; Tanner 1990b, p. 71).[4] This situation tends to occlude the complexities of nursing and obstructs a clear understanding

of what it means to care in a morally relevant sense. Therefore, the first part of the Chapter delineates and defends a distinctive conception of moral care.

The second part of the Chapter addresses the significance of care and justice in the moral life. Arguments are presented why an ethic based solely on care is inadequate for nursing and other social roles. In the third part of the Chapter, I propose a way to integrate caring and justice that retains the integrity of each concept. The proposed integrated ethic addresses the complex character of life in a liberal democratic society and how both justice and care are needed to enable people to live a morally laudable life. Even though the arguments used are directed toward advancing a plausible ethic for nursing, the foundations of the ethic can be used to guide practices in many other social relations.

The Language of Care

The language of care surrounds us. Everywhere people are trying to gain the competitive business edge or the public's trust by claiming to care. The health system is a prime example: health care, nursing care, medical care, critical care, emergency care services, hospice care, caregiving, caretaking, caring practices, caring professionals (Benner & Gordon 1996, p. 40). Claiming to care tends to soften the hard for-profit edge of business and the unpleasant,

painful, and sometime horrific situations that result in a person needing the resources of the health system, especially the assistance of health professionals. I suggest the following analysis of care gives us a clearer and richer picture of its meaning than what Tronto calls our currently "fragmented" understanding (1993, p. 101).

In everyday life, the word "care" is commonly used as a salutation by a person saying, "take care", rather than, "have a nice day". Additionally, care is used to convey personal feelings and affections, when saying: "I care for you" rather than "I like you". Caring is also used to convey that something is valued - "I really care about learning how to do that procedure right" rather than "it is important to me that I learn to do that procedure right". The reference to care is also used to indicate that actions will be performed as in, "I'll take care of that for you" or "I am going to be taking care of you today" rather than "I'll do that for you" or "I will be assisting you today" or "I will be your nurse today" (Blustein 1991).[5]

Additionally, the word "care" is often used in reference to actions or ways of interacting with others that have a distinctively caring manner or style. For example, there are actions that have become labelled as "care"[6]; there are social roles characterized as "caring" professions and occupations[7]; there are, social relations that are expected to involve "caretaking" activities.[8] However,

Tronto very clearly explains that actions often associated with or done out of a "disposition" of caring for another are actions that can be done without the person actually caring (1993, p. 104). Therefore, performing actions that are socially equated with caring does not necessarily mean the person performing the actions cares for those to whom the actions are directed (Curzer 1993a, p. 175). For example, women have personally described to me how it has taken years for them to come to care for a particular child even though the women looked after their child by engaging in "caretaking" activities and others described the women as caring mothers.

These various usages of the word "care" exist alongside another - namely, the moral concept of care with which they are often confused. This moral concept will now be elucidated.

The Moral Sense of Care

The moral sense of care is most commonly expressed as "caring-for" or "caring-about", and it means there is a specific connection, bond, engagement, or attachment with the other (Noddings 1984, p. 9; Tronto 1993, p. 102; Benner & Wrubel 1989, p. 1; Bubeck 1995, p. 135; Griffin 1983, p. 292).[9] The person, as carer, experiences a significant personal connection with the other that involves a feeling of responsibility toward the other. Therefore, the moral

sense of care involves an inclusion of the other into the carer's life, coupled with responses and actions that are done to promote the other's good. This means caring is not merely having feelings of affection or an interest in the other (Tronto 1993, p. 101), and neither are actions done purely out of self-interest since caring in this sense is predominantly other-directed (Blustein 1991, p. 30). For caring to occur the other (or the object of a person's caring) must be seen as an end and not as a means to the carer's ends (Tronto 1993). Care in this sense is a moral concept; it does not pick out an action, inclination, disposition, or attitude that can be identified in the absence of moral criteria.[10]

Three criteria comprise the moral concept of care. First, the carer experiences being "invested in" the other's good (Blustein 1991, p. 30). For example, what is often being expressed through a nurse's responses stemming from caring for a patient is: "It is important to me that you get better, not just because it is important to be healthy or that it is important for you to be healthy, or it is important to me, as a nurse, that you get healthy. Rather, it is important because <u>you</u> are especially important to me". In this way, the carer experiences the other as connected to the carer in a very significant way. Caring responsiveness expresses "active" concern about the other's good and an awareness of the other as worthy of the carer's emotional

investment (Blustein 1991, p. 31). Additionally, the care connection may be only unidirectional or one-sided since it does not require the recipient of care to care for the carer. For example, a father can care for his child without the child caring for the father. The father may only be experienced as having an instrumental value in the child's life, in which case care in its moral sense is absent in the child's connection with the father.

The second criterion applies to the way in which the carer's emotions are "commanded" in a certain way by the other's good (Callan 1992, p. 440; Griffin 1983; Noddings 1984, p. 32; Bevis 1981, p. 51). This means that when a person cares the connection with the other is constituted in part through emotional investment. The carer is susceptible to positive emotions, such as joy, when the other's good is promoted; the carer is disposed to experience negative emotions, such as sorrow, when the other's good is impeded.

However, emotional reaction to others' hardships or accomplishments is not enough to indicate the presence of a care connection.[11] Consider a case in which a nurse is involved in nursing a woman whose newborn has just died. If the nurse merely felt sorry for the woman and wished the woman did not have to suffer the pain of this loss or merely felt angry toward God for letting this death occur, the nurse's emotional expressions would not necessarily signify caring for the woman. The nurse could simply be expressing

sensitivity to the woman's vulnerability, suffering and loss or reacting to the personal belief that God is responsible for looking after the children and so God is to blame for letting this child die. Additionally, the nurse's emotional expressions could really be responses stemming from personal feelings regarding the death of a child and not be specific to the woman at all. This illustrates why it is necessary to reflect on emotional responses, so that nurses do not falsely consider themselves to be caring when they are interacting with patients by way of unscrutinized emotional reactions from personal beliefs or from emotional self-indulgence.

The third criterion of moral care is the carer's active promotion of the other's good (Fry 1988). This is the element missing in the example in the previous paragraph. Expressing anger toward God or feeling sorry for a mother in the wake of a child's death does not contribute anything to the good of the mother whom the nurse purports to care about. Therefore, it cannot be caring in any morally serious sense (Carse 1996, p. 105). Effective caring here requires an understanding of what might legitimately assist the bereaved mother and taking action commensurate with that understanding. Caring in its moral sense is best described as a mode of moral responsiveness that stems from the connection of care - i.e., the other's good being especially important to the carer.[12] The caring responsiveness is

guided by an accurate understanding of that good. Therefore, the responses and actions that moral care motivates are directed toward effectively promoting the good of those cared for.

Blustein suggests that care is also used in a propositional way (1991). For example, when a nurse states, "I care that people get the best possible nursing and not suffer needlessly". This usage certainly seems connected to the moral sense of care. But the connection is less straightforward than it might seem. Certainly the nurse's expression suggests a valuing of human life and the role of nursing in ministering to the good of others. On the other hand, the nurse's words may attest to an attachment to an ideal of professional service in nursing rather than a direct concern for the good of particular patients. This does not mean the nurse's actions must be regarded as morally suspect; it only means the actions done in a professional "caring way" are not necessarily a response that comes from caring for the patient.[13] While the concept of care addresses one significant aspect of the moral life, it cannot be the sole moral concept for nursing unless it is feasible to expect all nurses to care in the moral sense for every patient and person they encounter.

The Moral Significance of Care in Our Lives

Gilligan has been instrumental in reawakening scholars to the importance of care as a moral concept in our lives. This resulted from her challenge to Kolberg's moral theory, detailed in her book *In A Different Voice* (1982). Gilligan claims that moral judgements in the case of females are typically rooted in the connection of care with others. She also claims that such judgments are not inferior to the dictates of justice (Ibid., pp. 30-35). Gilligan has concluded that caring needs to be included in any adequate theory of moral development and education (Ibid., pp. 63, 174; 1995, p. 125).

However, Gilligan has not claimed the moral concept of care is sufficient to replace the concept of justice (Carse 1996, p. 84). Rather her important contributions have been two-fold. First, she has claimed that responses of caring are not necessarily morally inferior to responses that come from a sense of justice. According to Gilligan, people whose main mode of moral responsiveness is caring are not necessarily suffering from inadequate moral development. Second, she has underscored the importance of relational connections in our lives (1995, p. 125). These have a significant influence on identity that needs to be more clearly understood, even in the case of those whose moral responsiveness relies heavily on justice.

Care is now seen by many scholars as an important moral concept since the moral connection of care can enrich the lives of those involved in a very significant way (Noddings 1984, 1992; Callan 1992; Greene 1990; Dillon 1992; Held 1995; Tronto 1993; Watson 1988; Carse 1996). The care connection is qualitatively different than universalistic moral attitudes that do not involve the direct particularistic concern for the other's good and emotional investment in that good which caring in its moral sense entails. Being cared for by another often prevents the feeling of isolation and loneliness that can be experienced when a person is valued by others only in less direct and personal ways. Additionally, the carer's feelings of isolation can be reduced as caring for another binds his or her good to the other's good in an emotionally engaged way.

The care connection can be brief or enduring, and need not be reciprocated for caring to exist (Carse & Nelson 1996, p. 22). When caring is not reciprocated or when the care connection ends, it does not mean the person never really cared or there was an inferior quality to the caring. Rather, it can merely indicate that the care connection was unilateral, and this can occur for morally honourable reasons in various social relations. For example, in nursing, the context of the patient's vulnerability often influences nurses in coming to care for a patient without the patient coming to care for the nurse in return. This is

understandable since the purpose of the relationship is to meet the patients needs, and these needs can be met in a morally laudable way without the patient reciprocating care.[14] However, the patient will often, though not always, express appreciation for morally sensitive nursing received and may come to prefer the responsiveness of these nurses over others.

Social roles are constituted in ways that may facilitate or impede the development of care in the moral sense. Having a child places a woman in the social role of being a mother, which entails in our culture the obligation not only to fulfil the child's basic physical needs but also to care for the child in an emotionally engaged sense. On the other hand, our relative indifference to the work of mothering and our tendency to view caring as a "natural" phenomena in parenting often means that mothers are denied the assistance they need to meet role expectations of looking after their children in caring ways. In short, when the expectation to care for particular others is built into a social role, we need to ensure that the conditions under which the role is performed really makes it possible to fulfil that expectation.

On the other hand, it would be rash to infer that the moral demands of all social roles and relationships revolve around the requirement to care. Many human transactions are too fleeting and of a nature to preclude care from being

a realistic demand. People may come to care for each other in such circumstances, but caring cannot be held as a moral requirement or imperative. I may come to care for the shop assistant I intermittently encounter, but that is not required. What is morally necessary is that I treat her with respect and consideration and an openness to care for her.

Alternatively, Noddings suggests that care can and should be the foundational concept of morality (1984, p. 3). She claims that caring is innate and being cared for is essential for living well (Ibid., p. 83).[15] However, even if the capacity to care is innate and caring is essential for human existence, it does not follow that we must care for or be cared for by all others in order to live morally laudable lives.

Being able to care for everyone is unnecessary and an unrealistic moral demand.[16] It is unnecessary since the need for care can often be satisfied by having relatively few, strong and enduring caring relations in a lifetime (Carse & Nelson 1996, p. 22). This is not to deny that to be cared for may be experienced as a "personal need" in some relations. The clearest example is the relationship between children and parents. The demand for universal caring is also unrealistic because not every person will have the personal capability of caring for all others in the world. Indeed it is not clear that any person has the capability to

care for everyone, given the personal investment in the other's good that caring entails.

The context of nursing is an apt example of the limits of care in the moral sense. Consider the myriad, often perfunctory relations that an individual nurse will have with other nurses, physicians, health professionals, health workers, administrators, family members, clergy, etc. Given the complexity and range of these relations, it is impractical to imagine that any psychologically intact nurse is capable of forming the connection of care with each person the nurse routinely encounters. However, a nurse can maintain an openness to care and should not resist coming to care for others when moved to do so.

An Openness to Care as a Moral Responsibility

I claim that being open to care is qualitatively different than caring for others. In addition, I suggest that maintaining an openness to care is a moral responsibility.[17] The basis for this claim is that merely having an openness to care enriches our lives and those of others. An openness to care nurtures our moral sensitivity and empathic regard, which helps keep a full sense of humanity alive and healthy.[18] For example, nurses whose moral concern is confined to the more impersonal aspects of their relations with patients and are closed to the possibility of care shut themselves and their patients off from a rewarding form of

human connection. Yet, the nurse who is open to care may not establish a caring connection in many situations through no fault of her own or anyone else.

I suggest it is morally unacceptable to expect and hold nurses morally responsible to care for others, as this position implies an obligation to care. Such an obligation is oppressive in part because it asks too much of people in circumstances where we often cannot realistically expect care to take root. Moreover, it has the highly counter-intuitive implication that a nurse is obligated to care for (not merely look after) someone who may be morally repellant. The oppression results because caring involves the personal investment of the self in the other's good, and this cannot reasonably be demanded in many situations especially when the other's beliefs or behaviour are morally abhorrent. Therefore, obligating a person to care in such circumstances can require the person to undergo a "self-betrayal", and result in the diminution of "one's self-respect" (Blustein 1991, p. 39; Benjamin 1990, p. 50). Additionally, Bubeck claims the "work" of looking after other's needs is "burdensome" work that "does not require the existence of an emotional bond" for the work to be done (1995, pp. 134-135, 140).[19]

Suggesting that caring is the essence or hallmark of ethical practice can be powerfully oppressive for nurses. Nurses often find themselves claiming to care, as a

requirement of nursing, when really this is not what they are experiencing. On the other hand, the significance of care in an ethic of nursing can be realized when it is stipulated that nurses need to be open to care and express this openness through their ethical presence with patients. When a nurse is not open to care, "critical reflection" is needed to ascertain whether the reasons for this lack of openness is morally excusable or whether there is a culpable reason, such as racial hatred (Blustein 1993, p. 295; Friedman 1993, p. 140).

Respect for Persons and Justice

A fundamental moral connection that is significantly different from the moral sense of care is respect for persons (Friedman 1993, p. 135-137). Such respect is based on the intrinsic connection of living together in a shared community and involves acknowledging that being a person is "valuable in itself" (Downie & Telfer 1970, p. 15; O'Hear 1981; Silberstein 1989, p. 128). Therefore, evincing respect for persons involves acknowledging that each person, including oneself, possess an inviolable worth that is to be respected (Downie & Telfer 1970, p. 15; Callan 1992, p. 434; O'Hear 1981, p. 119; Griffin 1983, p. 291). This means a person ought to be respected because of what is valuable in being human (Downie & Telfer 1970, p. 20). Additionally, Gaita explains how our moral sensitivity to see the other as

a person can be awakened by appreciating that someone has probably loved this person; it helps us to appreciate the person as someone "precious" and "irreplaceable" (1992, pp. 154, 156). But even if the person was never loved, the individual is a person that has an inviolable worth that is to be respected. Accordingly, Jameton claims respecting an individual involves treating each person in consideration of their "uniqueness" but also as intrinsically equal to every other person (1977, p. 40). Thus the attitude of respect does not mean we merely value the abstract property of personhood; in respect we cherish the person as a unique and irreplaceable individual.

Respecting the other as a person does not require admiring the person or accepting what ever the person has done or wants to do as their right (Downie & Telfer 1970, p. 57; O'Hear 1981, p. 129; Shain 1994, p. 119); its demand is that we see and act towards others as persons worthy of consideration even when they have done a tremendous moral wrong. Notice that this means respect may be forthcoming even when we find it psychologically impossible to care in the moral sense. Similarly in relationships too brief or perfunctory for any genuine personal investment in the other's good to crystallise, respect may still be demanded of us as an attitude that morality requires (Callan 1991, p. 437; Friedman 1993, p. 135; Knowlden 1990, p. 93).

The moral response of justice needs to be a central concept as living a good life is being able to trust others to be duly responsive to our needs through respecting us as individuals (Downie & Calman 1987, p. 56).[20] For example, the work of nursing often involves patients being highly dependent on the nurse, and so, patients need to be certain the nurse will try to meet the patient's "needs" (Griffin 1983, p. 290; Gaut 1983, p. 321). Moreover, a nurse's finite personal resources have to be distributed among many different needy patients. Therefore, nurses need to be enabled to make distributive decisions fairly, without the bias or favouritism that would be inevitable if caring was the only precept in the moral life of nurses, since nurses cannot conceivably care for everyone (Griffin 1983, p. 294).[21] Additionally, the appeal to respect persons and the impartial adjudication of interests becomes imperative when distributive decisions have to be made among those who are equally cared for.

Even if caring was possible in every relation, justice is also needed to prevent a person from living under the delusion that their worth is contingent on being cared for by another (Hoagland 1990, p. 111). A moral life worth living needs to acknowledge that no matter who the person is or what the person has done, personhood has a worth that commands our respect. However, since caring is not feasible in all relations, it would be a dangerous and fragile moral

life, for us all, if we only had a moral responsibility to act ethically toward those for whom we care. Therefore, a sense of justice is necessary in the moral life so that each person is enabled to see their intrinsic connection and corresponding moral obligation to themselves and each other (Callan 1992, p. 434; O'Hear 1981). A suitably nuanced conception of the virtue of justice will not deny the individuality of the person nor the relational connections that are part of our humanity, because conveying respect involves a sensitivity to the individuality of the other and the relational context of his or her life (Downie & Calman 1987; Pelligrino & Thomasma 1996; Sherwin 1996; O'Neill 1996; Shain 1994).

In conclusion, a moral life worth having is one that contains both justice and caring. In many relations, all that is needed for a person to fulfil moral requirements is respect for the other and openness to care. However, there are many situations in our lives when what we need is someone to make the personal connection of care that takes us from only being respected to also being included as especially significant in another person's life. On the other hand, no matter how intensely or unselfishly a person cares, caring cannot replace justice, since justice involves the interpersonal recognition of each person's inviolable worth and that recognition is not an essential characteristic of care.

An Integrated Ethic

I have proposed that justice and care are properly integrated into an ethic that has a distinctive place for each (See also Hoopfer 1996). This integrated conception is an alternative to theories that make either care or justice the sole ideal for ethical practice.[22] On my conception, justice and care are complementary rather than competitive elements in the moral life. Integrating justice and care in an ethic is conceptually possible and morally attractive, even though others contend the "paradigms are incompatible" (Benner 1990, p. 6; Katim 1995, p. 232).[23] I suggest the crucial link that enables the integration is the moral good as human flourishing. This means the care and justice worth having is directed toward the good of the other and will, at least in the ordinary course of events, conduce to the other's good without forgetting the self (Downie & Calman 1987, p. 58; Pelligrino & Thomasma 1996, p. 89; Deigh 1995, pp. 758-759).[24] Therefore, an accurate understanding of human flourishing is basic to ethical practice in any human relation[25], regardless of whether caring or justice is the operative virtue.[26] For example, without an understanding of the centrality of differing religious affiliations to human flourishing, we cannot respect persons in their religious differences. Similarity, without an understanding of the relation between loving attachments and the good, we cannot effectively care for others in bereavement.

I refer to the "ethical presence" of an individual, as expressing respect for persons and the openness to care, and I assume that both virtues are guided by an accurate understanding of human flourishing.[27] Both these attitudes involve having empathic regard that enables the individual to perceive the other's actual and potential vulnerability, suffering, and well-being (Dancy 1992, p. 451). This brings the third element of ethical presence into focus. The ethical presence of the individual is properly informed by an understanding of human good in general and the good of the particular human being one is dealing with.[28]

Effective ethical practice is enabled by combining ethical presence with relevant knowledge, skills, and abilities through "perceptive rationality".[29] I suggest perceptive rationality is a complex ability that comprises perceptive objectivity, rational reflection on prior moral experiences, as well as an alertness to morally relevant phenomena that morally "obtuse" persons will tend not to notice (Little 1995, p. 121; Tronto 1993, p. 129). For example, respect for persons and the openness to care intrinsic to ethical presence will involve a susceptibility to compassion that sensitizes the moral agent to experiences of suffering and vulnerability that others may not even notice.

Human Flourishing as the Objective Good

I concur with Hampton that a person's good can be discerned by objective moral criteria that are based on the idea of human flourishing (1993).[30] This view entails that human needs can be objectively distinguished from mere preferences or desires. Hampton, like Nussbaum (1988, 1990, 1995a, 1995b) and Wolf (1995), is not suggesting that we have any infallible basis for discerning human good. Her point is only that we often have good reason to interpret what constitutes flourishing of others in one way rather than another, and that these reasons are not reducible to the projections of desire or the conventions of society, culture, or religious ideologies.

Hampton has made a second significant contribution to moral theory through dividing needs into the categories of the universal and personal, and showing how both kinds of need are articulated in the moral life.[31] The universal needs are those all human beings have and are required for flourishing (Ibid., p. 148; Bubeck 1995, p. 132; Kolm 1996, pp. 321-322). The specific or "personal" needs are those each individual has that are required to enable the particular person to flourish (Ibid., p. 150). To a large degree, the personal needs are derived from the choices the person makes during the course of a personal life-span.[32] For example, my need for access to material in moral philosophy is rooted in choices I have made to pursue

particular interests that do not universally exist among human beings. The critical relation between these two kinds of needs is that the content of specific individual or personal needs cannot conflict with what is required to meet the person's universal flourishing needs (Ibid., p. 152). Moreover, personal needs will be justifiable in terms of considerations regarding universal human needs. Thus my need for access to material in moral philosophy is connected to the universal human need to develop my capabilities in ways I find meaningful.

There is resistance to the idea that ethical practice must be oriented to objective human need. In nursing, resistance is often based on the belief that attention to the universal results in the person being reduced to the status of object (Watson 1988; Gadow & Schroeder 1996). But subscribing to the importance of certain universal aspects of human flourishing does not negate the person's individuality or conduce to the person being treated as an object. The universal can be foundational, accompanied with each person having specific "functional requirements" that can be further individualized by each person making autonomous choices on how to meet functional requirements (Nussbaum 1988, p. 153; Wolf 1995, p. 108; Adler 1970).

The following example illustrates how an objectivist can be sensitive to a person's individuality. Consider that each person has the universal need for nourishment. Each

individual person has specific nutritional functional requirements that are based on the person's unique biological (genetically influenced) character. But as Wolf explains (1995), universal biological needs vastly under-determine the (dietary) choices an individual might make in pursuing his or her own good. For example, on religious or ethical grounds a person might choose to live the life of a vegetarian, and through this choice, particular personal needs are created. The vegetarian thus comes to have a personal need to meet functional nutrient requirements on a vegetarian diet, preferably with foods she or he likes to eat which are readily available in the particular environment in which the person lives.

Alternatively, using another example, it would not be morally acceptable to acquiesce to a woman's desire to have her baby delivered early for reasons of mere convenience. This is because the unnecessary early birth can inhibit both the woman's and fetus' universal needs. The need for a safe delivery outweighs the mere preference for delivery on a convenient date. Indulging the preference would be uncaring and unjust when the early delivery is contrary to the good, assuming that parenthood involves a basic commitment to the mother's and fetus' good and the woman's desire is based on a misunderstanding of the hazards of early deliveries.[33] What determines if a response is caring or just, in the morally relevant sense, is partly whether the response

corresponds with a rationally defensible understanding of the good. This means that for a desire or preference to be a virtuous choice, it must be a choice that is in accord with the person's good (Bishop & Scudder 1996, pp. 92-97).

These simple examples illustrate how universal needs, particular needs and the exercise of choice all interact in a credible conception of human flourishing. Therefore, a blanket repudiation of universality blinds critics to this point. Moreover, blanket repudiation leaves the concept of the good open to subjectivist or relativist interpretations. For example, subjectivism and relativism provide no credible response to the mother who thinks a dangerous early delivery is good for her simply on grounds of convenience. Situating justice and caring within the context of an objectivist interpretation of the good is needed to ensure human flourishing and to prevent justice and caring being corrupted by the unscrutinized influences of socialization and group pressures (Carse & Nelson 1996, p. 20).

Autonomy as a Constituent of Human Flourishing

Another source of scepticism about objectivist interpretations of the good is the idea that they cannot support the importance of autonomy in human life. I contend that this is mistaken. An objectivist theory can acknowledge the importance of autonomy in the individual interpretation of universal and personal needs and also in

the creation of personal needs through the autonomous choice of personal roles and projects.

Davis implies autonomy only applies to those individuals capable of determining and carrying out a life-plan (1990, p. 27). Griffin claims a patient "relinquishes" his or her autonomy by "becoming a patient" (1983, p. 291). But even when an individual lacks the capacity to determine and carry out a life-plan, the potential for autonomy is something we still can and should strive to realize as a constituent of the individual's good, especially by those living in a liberal democratic society where human flourishing must depend in large measure on individual choice (Downie & Telfer 1970, p. 15; Thomasma 1995).

There is no doubt that each person has varied capacities for being autonomous and exercising individual autonomy. But facilitating a person's autonomous development empowers the person to flourish by meeting his or her own particular needs within the limitations of the person's abilities and opportunities (Downie & Telfer, 1970, p. 15). Even if a person's capacity for autonomy is very limited or difficult to estimate, all people need to respond to the other, and on behalf of the other, in a manner that acknowledges and nurtures the capacity for autonomy (Thomasma 1995, p. 18; Rose 1995, p. 157). This means that choices made for the present should not "close off or impair" the potential for developing the other's

capabilities for autonomy in future situations (Wolf 1995, p. 111). This distinction is useful for helping guide our interactions with children, with unconscious patients, and with any person who is somehow impaired from being capable of making autonomous choices (Penticuff 1990).

A richer conception of autonomy than that provided by Davis (1990) is Archard's position that "autonomy is the ability of an individual to rationally and critically reflect upon their character and situation, and to make choices in light of this reflection" (1992, p. 161). For the reflection to be morally complete, it must be guided by a commitment to live a flourishing life in mutual respect with others.[34] This explains why a person is not morally entitled to act on choices or demand actions from others that are against the person's good. Such actions cannot be justified on the basis of autonomy when its moral context is rightly understood. Some "cries for rights" may be a demand for personal preferences that are not consistent with the person's good (Benjamin 1990, pp. 12-20; O'Neill 1992, p. 221; Curtin 1979, p. 3; Noddings 1990b, pp. 29-30). Nevertheless, the importance of autonomy in the context of a plausible objectivist account of the good does explain why we must take the desires of others very seriously if we are to treat them with respect. For if self-chosen projects create particular human needs to which moral agents must be sensitive, it will typically be only through dialogue with

others that their good can be discerned. Moreover, the necessary dialogue will have to be a discourse in which the other's preferences are carefully considered, though not indiscriminately indulged.

The objectivist understanding of autonomy also does not entail that unfettered paternalism is an acceptable moral practice. Paternalism is coercive intervention in others' lives with the purpose of "making people do what is good for them or [to] prevent people from doing what is bad for them" (Jameton, 1984, p. 90). The problematic aspect of paternalism is the coercive way people can be treated. When autonomy is situated as necessary in the good life, a well-meaning person will often have to inhibit the desire to control another's life-plan. Actions required to meet another's particular needs may be different from what a person considers is the right thing to do. On the other hand, the benevolent other's perspective can rarely be authoritative regarding the individual's good because that good depends on idiosyncrasies of perspective in the interpretation of universal needs and the importance of individual choice in the construction of personal needs. For example, a benevolent dietician cannot unilaterally decide what is "good" for someone to eat since this depends in large part on individual taste and ethical or religious choices (e.g., vegetarianism or Kosher diets) that the dietician cannot dictate. Respect for persons and caring,

which both involve promoting autonomy, as an aspects of the other's good can prevent moral agents from resorting to paternalism in all but the most extreme cases.

An individual's specific flourishing is based on a complex, unique interrelation of universal and personal needs. To act in a way that is duly responsive to these considerations will tend to restrain paternalistic intervention. Consider the patient who wants to be alert and clear-headed to meet a very special friend who is coming to visit. The nurse knows that adequate analgesics assist the tolerance of severe pain, that many people experience a lack of cognitive and verbal acuity with large doses of analgesics, and that this patient is willing to endure some pain in order to be alert and visit with a friend. On the basis of that knowledge, the nurse acknowledges there is some risk to the patient's flourishing but not an "unreasonable risk", and hence, paternalistically insisting on a high level of medication would be wrong. On the other hand, it would be wise to advise the patient that it might be necessary to change her mind and take analgesics, if during the visit the pain becomes unbearable.[35] In short, the morally responsive nurse adjusts the nursing and medical therapeutics in light of the patient's needs but defers to the patient's autonomous judgment about her own good, even if the nurse has some misgivings about that judgment.[36]

But it is crucial in these circumstances that the moral agent not only act rightly, whether the motivation is respect, care, or both, but also that she understands how that action is to be defended in the light of an objective understanding of the patient's good. Nurses will experience psychological dissonance when reprimanded by an employer or another professional for not giving "adequate analgesic". The nurses might then consider that they have made a mistake in their judgement, and be disposed toward a more paternalistic response on future occasions. On the other hand, nurses are enabled to support their responsiveness as ethically appropriate when they have a developed "moral understanding" of the context of ethical practice (Gaita 1991, p. 145). Nurses are then able to awaken others to see that acting paternalistically negates the patient as a particular, unique individual and is a moral insult to the patient. Having a developed moral understanding helps nurses decrease the incidence of both patients and nurses being morally abused. Moral understanding, even for people in socially subordinate roles, can be a form of power that countervails wrongdoing.

If we accept that morality places constraints on what we can legitimately choose to do, then we are acknowledging there are some objective boundaries in the moral life. And so, whether we like it or not, all individuals have a responsibility to ensure their responses and the responses

of others are based on a defensible understanding of the good and the right.

Conclusion

An ethic based exclusively either on caring or justice embodies an incomplete understanding of morality. The proposed integration of both justice and caring acknowledges the separateness and essential importance of each concept for enabling a full ethical life. Caring is not needed to make justice more humane; its value is rather to recognize the personal closeness or solidarity in another's good that is a significant part of our moral lives. Similarly, justice is not a substitute for caring; justice affirms our belief that people have a dignity that commands our respect, whether we care for them or not.

I contend that integrating caring and justice, within the context of an objective reading of human good is the proper basis of "ethical practice" in nursing as in other social roles. Some scholars support an alternative to the objective good, and claim a subjectivist or relativist interpretation as appropriate in the moral life. I have shown that the grounds for this view are unconvincing.

Notes

1. See Gilligan, C. (1982). *In A Different Voice*. Cambridge: Harvard University Press; and Noddings, N. (1984). *Caring*. Berkeley: University of California Press. Gilligan has not claimed the moral concept of care is sufficient to replace the concept of justice or that care needs to be central, as a foundational moral concept, in the moral life. Alternatively, Noddings claims justice has a place in the moral life, however, she has not explicitly acknowledged the importance of justice in the moral life in her "ethic of care".

2. Madeleine Leininger claims caring is the essence of nursing (1981, 1984). Fry claims care is a central concept for nursing ethics (1989a, 1989b). Watson (1988) and Gadow (1980) have proposed that an ethic for nursing needs to be based on the philosophy of care. Kuhse claims the idea that caring is sufficient for guiding nursing practice "has been conveyed to nurses" in Australia by their Nursing Federation (1993, p. 32). Curzer claims even if care is accepted as "a way of being" in the moral life it does not necessarily follow that care has to be "central" in the moral life (1993a, p. 176). Cooper claims that caring palliates the impartial nature of a sense of justice (1990). However, she claims an ethic for nursing needs to include caring and justice in a way that counters dichotomous thinking about these moral concepts. Benner & Wrubel claim justice is remedial to caring (1989). That is to say, the virtue of justice is needed when we need some more remedy for the limitations of care as a moral ideal. Davis previously argued against a rights-based ethic being sufficient for nursing (1985). However, her arguments were based on a flawed conception of justice and individualism. More recently, Davis supports the inclusion of both justice and care in an ethic for nursing (1990, 1997), as does Kelly (1990), Kuhse (1995) and Gallagher (1995), however, the scholars do not provide insight into how they envision the integration of these two moral concepts.

3. Morse et al. identified seven different ways the concept of care was used in the nursing literature (1990). Curzer claims the word "care" is used ambiguously in nursing (1993a, p. 174).

4. This can be supported by taking almost any nursing journal article or textbook and seeing how care is frequently used in making reference to any action done by nurses.

5. Davis claims there is a more deeply ethical sense of caring than the "notions of caring" that are commonly expressed in

nursing (1990, p. 31). Curzer claims the use of the word care in nursing is often in reference to "taking care of patients" (1993a, pp. 174-175).

6. Bubeck defines care as "an activity" directed to meeting the needs of others which they cannot meet themselves (1995, p. 129). Bubeck makes a valuable contribution by providing a framework for understanding the burdensome aspects of women's work (Ibid., pp. 127-174). She explains how expecting women to do the work of meeting the needs of dependent others is a social injustice and exploits women, especially since this work is necessary in society, and yet, is not well-paid or not paid at all - ie. women looking after children or the elderly. Though Bubeck's uses a limited sense of the word care, she admits that defining care as an activity is merely a "functional definition" and that in "real life" caring is the expression of "emotional bonds" (Ibid., p. 135).

7. Nursing is commonly referred to as a "caring" profession or practice (Curzer 1993a, p. 174; Boyer & Nelson 1991, p. 158; Benner 1994b, p. 6; Benner & Gordon 1996).

8. Nursing is described as involving "caregiving" (Benner 1994a, p. 43; Leininger 1981, p. 7). Bubeck claims "women's work" involves taking care of others and so any relation that involves meeting the "dependency" needs of others can be classified as including caretaking (1995, pp. 127-185; See also Noddings 1984, p. 9; and 1990, p. 125).

9. I argue the care connection is formed when something or someone is valued in a specific way. Therefore, a person can care for the self when the self is valued without this necessarily involving selfishness. Additionally, a person can care for an object or other living things that are not human.

10. I concur with Tronto that "fragmented conceptions of care" exist and operate to obscure a full understanding of the moral significance of the word (1993, p. 101).

11. A researcher suggests the following indicates that the nurse is caring: "[As] I was following all the physicians' orders, my mind was just despising what I was doing. I don't want to be like this when something happens to me. I told my head nurse but it was just another story. After that I just buried it in the back of my mind" (Gaul 1995, p. 48). This may be an example of emotions that signify a caring inclination. But it cannot be an instance of effective caring because by the nurse's own admission, the nurse complied with the physician's direction to act in a way that was deemed uncaring by the nurse.

12. My delineation of care as a moral connection and caring as a mode of moral responsiveness is not dissimilar to care being referred to as a "mode of thought" (Gilligan 1982, p. 2; Noddings 1984, p. 6), or to care as a "mode of response" (Gilligan 1982, p. 53), or caring as a "moral orientation" (Noddings 1992b, p. 16). Bubeck alludes to caring being a form of moral responsiveness (1995), while in her work a functional definition of care is used. Alternatively, Shogan refers to care as moral motivation (1988). My position on moral motivation is that moral sensitivity to the other as a person whose good is especially important to me enables the moral responsiveness of caring. My understanding of the relationship between the moral concept of care and moral motivation is similar to O'Hear's (1981).

13. It is not uncommon for nurses to come to care for physicians during their associations with each other. This can result in nurses acting in "caring ways" with patients, even though the patient's good is not morally motivating for the nurse. In other words, the nurse does experience caring, but it is a caring for the physician.

14. Griffin claims a nurse sees "a human being at his most vulnerable, where appearances and descriptions no longer mask personality, and where everything most valuable - life or whatever makes it most meaningful, is being risked" (1983, p. 293).

15. Viewing caring as innate and necessary for human existence is also supported throughout Madeleine Leininger's writings on caring in nursing (1981, 1984, 1986, 1990).

16. Noddings also claims it is unrealistic to care for everyone (1984, pp. 18, 86). However, she makes the additional claim that a person is to act as if they care when caring is not experienced by the moral agent (p. 38).

17. My position is similar to Noddings's claim that we can maintain a readiness to care for others, however, this "state of readiness" is different than caring (1984, p. 18).

18. Similarly, Curzer claims caring tends to increase the moral agent's "attentiveness and conscientiousness", which, in turn, tends to benefit the other (1993a, p. 177).

19. Bubeck claims being expected to always be other-directed in meeting the needs of others can result in the person feeling like a "servant or slave" and not having a life of one's own, especially when the person is expected to be "selfless", which she claims has been a socialization pattern for women in many societies (1995, pp. 150-151).

20. Similarly, Friedman and Calhoun claim all people, intimate and strangers, deserve respect, and that people to whom we are committed to in a deeper way deserve more (1993, pp. 135-137; 1988, p. 40 respectively).

21. Nurses have reported that caring for patients results in an emotional closeness that tends to impede the nurse in the social role of nursing (Kahn & Stevens 1988, p. 206: Benner & Wrubel 1989, p. 391).

22. The main difference between this approach and Dillon's views is care and respect remain as two separate concepts rather than being combined to form the concept of "carerespect" (1992). The difference between the integrated approach and Curzer's views is that Curzer only supports nurses being open to care but not coming to care for patients (1993b, p. 55).

23. Some may argue the concepts are competitive since moral agents will experience moral dilemmas stemming from having to allocate resources between those to whom one cares and to those whom a connection of care does not exist. However, it is not the moral concepts that are the cause of moral dilemmas, rather, being a moral person in a less than ideal world is a substantial cause of not being able to meet all the needs of the self and others.

24. I agree with the claim that a sufficient moral foundation for nursing must emphasize that a nurse's commitment to the self is "altogether compatible" with the commitment to other's (Packard & Ferrara 1988, p. 69).

25. Jameton claims "nursing competence finds its rationale in its effect on patients" (1984, p. 89).

26. The divisions of labor in society has created occupation groups that have developed specialization abilities in meeting the needs of others, in this way, nursing responses in meeting the needs of patients will be different than parental responses. However, parents and nurses can both engage in the same moral responsiveness - ie. justice and an openness to care or justice and caring.

27. Benner claims nurses must have "ethical comportment" which she defines as the "embodied, skilled know-how of relating to others in ways that are respectful and support their concerns" (1991, p. 2). Ethical comportment is similar to what I refer to as having ethical presence in performing ethical practice. However, the ethical practice I support is based on an objectivist moral context as the nurse's ethical responsiveness is directed toward promoting an accurate

understanding of the other's good. Alternatively, "ethical comportment" is guided by the subjectivist context of the patient's "concerns" which it is claimed a nurse is to respect and support (Ibid.).

28. Gaut holds that a moral awareness requires an attention on the other and on the self (1983, p. 318). See also Nussbaum (1995a, p. 109) and O'Hear (1981).

29. I have adopted Noddings's term of perceptive rationality as the best description of the intellectual perceptive reasoning process that is involved in enabling ethical practice (Noddings 1984, p. 171). However, I do not accept her conception of perceptive rationality, as she suggests that caring is "essentially nonrational" which limits her conception of caring to being a responsiveness that stems from "natural inclination" and a subjective moral context (Ibid., p. 25). Rather, my conception holds that perception and rationality must be continuously combined for ethical practice to occur which is similar to the views of Griffin (1983, p. 292); Blum (1994); and Vetlesen (1994). Similarly, Tronto claims ethical practice in the form of "practical rationality" occurs through the culmination of "thought and action" (1993, p. 108). While I partially agree with Tronto, she does not sufficiently address the importance of ethical presence in ethical practice. In addition, she does not situate ethical practice within an explicit objectivist context.

30. Martha Nussbaum also holds that "a full account of the human good and human functioning must precede and ground" moral concepts rather than leaving choice open to mere subjectivism (1988, p. 150). She has extended the development of her ideas to social policy development in her article: *Aristotelian social democracy* (in Douglass, G.M. & Richardson, H. 1990, pp. 203-252).

31. The categorization of needs has been a long standing tradition and while there are variations to what belongs in each category, there are also striking similarities. See Nussbaum (1988, p. 48); Nussbaum (1990, 1995a, 1995b); Johnston (1994, p. 161); Rawls (1971, pp. 433-439); Bubeck 1995, p. 132). Numerous other scholarly works have discussed basic human needs - e.g., Erik Erickson and Abraham Maslow. However, many objectivist accounts of human need are vulnerable to the objection that they do not sufficiently respect the individuality of human beings. On the other hand, Nussbaum suggests that a more appropriate approach would be to protect and support the general capacities that enable people to autonomously meet their own needs (1988, 1995a). In this way, people are enabled to choose and live a life that is

individualized, and what Johnston calls a more meaningful life (1994).

32. This pertains to the fact that what each person values and the emphasis they accord to certain aspects of human flourishing will remain irreducibly plural. Benjamin claims ethical theory will need to be based on a broad "pragmatic conception of ethical knowledge and reasoning tempered by an emphasis on moral integrity, critical reflection, and comparatively firm but limited principles of overall welfare and equal respect" (1990, p. 76).

33. There will be circumstances when early delivery is morally justifiable because it is necessary for the woman and the fetus to flourish.

34. Like many other scholars, I do not believe there is such a thing as unsituated autonomous choice. This is because how we have developed is influenced by genetic endowments that are beyond choice and we have also been influenced by socialization before we were able to reflect and consider the ramifications of the socialization practices. However, this does not mean that in the moral life actions should not be taken to enable each person to develop abilities to exercise his or her own capacity for autonomy by reflecting on who the person is, how the person came to be who they are, and if how the person is now enables the person to live a flourishing life. A developed capacity for autonomy can enable the person "to shape at least some part of our world in ways that will give our lives meaning" (Johnston 1994, p. 138). Socialization practices can oppress the individual and autonomy provides an important bulwark against that oppression. This position on autonomy has been largely drawn from experience and from the ideas presented in David Milligan & William Watts Millers (Eds.) (1992). Liberalism, citizenship, and autonomy. Aldershot: Avebury.

35. Feinberg suggests that interference in a person's decision can be initially justifiable if the decision involves an unreasonable risk to the person (1973). However, if on reflection and full consideration, the person decides taking this unreasonable risk is the best option, then the previous interference must be withdrawn (Ibid., pp. 47-50).

36. Benjamin claims being respectful of the other's legitimate point of view can enable compromise to occur that enables people to make the best of what either or both parties may "regard as a bad situation" (1990, p. 7).

Chapter III

NODDINGS'S ETHIC OF CARE AND NURSING

Nel Noddings could be called a visionary for her unwavering determination to have the concept of care achieve a prominent place in ethics. She has been successful in her quest, as many scholars now acknowledge the importance of caring in the moral life. Noddings's ethical theory has been influential among nursing scholars, although it has provoked some criticism in the nursing literature as well (e.g., Crowley 1994; Bishop & Scudder 1996, pp. 49-65; Fry 1989, p. 84; Johnson 1993, p. 308; Nelson 1992; Kuhse 1993, 1995; Curzer 1993; MacDonald 1993; Olsen 1992; Schultz & Schultz 1990; Pask 1991). What follows is a critique of Noddings's ethic that focuses mainly, though not exclusively on nursing.

The critique of Noddings's version of an ethic of care is presented in three parts. First, Noddings's conception is criticised for its latent ethical subjectivism. This undermines the conception's usefulness in calling into question established practices in nursing and helping nurses to resist oppression and exploitation. Second, the role of justice in Noddings's ethic is not explicitly and adequately developed. Third, Noddings's emphasis on so-called natural caring as the primary moral virtue imposes an unrealistic and inherently oppressive ideal on nurses.[1]

Noddings's Conception of Care

For Noddings, caring comprises "twin" sentiments -- natural and ethical caring (1984, pp. 79, 80). Both sentiments constitute the "active virtue" of morality. Natural caring is conceived as comprising an "innate need to care and be cared-for" that is "latent" in everyone and becomes activated by experiencing caring through relations with others. Natural caring is most often initiated through being cared for by a parent and becomes developed through successive caring relations. Natural caring is experienced as, "I must and I want to" do something for the other. The most intimate situations of caring are those that involve natural caring (Ibid., pp. 5, 79, 80, 83; 1992a, p. xi).[2]

The person's ethical ideal is developed from two sources: a "longing to maintain, recapture, or enhance the most caring tender moments" and from "the natural sympathy human beings feel for each other". An "impassioned and realistic commitment" to "openness" is also required since both sentiments can be "denied". Therefore, the ethical ideal is constituted by the person's "best pictures of caring". It does not comprise hoped for or idealized visions of caring, as this leads the person into "abstraction" and the "hypothetical" rather than the "attainable". Noddings assumes that responses stemming from natural caring are morally laudable, and do not need to be subjected to critical reflection unless the cared-for

challenges them. Natural caring is claimed to occur from "feeling directly for the other" and it is the "enabling" sentiment for ethical caring. Since natural caring arises only occasionally and is not always sustained in peoples lives, the second sentiment of ethical caring becomes necessary (1984, pp. 37, 79-81, 100, 104, 109; 1992a, p. 110). Effective caring for Noddings means there must be more than an attitude of caring, the caring must be "completed in the cared-for" (1984, p.11).

Ethical caring is experienced when caring does not come naturally or when a person experiences the initial feeling of "I must" with an accompanying "I do not want to".[3] Ethical caring is summoned by the self because of "a longing" to recapture the feelings of previous caring experiences and from "a commitment" to create and sustain caring relation, and so, it is qualitatively different from natural caring. Ethical caring occurs by virtue of the belief that caring is the "superior" way of being in relation with others (1988, p. 219). This means that when spontaneous, natural caring is difficult or impossible for us, the ethical ideal of caring still has "categorical" force (1984, pp. 9-10, 79-83, 86).

The ethical self is summoned by asking: "How will I feel about myself if I do not respond as one-caring"? It is claimed the person would answer: "I would not feel good about myself", as the person's ethical ideal is that of

being "caring" when in relation with others. And so, by reflecting on the ethical ideal the person experiences an "obligation" to, at least, meet the other as "one-caring". This is accomplished through displaying an "attitude of caring" and being in "a state of readiness to care". To do otherwise, would diminish the person's view of the ethical self. The person sets aside feelings of, and excuses for, not wanting to care and attends to the "reality" of the other being a person with needs. The carer's ethical self comprises the self as one-caring and the self as cared-for. Upon reflection on the ethical ideal, the carer changes the "I do not want to" with "I ought to". For Noddings, the moral end or good of caring is the creation and maintenance of caring relation, and ethical caring is necessary to that end (Ibid., pp. 17, 49, 80-89, 94, 100-102; 1992, p. xi).

I concur with Noddings that caring is based on an intense personal connection with the other that involves the one-caring experiencing feelings and emotions that are directed toward the other's good. I also agree with Noddings that there is a substantial "talk of care" that tends to value "caretaking actions" rather than caring (1984, p. 127), and that we need to differentiate between the "perfunctory care" of looking after someone and the moral sense of care (Ibid., p. 9, 12-13, 26). However, Noddings's support of caring being "directed toward the welfare, protection, or enhancement of the cared-for" is

based on subjective experiences (Ibid., p. 23) that may only result in responses being done in the "name of caring" rather than being anything that accords with the moral sense of care as outlined in Chapter 2. This means, an ethic based on natural caring allows for an unscrutinized subjective view of the other's good that may not in fact be defensible (Card 1990, p. 106; Friedman 1993, p. 152). Therefore, responses guided by natural caring can be corrupt and oppressive, for even if caring is an innate need, the reality is that human consciousness is largely socially developed and socially developed beliefs about the good may be damagingly wrong.[4] Clearly, the interaction between social influences and the innate needs to care and be cared for does not guarantee development of a moral consciousness that will result in morally laudable caring responses toward the self or others (Blustein 1991, p. 40; Puka 1990, p. 74; Puka 1991, p. 200). Therefore, when an objective account of the human good is lacking, "pathological caring" can become accepted as the moral norm.

The second significant limitation in Noddings's ethic of care is the underdeveloped sense of justice. Noddings acknowledges that justice is likely needed in an ethic, yet, by her own admission, its role in her ethic remains undeveloped (1990a, p. 122; 1990b, p. 28; Noddings 1984, pp. 5, 8, 26, 56, 92, 176). On the other hand, Bubeck provides a lucid argument supporting her claim that circumstances of

justice are implicit in Noddings's ethic, since life situations require carers to make decisions regarding how to distribute their caring between those cared-for (1995, pp. 199-208). Bubeck's critique supports the claim that an ethic cannot be solely based on care, as by necessity, justice plays a complementary function to care in the moral life.[5] Similarly, I argue in the next section that justice is foundational to Noddings's overall theory because of the role she assigns to ethical caring. Nevertheless, I argue that Noddings's depiction of ethical caring provides a less satisfactory interpretation of justice as a virtue than the interpretation canvassed in Chapter 2.

The lack of an objective context for caring and Noddings's exclusion of justice in her ethic are two systemic problems that I now address.

The Subjective Conception of Caring

Natural inclination is an inadequate foundation for morality because even if we could be sure that such inclination is morally wholesome, its content will inevitably be subject to profound social influence, and we can have no guarantee that the influence will not be corrupting. Noddings does not acknowledge this, though she does concede that it is unrealistic to think people will be able to sustain natural caring in all relationships and encounters (1984, pp. 80-82). Thus, she agrees that her position that morality can

be based on the natural inclination to care is severely weakened, and yet, she claims this does not mean the basis is "destroyed" (Ibid., p. 130). Rather, Noddings claims when people do not respond from natural caring their caring responses will involve rational deliberation in the form of reflecting on subjective "best pictures" of caring (Ibid., p. 80). In this way, even though Noddings claims rationality will be necessary for ethical practice (Ibid., pp. 35-36), the subjective basis of rationality she provides is too sparse.

It is Noddings's claim that what we "inevitably identify as good" is that which we have experienced and "been dependent upon for our continued existence" (1984, p. 49). Alternatively, I argue while what we have experienced and have been dependent upon for our continued existence may be what we tend to identify as the good, this does not mean it is morally sufficient (Blustein 1991, pp. 28-30). Rather, it might only be all that we can hope to expect from living in a society that has systematically oppressed us (Houston 1990, p. 116). For example, women who grew up in harshly patriarchal societies are apt to have "best pictures" of caring that are infected with their society's rampant sexism. All that Noddings can justifiably claim is that responses coming from natural inclination <u>might be</u> morally laudable, but are not necessarily so.

Moreover, even if the best picture of care that underpins someone's moral responsiveness is commendable in light of objective criteria of human good, the picture will not necessarily capture the sensitivity to the context that enabled the actual response to occur. This can result in people coming to assume certain actions are "caring" regardless of the circumstances or the situation, and thereby over-generalizing a moral response beyond its proper boundaries. For example, helping an elderly person is often referred to as "caring", even when the elderly person prefers independence. The elderly person often tolerates the other's interference and deems the other as "having a good heart", even though he is a bit pushy and insensitive. The individual who exhibits this intrusive behaviour may be over-generalizing a best picture of caring drawn from his own childhood or previous experiences. The dangers of moral over-generalization in nursing are obvious, and Noddings's conception of care does little to contain them.

Noddings does offer some criteria for delineating what is to count as morally laudable care. But the three criteria do little to blunt the subjectivist thrust of her theory. The first two criteria are very weak. These are the needs to create and maintain the "caring" relation and assist the "cared-for" achieve his or her personal projects (Noddings 1984, pp. 24, 74, 132; 1992a, p. 21). The third criterion -- that caring responses conduce to happiness and

joy -- is more robust, but is still too crude a basis for identifying morally laudable caring (Noddings (1984, pp. 6, 24, 37, 59, 74, 132-147). I shall examine these criteria in turn. My basic claim is that care in the moral sense, which I outlined in Chapter 2, only sometimes warrants the creation and maintenance of caring relations and assisting others in their projects. Noddings provides no adequate direction about how we are to distinguish circumstances in which such responses are warranted from circumstances in which they are not (Bubeck 1995).

The plausibility of Noddings's first criterion derives from the fact that relations of mutual affection and intimacy are a vital human good, and therefore, maintaining such relations is often morally laudable. But even then, the moral quality of caring responses given and received is critical, and any rationally defensible ethic must connect that quality to objective criteria of good and justice of a kind that Noddings does not supply. For example, in some relations a natural inclination to care does exist. Yet, the responses that come from the natural inclination or a subjective ideal can be self-protective, suffocating, and controlling toward the other (Hampton 1993, p. 149). A parent may "care" intensely for a child, but only as an extension of the parent's <u>own</u> good. This means the care connection, in the moral sense of care, has not been formed since the necessary personal investment in the child's good

has not developed. Moreover, even when parental attachment is genuinely altruistic, it may still be marred by a defective understanding of what would conduce to, or militate against, the child's good. In both of these cases the desire to create and maintain a connection of care is insufficient to secure caring in the moral sense - ie., caring of a sort that we could reasonably commend as an authentic moral virtue.

Moreover, although the imperative to maintain caring relations may be typically compelling in some contexts, such as parenthood, it is often much weaker elsewhere in our lives. The morally responsible nurse may well be open to coming to care for patients, but she or he surely has no obligation to maintain relations indefinitely when the nurse has come to care for a patient. It may be that demanding people maintain caring in a relation in which caring has been experienced is Noddings's way of sensitizing people to each other, and is her attempt to help them come to see the harm that can result from not seeing the self and other as connected in any significant way. However, there are better ways to guide this kind of moral development and reflective understanding than demanding the preservation of caring. For example, regardless of whether a person was to sever or change a relation in a morally sensitive or harmful way, each party in the relation needs to reflect on the situation for gaining moral understanding about the self, the other,

and the demands of morality (Calhoun 1988, pp. 454-455). This reflection can enable the person to engage in the appropriate personal moral work needed to advance continual self-development. A person may wish things could have been different. Yet, on reflection, come to see that at that certain point in time an established caring relation could not be continued in a way that would preserve self-respect and legitimate self-interest, while also attending to the other's good (Tronto, 1987, pp. 660-661; Udovicki 1993, p. 57).[6]

The second criterion stipulates that caring requires the carer to assist others have their "wants and desires" satisfied (Noddings 1984, pp. 24, 72, 81). However, a person's wants and desires can be morally abhorrent. That possibility is obscured by the second criterion which requires an unqualified trust in the other's judgment regarding his or her good.[7] Here again, Noddings's argument does reflect an important truth - viz., that trust is central to caring occurring in a relation (Ibid., p. 65). But we still need Annette Baier's distinction between "appropriate trust" and "proper distrust" (1985) if we are to avoid a so-called "care" that merely assists the other in acting against the good (Houston 1989, p. 96; Friedman 1993, p. 155; Carse 1996, p. 105). The ethic leaves the moral agent in a moral quandary between making the other happy by satisfying their desires and wishes versus engaging in

actions the carer rightly deems to be in the other's best interests.

Noddings does evince some intermittent awareness of this problem. At one point, she suggests that the carer need not indulge the other's wants if the carer believes that this would be contrary to the other's best interests (1984, pp. 24, 72, 81; 1992b, pp. 15, 17). But without an objectivist understanding of the good, this merely compounds the problem. For unless caring that frustrates the other's wants can be justified in terms of a rationally defensible account of the good, it is merely an arbitrary preference for the carer's wants over the other's wants.

The third criterion Noddings stipulates is that the caring response conduces to happiness and joy. Unfortunately, the subjective state of happiness may coincide with relations of subordination and oppression (Fromm 1947, p. 15; Bubeck 1995, p. 153), and may even help to conceal them.[8] A "caring" that conduces to happiness in these particular circumstances could not count as caring in the moral sense.

Some might object to my position that Noddings's ethic lacks objective criteria of the good. They might argue the appeal to the value of "natural caring" suggests some foundation in human nature exists that takes Noddings's "caring" beyond subjective or societal distortions. However, Noddings provides no criteria for discerning such a

foundation nor does she offer any argument for supposing that what is natural, however it is discerned, is also morally laudable. This is a fatal defect for her ethic of care.

A recurrent focus, in critiques of Noddings's philosophy, is the significance of the universal in ethics (Card 1990, p. 101). My argument for situating caring within the context of an objective conception of the good can be considered as supporting an ethic based on a universal rather than a subjective moral boundary. Noddings's rejection of the universal is based on her assumption that a universal ethic must be governed by highly general moral principles which are elevated above the value of persons and blind us to the particularity of moral situations (1984, pp. 16, 33, 56-57, 107; 1990a, p. 121; 1990b, p. 28). However, as I have argued in Chapter 2, universal ethical considerations may be grounded in the good for human beings and may require, and not merely permit, close attention to the particularity of individual lives and relations.

The irony of Noddings's attack on the universal is that she claims the caring attitude is "universal" (1984, pp. 5, 28, 92; 1990b, p. 30). She contends people have universal access to caring memories and that a person is to be open to caring by meeting others as one-caring (1984, pp. 85, 104, 130; 1992a, p. xi). Another place where the universal

exists in her theory is in "ethical caring", which involves the dual universal responsibilities to meet the other as one-caring and to acknowledge the other as a person. And so, by her own admission, Noddings has not totally rejected the universal, although, only a sparse conception of universality is represented in her ethic (1984, p. 5; 1990b, p. 30).

Justice in Noddings's Ethic

Noddings claims that at the very least "ethical caring" is necessary for a person to be deemed moral (1984, pp. 75, 80-84). She acknowledges that a person may lack the natural inclination to care in circumstances where we still have moral responsibilities to others. Therefore, Noddings has enlisted the category of "ethical caring" to capture the virtue we need for these circumstances.

I argue Noddings's conception of "ethical caring" is tantamount to a conception of justice. For example, Noddings's claims that summoning "ethical caring" requires seeing the other as a person who has needs (Ibid., p. 84) and that the ethical self "is born of a fundamental relatedness" that influences caring for others (Ibid., pp. 49, 51, 56) through seeing the other's reality as being possible for the self (Ibid., p. 15). She also claims an educator's caring relation with students starts from a "position of respect" (Ibid., p. 176). In addition,

Noddings suggests that even when a moral agent does not care naturally they still engage in actions that are in "behalf of the cared-for" (Ibid., p. 38) out of "regard" for others (Ibid., p. 52). Noddings also assumes that in giving ethical care the moral agent remains open to the possible occurrence of natural care in dealing with the other (Ibid., pp. 38, 84, 92, 105).[9] Thus when ethical caring is engaged, the moral agent's motivating thoughts roughly take the following shape: "Somebody should do something to help this person. However, I don't want to do anything. But I ought to do something. After all, this is a person who has needs, and I should try to meet them regardless of how I feel about this person." Such thoughts are supposed to occur alongside the background belief that natural caring enriches our lives and those of others, and hence, we should be open to experiencing it. Of course, these thoughts need not occur explicitly to the moral agent; they merely indicate the general context of moral conviction within which ethical caring is exercised.

Ethical caring as I have just delineated it is substantially a conception of justice, even though that is not how she explicitly presents it. That is so because it embodies the idea that others have a worth that properly evokes our concern and respect regardless of whether we feel inclined to further their good. Moreover, Noddings also builds the value of openness to natural caring into her

ethical ideal (1984, pp. 17-18, 104). This creates some obvious similarities between her ethic of care and the integrated conception of justice and care I outlined in Chapter 2. But the important difference that remains is that Noddings's understanding of care is cut adrift from any objectivist account of the good, and because of that, her theory cannot reliably expose the injustice of practices that deny people the goods to which they are entitled.

An example of this particular problem in Noddings's theory is her disregard of the good of self-concern. The insistent emphasis in her ethic on caring as other-directed exposes the carer to abuse by others. The problem is exacerbated by the fact that Noddings does not hold the cared-for as having any moral responsibility to the carer (Ibid., pp. 24, 70-74, 121). Since people who lack self-respect may be socialized to accept this lack, their plight can only be exposed as an injustice if we insist that self-concern is a good that a just society must honour regardless of whether members of the society acknowledge its importance or not.

Some scholars have claimed that caring for the self should be a major moral concern in any morally defensible conception of care (Friedman 1993, p. 159; Hoagland 1990, p. 111). I agree. Noddings does concede that there is a "caring" for the self in her ethic. This allegedly occurs with reaching out and caring for the other (Noddings 1984,

pp. 14, 74, 80, 132).[10] But this seems to be a merely derivative valuing of the self since it lacks any direct focus on the worth of the carer (Hoagland 1990, p. 111; Houston 1990, p. 116; Houston 1989, p. 88). A plausible ethic must acknowledge the worth of the self as individual as well as in relation (Calhoun 1988; Friedman 1993; O'Hear 1981). Otherwise, the moral agent only has value by virtue of being other-directed (Hoagland 1990, pp. 110-111).

Noddings resists the importance of caring for self, even though she acknowledges the unidirectional stance of caring in her ethic is problematic (1989, pp. 224-225; 1990a, p. 123). She claims caring for self invites the development of egoism, which is morally inferior to her "other-directed" conception of care (1990a, p. 121). Alternatively, Hampton suggests that in certain situations caring for the self is the morally superior choice (1993, p. 164). This is not to deny that inordinate self-centred attention is morally harmful. But to reject inordinate self-interest is not to say that caring for self is morally wrong. Caring for self is in fact one essential way of countering oppressive egoism and group bias (Calhoun 1988, p. 455; Carse 1996, p. 104). In other words, Noddings's worries about egoism reflect a confusion, on her part, between legitimate self-interest and self-respect on the one hand, and sheer selfishness on the other.

Noddings claims a person can "withdraw" or "retreat" from a relation to avoid physical and ethical harm (1984, pp. 89, 115; 1990a, p. 125). But this is morally permissible only until the carer has retrieved her moral strength so that she is again able to meet the abuser as "one-caring" (1984, p. 105). Additionally, Noddings claims the carer must not sever the relation or suspend caring in the relation (1990a, p. 124), unless the carer is convinced that no other could possibly care for the abusive other (1984, p. 115). The limited way of responding to an abusive other is more than idealistic; it entails a degradation of the self (Bubeck 1995, p. 159; Little 1996, p. 13; Carse & Nelson 1996, p. 25).

If a moral agent does not respond in this way to the abuser, she has to see the self as "guilty" for not caring, and given Noddings's conception of care, she has reason to esteem herself less highly (1984, p. 38). But this is a double bind because returning to an abusive spouse will expose her or him to the other's contempt. Thus the self is degraded whichever option is taken. Additionally, Noddings considers being unable to meet another as "one-caring" is more than just an excusable moral failing, she describes it as an "evil" that cannot be redeemed (Ibid., p. 115). It is irredeemable because the person's ethical self is constituted by what they have done, and so, the evil of not caring can never be forgotten.

These difficulties are compounded in Noddings's theory by the fact that there is no provision to hold the abusive other as morally responsible for their actions. Rather an abusive other can only be considered as not having experienced enough caring, implying that the carer has failed again, especially since, the carer is held responsible for nurturing the abuser's ethical ideal, regardless of the abuser's responses (1984, p. 116; 1990a, pp. 124-125).

Noddings recognizes a moral agent's ethical self will be affected by others' actions. She does not acknowledge the harm of a moral agent being destructively transformed by another's immoral values (Friedman 1993, pp. 139-140; Card 1990, p. 107; Davion 1993), and how this contributes to the establishment of morally problematic practices in a social group or in society. In fact, Noddings claims the loss of the self to the "evil" of another is an "unavoidable danger" of "caring" (1984, p. 116). Alternatively, I argue the harm, to the moral agent and to society that can occur through "the processes of caring" that Noddings prescribes needs to be prevented and cannot be justified from any moral perspective that takes seriously the worth of the carer.

Consider that the engrossment Noddings prescribes as intrinsic to caring involves being open to the person with a non-selective, receptive attitude (Ibid., pp. 19, 112; 1992b, p. 15; 1996, p. 161). Therefore, remaining as "one-

caring" with those engaged in abusive responses places the person at risk of undergoing "a kind of moral paralysis" (Houston 1990, p. 116). Similarly, nurses being educated to be carers in a society that has embedded morally dubious patterns of practice places nurses at risk for being morally paralysed. "Motivational displacement" of the sort that Noddings commends is characterized as a desire and a sharing of motivational energy to help the "cared-for" satisfy an expressed need or interest (Noddings 1992a, p. 91; 1984, pp. 17, 33; 1996, p. 161). Card claims that motivational displacement coupled with the lack of valuing of the self threatens to make the moral agent a chameleon -- changing values to accommodate to the situation (1990, p. 107). To resist these risks, a moral agent would need to have a solid moral ideal and character to withstand not being diminished by the immoral actions and values of others, even when these have been accepted as "standard practice" in a society.

Card claims we need to acknowledge the limitations of human beings and accept a more realistic view of what ethical responses may be needed to enable a person to resist evil (1990, p. 101). I suggest that an ethic that integrates justice and caring and acknowledges the distinct value of each self, while connecting these concepts to an objective interpretation of human good, can overcome the limitations of Noddings's ideal of care (Blustein 1991, pp. 40-41; Flanagan 1991, pp. 423-427; Downie & Telfer 1970, p.

53; Carse 1996, p. 103). The carer who has been brutally abused may find that she can no longer care for the abuser while maintaining the good of self-respect. The argument of Chapter 2 suggests that there can be no virtue in continuing to care in these circumstances, even though the abuser still deserves the just treatment that all persons are entitled to.[11] Being closed to caring with a specific abusive other also does not negate the possibility of becoming open to care for the person again, through the moral responsiveness of justice - i.e., respecting the other a person. But this should not be an expectation, even if it might be helpful for the other's rehabilitation, as this would negate respecting the moral agency of those victimized by the other.

The Scope of Noddings's Ethic of Care

A final aspect of Noddings's ethic of care that requires our attention is the problem of scope - i.e., the problem of who is included in the range of people to whom care is due. Noddings's ethic confines moral responsibility to those with whom a carer is in relation where there is some reasonable possibility of care being "completed" in the other (1984, pp. 86, 89, 113; 1990b, p. 31). But in nursing, as in so many other practices, virtue requires us to consider the needs of people we will never meet or encounter directly (Schultz & Schultz 1990, pp. 81-82). A critique of

Noddings's position demonstrates how theoretical contortions are used by Noddings to help her maintain the claim of caring as the moral ideal, even though, I argue, the problem of scope can only be adequately addressed by fully opening the door to justice.

I agree with Noddings, that a person does not have the energy to care for everyone (1984, pp. 18, 52, 99; 1990b, p. 32). However, as several critics have noted, Noddings takes the limits of our capacity to care to justify a severe dilution of our responsibility to those with whom we have no direct connection of care (Card 1990, p. 102; Friedman 1993, p. 133). Noddings's position is unacceptable because we all have a responsibility to be morally sensitive of those who will be affected by our decisions and actions (Friedman 1993, p. 135; O'Hear 1981; Card 1990, p. 102). For example, justice does not always require a person to take actions to actively advance the good of strangers, rather it requires being morally sensitive of strangers as persons to whom we are ethically connected. In this way, we have a moral responsibility to refrain from actions that will actively impede their flourishing but more onerous obligations will clearly depend on contextual variables. An individual might not be morally obliged by justice to send food and clothing to strangers, if the individual was herself destitute. However, the person would, at a minimum, be obliged to

refrain from spreading hate literature about strangers and from talking disrespectfully about strangers.

Alternatively, Noddings has tried to make her ethic more responsive to those outside the personal "circle" by introducing what she calls "chains of trust" (1984, p. 121; 1992b, p. 17). She claims strangers have to be linked to the moral agent through a relation with an intermediary other, in order for the moral agent to have a moral responsibility to a stranger outside the circle (1984, p. 86). However, the chains of trust still fail to acknowledge the existence of any moral responsibility to those outside of this linkage, and so, the "chains" do not rectify the ethic's lack of a moral responsibility to "unconnected" strangers (Card 1990, p. 102).

Followers of Noddings's ethic are left to think they can abstract themselves from the complexity of the moral life and make decisions that are only defined by their own personal relations and encounters. But no such abstraction is possible without at the same time abrogating the moral ties that justice entails beyond the confines of chains of caring (Friedman 1993, pp. 135, 154). Noddings's ethic is therefore insensitive to the many kinds of human relations we experience, and the ways in which moral responsiveness may have to take different forms (Blustein 1991, p. 27; Card 1990, p. 104).

Conclusion

I have argued that Noddings's ethic is not grounded in a plausible, objectivist understanding of human good. This opens her conception of care to subjectivist and relativist interpretations that militate against the good of others (Card 1990, p. 107). Moreover, Noddings fails to find any satisfactory role for justice in her theory. While Noddings acknowledges that seeing the other as a person is essential to being morally responsive to those we do not "naturally care-for", the centrality of justice to the moral life is systematically evaded in her work. The problems this creates are especially severe in her failure to develop a credible account of our moral responsibility to people with whom we have no connection of care.

Notes

1. Noddings stipulates that her's is a relational rather than a virtue ethic (1984, p. 80; 1992b, p. 16). However, this contrast is confused since virtues like justice and caring presuppose relation.

2. Noddings is clear that natural caring is not to be thought of as "love", and a person does not have to be in love in order to care (1984, p. 112). Additionally, while Bubeck's conception of care differs from that of Noddings's, she too claims care and love are separate expressions even though she claims both may coincide in a relationship (Bubeck 1995, p. 134).

3. Ethical caring is often experienced by being in relation to the "proximate stranger" who is someone the person does not yet care-for (Noddings 1984, p. 113). Noddings also refers to ethical caring as necessary when a carer is unable to maintain the "natural caring inclination" with someone with whom that inclination is usually present.

4. David Archard admits that "biological endowment" is a factor in a person's "social identity" that is expressed through what is commonly referred to as the person's autonomous choices and actions (1992, pp. 158-159). However, like myself, Archard also cites the influence of socialization through the mechanisms of education, family, historical and social settings. In this way, biological endowment and socialization can impact heavily on a person's moral consciousness and the resulting responses toward others.

5. Bubeck claims "principles of justice form in fact an organic part" of Noddings's "practice of care" (1995, p. 206).

6. Gilligan contends that terminating a caring relation is acceptable, as long as it is not done on egoistic grounds, and as long as the relation is severed in a caring way (1982, p. 95). On the other hand, I suggest that it does not even have to be done in a caring way as long as it is done in a respectful way. But this option is not open to those who operate from an ethic based only on care.

7. Noddings claims that, a "caring ethical ideal" requires putting aside moral judgments about the other and having "faith" that a "caring relation" is needed to help the other to care (1984, pp. 25, 57).

8. A society can be structured so that people believe they should feel happy about social customs that are morally problematic. For example, Bubeck claims women have been

socialized to willingly accept the burden of "women's work" even though that burden may be unjust (1995, pp. 137-174).

9. Noddings claims "caring" is "an attitude that pervades life", even though we are unable to care for everyone (1984, p. 112; 1990b, p. 32). While she envisions a life where everyone cares for each other, as morally superior to what we presently live in, she realizes this is not likely to occur. Thus "pervasive" caring would seem to be endorsed as a distant ideal rather than an established fact. There is a partial convergence between this ideal and the argument of Chapter 2 insofar as my argument commends an "openness" to care as a pervasively appropriate attitude.

10. Noddings claims the person is justified in caring for the self, since this is needed to enable the self to care-for others (1984, p. 100).

11. It may need to be qualified that not caring is not the same as being uncaring. Therefore, just because a person does not care does not allow the person to retaliate in kind. An integrated ethic guides the person to maintain their moral sensitivity to the other as a person even when care in the moral sense is impossible. See also Hampton (1993, p. 159).

Chapter IV

GADOW'S AND WATSON'S ETHICS FOR NURSING

Gadow and Watson are influential scholars in nursing, each of whom espouses a distinctive version of the ethic of care. A thorough critique of Gadow's "ethic of advocacy" and Watson's "ethic of transpersonal caring" is needed to address each of their claims. Gadow has been working on an "existential advocacy" conception of nursing since at least 1980. Recently, she has referred to her conception of nursing practice as an "ethic of advocacy" (Gadow & Schroeder 1996, p.132). Watson claims to be developing a Human Science and Human Care Theory that envisions the moral ideal of nursing to be "transpersonal caring" (1988, p.68).

My critique of Gadow's and Watson's theories has been structured to address four questions. First, how are their arguments based on the concept of care? Second, what are the similarities and differences between their theories? Third, are the limitations of the ethic of care I ascribed to Noddings in Chapter 3 evident also in these version of the ethic of care for nursing? Fourth, is either theory (or both) sufficient for guiding the practice of nursing?

The Concept of Care

The widespread insensitivity to the diversity of meanings inherent in the language of care has tended to divest the

phrase "nursing care" of any determinate sense in much nursing discourse.[1] As one nurse discovered, in a different context, "Labels, as I found out, can be misleading and can dull good nursing sense" (Benner 1994b, p. 55). As I noted in Chapter 2, a lot of good nursing, even when practised by morally exemplary nurses has little to do with care in the specific moral sense. Rather, it is "care" only in the thin sense that applies to whatever we value.[2] At other times, the word "care" is used in nursing to refer to being sensitive to the patient as a person, to being sensitive to the patient's needs, or open to the experience of care in the moral sense even when the experience does not occur (Ray 1981, p. 26; Gaut 1986, p. 82; Bottorff 1991; Millette 1994, p. 669; Wolf 1986, p. 91; Brown 1986, pp. 60-61; Boon 1998, p. 28). And frequently, the word "care" is used in referring to specific actions or behaviours that are performed by nurses and sometimes is used as a synonym for nursing (Valentine 1991, p. 100; Leininger 1981, p. 9; Leininger 1984; Gardner & Wheeler 1981a, p. 73; Gaut 1986, p. 78; Perry 1994, p. 39). It would be less tendentious simply to talk of nursing and discard the potentially misleading use of the word "care" in many situations.

Additionally, there has not been a clear separation between the concepts of care and respect for persons in discussing ethics in nursing (Curzer 1993b, p. 53; Gardner & Wheeler 1981b, p. 111; Perry 1994, p. 283; Wolf 1986, p. 91;

Brown 1986; Riemen 1986).[3] It is understandable how confusion between the two moral concepts has occurred since, to use Gaut's words, "respect for self and others is a necessary condition for all rational action, especially caring" (1983, p. 319; See also Gaut 1986, p. 82). However, while respect can lead to the person coming to care for another, respect and care are two separate moral attitudes that inform two different modes of moral responsiveness -- justice and caring.[4] A clearer and more realistic ethic for nursing is possible only so long as we distinguish clearly between the demands of respect and the bond of care. In Chapter 2, it was argued that care in the central moral sense refers to a specific bond, engagement, or attachment to the other's good that entails the carer's emotions being commanded in a certain way. In addition, a person's responses and actions must be guided by an accurate understanding of the other's good in order for the responses to be deemed as true caring.[5] This means, a nurse who feels a "caring" inclination toward a patient, but whose responses impede rather than promote the other's flourishing cannot be understood as <u>effectively</u> caring in the moral sense, even though the nurse makes the claim (Bevis 1981, p. 50).[6] Therefore, caring as a mode of moral responsiveness involves responses flowing from the moral connection of care, and while not exclusively other-directed, caring is predominantly so.

Gadow's Ethic of Advocacy

Gadow claims that "the ideal of nursing advocacy" is based on a "philosophy of care" (1980, p. 80; 1990b, p. 34), and that "care is the ethical principle" and "the moral end" that nursing needs to follow (1988, p. 7).[7] However, Gadow uses the word "care" in reference to the actions done by nurses, as demonstrated by her use of terms: "nursing care", "care provider" and "receiving care" (1980, p. 87; 1989, p. 538). Gadow also uses the word "care" in reference to the nurse-patient relation, and since she provides rich descriptions of this relation, an analysis of these descriptions is used to determine whether her ethic is based on the moral connection of care (1990b, pp. 33-40).[8]

The nurse-patient relation of "advocacy nursing" is described as a "partnership" relational connection (Gadow & Schroeder 1996, p. 131). It is not a relation of "mutuality"; it is unidirectional or "one-sided" (Gadow 1980, p. 90; Gadow & Schroeder 1996, pp. 128-132).[9] The connection is "not a sharing with the patient" (Ibid., p. 88); it is an "existential engagement" of each person's "subjectivity" (Gadow & Schroeder 1996, p. 131; Gadow 1990b, p. 38). In this way, nursing practice is claimed to embody "the attentive discernment and valuing of an individual as a situated, infinitely detailed, and unique being who is always under construction and yet whole" (Gadow 1995a, p. 243; Gadow 1980, p. 89). The "entire self" of the nurse is

described as being involved in interacting with patients through "an engaged, relational respect for individuals that epitomizes caring" and that involves being ultimately concerned with the patient as a unique human being. This concern is developed by seeing the self and patient as "intrinsically" related and it enables the nurse to see the patient's experience through "sustained objectivity" (Gadow 1980, pp. 89-90). Seeing the other in this way is accomplished by the "embodied" nurse attending to the patient (conscious or unconscious) with "empathic regard" and achieving an "emotional involvement" with the patient (Gadow 1980, p. 91; Gadow 1988b, p. 12; Gadow 1990, p. 38).[10]

The emotional involvement is experienced as "feeling the other's feeling" from the "proper perspective" of "objectivity" (Gadow 1980, pp. 89-91). For example, when the patient feels sad or has pain, the nurse responds with empathic regard so that the patient's feelings are "vicariously visualized" by the nurse (Ibid., p. 91). Gadow claims this kind of nurse-patient engagement involves a "genuine out-reaching" to the patient and "entry into" the patient that represents an "authentic transcendence of [the nurse's] self" (Ibid., p. 92). On the other hand, Gadow insists the nurse must resist "emotional identification" with the patient's feelings, as this results in "emotional infection" which would prevent the nurse from being able to

gain the objective perspective that is essential for nursing practice (Ibid., pp. 91-92). Rather, the nurse is to "integrate" how the patient "feels" with "knowledge", and it is this integration that enables the nurse to alleviate the patient's distress in a morally appropriate manner (Ibid., p. 88).[11]

In relation with the patient, the nurse remains at the level of "reflection", since it is claimed the nurse can only be "externally involved" in the patient's experience (Ibid., pp. 88-89). The nurse's responsiveness is "not expressed through immediacy of actions" (Ibid). Responses are to be: "reflective", "consciously directed", and "deliberate" (Ibid., pp. 88, 92). The specifics of the connection enables the nurse "continuously" to respond to the "dialectic" of the patient's "self-object body relation" (Gadow & Schroeder 1996, p. 130).[12] This involves the patient "freely deciding how to interpret the otherness of the body...as long as the meaning includes more than objectness" (Ibid). The nurse assists this process by being a "coauthor" to the "relational narrative" that in essence is an expression of the meaning this experience has for the patient (Ibid., p. 131; 1990c, pp. 53-54; 1996, p. 9). It is claimed this kind of dialectical process enables the patient to achieve "the self-unity" that is envisioned as a "reconciliation of the person with the body-as-other" (Gadow 1980, p. 96). Additionally, the specific conception of

"self-unity" is claimed as being necessary for "authentic self-determination" to occur (Ibid., pp. 85, 97; 1990c, p. 55; Gadow & Schroeder 1996, p. 130). In the end, the "moral position" of "advocacy" has been met when patient's decisions are self-determined and are used to guide nursing practice (1990b, p. 34).

Gadow stipulates that the connection between the nurse-and-patient is the "intrinsic" or "existential" connection of two human beings which enables the nurse to have appropriate moral sensitivity to the patient as a person. What is not immediately clear, however, is how Gadow's ideal of "existential" connection between patient and nurse is related to the moral concepts of care and justice discriminated in Chapter 2. Gadow's strictures about the avoidance of emotional infection, her emphasis on the reflective and deliberate character of the nurse's moral responsiveness, and her sharp distinction between the bond of friendship and the relationship of nurse to patient (1980, p. 90) all suggest that important facets of her ideal appeal to the values of justice and respect for persons. But Gadow now repudiates any such interpretation.

Gadow has recently claimed that an ethic for nursing needs to "turn away from" ethics based on the principles of liberty and justice and "turn toward" an ethic based on caring (1995a, pp. 241-243). Gadow refers to this as making the "existential turn" away from "rational ethics" based on

the principles of liberty and justice, and toward a "relational ethic" based on caring (Ibid).[13] It is not immediately clear whether this is supposed to mean that her ethic of advocacy now entails a wholesale rejection of justice or whether justice is only to be assigned a more modest role in nurse's ethical lives, subordinate to the primary imperative of care. In either case, Gadow's ideal must founder on the same problems that beset Noddings's ethic of care (as detailed in Chapter 3). In other words, if the ethic of advocacy is a bona fide ethic of care, assigning justice and respect for person to a marginal or derivative place in the moral life, at best, then it will inevitably impose unreasonably burdensome emotional demands on nurses who must "care" in some strong sense about all patients, and it will also fail to give a credible account of nurses' moral obligations to those with whom a caring connection is not developed.

I suggest that many of the appealing aspects of Gadow's ethic of advocacy, which are undermined when we construe it as an ethic of care, are best interpreted in the light of an integration of care and justice along the lines I defended in Chapter 2. That integrated conception enables the moral agent to see the self and others as both distinct persons and relational connected beings. For example, nurses will see themselves as independent moral agents, intrinsically connected to patients through respect for persons but also

open to the more intimate bond of care which will sometimes take root in their lives. Gadow's account of empathy and vicarious emotion in nursing might thus be read as indicating some of the psychological requirements of an openness to care. Nevertheless, it is critical to the integrated conception I have defended that an openness to care not be regarded as an "existential turn" away from justice. On the contrary, whether nurses come to care for patients or not, they owe them a respect which justice requires regardless of contingent emotional bonds (Curzer 1993b, p. 53). To the extent that Gadow's "existential turn" obscures this requirement, it cannot be an acceptable ethical ideal for nurses.

Watson's Ethic of Transpersonal Caring

According to Watson, her "ethic of transpersonal caring" is developed on three interconnected levels of caring: transpersonal, human, and ethical (1981, 1985, 1988). The level of "transpersonal caring" is the "ideal" engagement of the moral life. It is this specific kind of "intersubjective" engagement that Watson claims nurses are to "strive" for even if they cannot always achieve it (1988, pp. 60, 68). The engagement is represented as a "spiritual union" with another that involves a "contact between the subjective world of the experiencing persons" (Ibid., pp. 58, 66; 1997, p. 52). Within that experience, each can gain

an "inner harmony with the mind, body, and soul" (1988, p. 58). Watson claims this kind of union is experienced as "a freeing of both persons from their separation and isolation" (Ibid., p. 68). The union is claimed to have been established when the carer is able to "detect accurately" the cared-for's "condition of soul" and "transmit" the feelings that inhere, perhaps unconsciously, in that condition, back to the cared-for so he or she can "experience the same feeling" in a more mature or vivid form (Ibid; See also Watson 1989, p. 131). Watson claims this process can only occur through caring. Caring is necessary to enable the patient to discover and express what is deep within themselves. Additionally, the union is claimed to "keep alive" a sense of "common humanity" by allowing each person to see the commonness they share with each other (Watson 1988, p. 60). "Human caring" is derived from "transpersonal caring".

Human caring has three elements: a humanistic-altruistic belief and values system; a commitment to care; the satisfaction of receiving through giving (Watson 1981, p. 62; 1985, pp. 10-11). This level of caring is "derived" from childhood experiences of caring, in the transpersonal sense, and is expanded by exposure to and the study of different philosophies, beliefs, cultures, and life-styles (Watson 1985, pp. 9-11). Human caring is based on the belief that humans have the capacity to view humanity with

love and to appreciate diversity and individuality (Ibid). It is experienced as "the joining of another to oneself" that enables each person to actively engage in the "process of being and becoming" (Watson 1988, pp. 55, 67). The joining occurs through extending the self by including the other, person or object, into a "prominent place in one's life" (Watson 1985, p. 12). However, since human caring and transpersonal caring may not be experienced, "ethical caring" is required.

Ethical caring is summoned by a nurse in order to "protect patient dignity" (Watson 1988, p. 71). The nurse acknowledges that it is through caring that patient dignity is protected, and in this way, a nurse's responses contribute to "enhancing human dignity and preserving humanity" (Ibid., p. 31; Watson & Ray, p. 2). The nurse makes this contribution by assisting patients to find meaning in their experience and obtain a "new self-unity" so that they can make or at least participate in making "self-determined" decisions regarding their health (Watson 1988, p. 66). Additionally, ethical caring is enacted because the person acknowledges the value of human care, has made a commitment to care (Ibid., pp. 31-32), and so meets the other as "one-caring" (Watson 1989b, p. 127). Meeting the other as one-caring requires the person to possess and enlist the attitudinal processes of: sensitivity to self, openness to others, altruism, congruence, empathy, and non-

possessive warmth (Watson 1985, pp. 26-30). Meeting the patient as one-caring enables "a knowing" of the patient that enables the nurse's responses to be in concert with who the patient is and wants to be (Watson 1985, pp. 23, 25). Additionally, Watson claims, meeting the other as one-caring requires the nurse using the "natural self", and it is through meeting others in this way that the nurse is involved in trying to develop the intersubjective connection of transpersonal caring with the patient (1988, p. 66).

Ethical caring involves "engaging in concrete caring acts" while striving to develop the transpersonal caring connection (Watson 1988, pp. 31-32). Since transpersonal caring is an ideal that is not often achieved, nurses will often be engaged in performing actions done in the "name of caring", in other words, "approximations of care" (Ibid., p. 34). Watson insists the nurse needs to keep in mind, the performance of "caring actions" does not necessarily mean caring has been achieved (Ibid). Additionally, Watson claims caring responses are directed toward the "dignity" of the other, since this, above all else, is the "important end of caring" (Ibid., p. 58; Watson & Ray 1988, p. 2).

In analysis, Watson's interlocked conceptions of transpersonal, human, and ethical caring raise many questions. But enough has been said to show that her theory is exposed to some of the same criticisms that I have already pressed against the ethic of care. The ideal state

of transpersonal care embodies a profound spiritual intimacy that might be intermittently approximated in the closest personal relationships. But the ideal would seem utopian in a negative sense for nurses insofar as the often brief and perfunctory encounters between nurses and patients are not a fertile ground for a deep intimacy. To suggest otherwise to nurses is merely to encourage guilt about failing even to approach an impossible ideal. (In Chapter 5, I discuss how the unrealistic ideal of caring as the moral ideal for nursing can result in nurses being morally harmed).

The concept of human caring takes us close to something like Noddings's notion of natural caring with its emphasis on roots in childhood experience, affective connection with the other, and the "satisfactions" of giving. Unfortunately, like Noddings's conception, Watson's idea of human care is not adequately supported by an objectivist understanding of human good. Watson's only suggestions about how nurses are to interpret the good of the patient in exercising care are focused on appeals to patient "dignity" or "self-determination" (1988, p. 63). But Watson offers no guidance as to what is involved here beyond assisting patients in clarifying their wants. That being so, her ethic is left dangerously open to subjectivist interpretations.

Watson's ideal of ethical caring might seem to carry us closer to the virtue of justice, since her depiction of what

ethical care demands rests on the assumption that individuals are owed moral concern even in the absence of the deep interpersonal connections that come with caring. Moreover, her insistence on patient dignity as the focus of ethical caring also appeals to the vocabulary of justice. But here again a latent subjectivism is hinted in her suggestion that concern for dignity must always be a response to "what the patient is and wants to be" (1985, pp. 23-25). I develop this point more fully in the next section. In addition, like Noddings, Watson seems to conceive ethical caring as an inferior substitute for more intense forms of caring connections. In ethical caring, the nurse must always strive for the deeper levels of caring attachment. But as I argued in Chapter 2, justice and its underlying attitude of respect for persons is not a "second-best" alternative to care, but a basic constraint on all human encounters, whether caring exists or not.

Criticisms

The foregoing sections have revealed some serious limitations to both Gadow's and Watson's conceptions of an ethic of care for nursing. In what follows, I consolidate these objections by placing them in a comparative context and connecting them to the argument of other chapters.

First, the moral end of nursing as both Gadow and Watson conceive it is patient dignity, and this in turn is

understood as patient self-determination (Gadow 1979, p. 94; Gadow 1980, pp. 84, 90-96; Gadow 1985, p. 32; Gadow 1990c, p. 55; Gadow 1996, p. 9; Gadow & Schroeder 1996, pp. 130-131; Watson 1989b, p. 129; Watson 1988, pp. 54, 57, 63; Watson 1997, p. 49; Watson & Ray 1988, p. 1).[14] Neither theorist supplies criteria that would help nurses to discriminate reliably between responsible self-determination, directed at the patient's authentic good, and self-determination that involves self-inflicted harm or harm to others - including harm to nurses themselves.[15] This may be because both theorists are implicitly committed to a subjectivism about the good, so that the good is always self-determined. But as I showed in Chapter 2, a plausible account of either the role of care or justice in the moral life cannot be defended in the absence of an objectively conceived good. Autonomy or self-determination is certainly one important ingredient in the good of patients to which nurses and physicians must be sensitive. But it cannot be made into the only good without making moral concern into little more than indulging the wants of others and without having the nurse relinquish any credible sense of moral agency (Davis et al. 1997, pp. 51, 95; Sherwin 1992, p. 70; Carse & Nelson 1996, p. 26). I concur with Boyer and Nelson that patient self-determined decisions sometimes need to be challenged (1991, p. 155). And I add, sometimes the morally

responsible response must include denial of the patient's self-determined decision.

Ironically, patients can be harmed by nursing responses being guided by patient self-determination.[16] The harm stems from self-determined decisions and actions that are contrary to the patient's good.[17] Uncritical deference to patients' self-determination means that patients are not assisted to see themselves as moral agents who are connected both to their own (objective) good and the good of others by virtue of shared membership in a moral community that limits what the patient can freely choose (O'Hear 1981, p. 127; Shain, 1994, p. 119; Benjamin 1990; Blustein 1993). In other words, they are not assisted to understand that moral connections properly constrain their choices regardless of current preferences or relationships.[18]

Moreover, nurses do not have the luxury of only nursing one patient, nor do nurses work and live in an environment that has unlimited resources for nursing patients. Both Gadow and Watson do not sufficiently attend to the relational context or the resource and institutional constraints within which an ethic for nursing must be developed. There are not unlimited resources for ensuring every patient's particular desires or needs can be satisfied in an "idealized" way. Patients live with nurses and others in a highly contextualized social world. It needs to be considered that while a nurse may only have to be in the

"physical" environment with one patient at a time, in actuality, the nurse is having to juggle meeting the needs of many patients. This will influence the specifics of the nurse's moral responsiveness in every nursing interaction in many ways.

Of course, no ethic for nursing can make this task an easy one. But the inattention to considerations of justice in both Gadow's and Watson's work aggravates the problems for nurses attempting to balance potentially conflicting demands from many different sources. Instead of impossibly high ideals that can scarcely ever be approximated, what nurses need ethically is the ability to think reasonably about what just claims patients have and the nurse's corresponding duties in honouring those claims (Aroskar 1985, p. 60; Kolm 1996, pp. 321, 482). The language of justice becomes salient in situations of scarce resources and conflicting demands where there is need to think of what is due to others in circumstances where what is due is commonly far less than we would ideally like to give. Only the language of justice can meet that need, and without it, an ethic for nursing that is based on care becomes an oppressively demanding and burdensome ideal for nurses (Kuhse 1995, pp. 217-218).

Watson's and Gadow's lack of attention to matters of relational and institutional contexts leads to another problem. They fail to make sense of the nurse having moral

responsibilities to anyone other than the patient. Surely nurses have moral responsibilities to themselves and to others, regardless of the relational connection. For example, ethically responsible nursing must reflect not only the good of the patient but also the good of those who are also in relation with the nurse and patient. Moreover, nurses have to understand their responsibility to patients in the larger context of their ties to the moral community as a whole. For example, ethically responsible nursing for a sexually promiscuous patient who is HIV positive must consider not just the good of the patient but also the interests of those liable to be harmed by the patient's sexual behaviour. Here again considerations of respect for persons and human flourishing, rather than an ideal that enjoins us merely to care for the patient in a more profound way, are critical to morally defensible judgment. (I say more about moral assessment of the institutional context of nursing in Chapter 5). Additionally, nursing involves interacting with many others who are not patients. Surely, nurses have a responsibility to respect these people, even though the primary focus of the practice of nursing is the patient (Curtin 1979, p. 2; Benner 1997, p. 49).

Some of the criticisms I have levelled against Watson and Gadow may be more fundamental than others. For example, it might be possible to expand the ethics of advocacy and transpersonal caring beyond the limits of the dyadic

relation between nurse and patient on which the authors focus without undermining the basic elements of their respective theories. But that expansion will also raise questions about the limits of the claims that patients and society at large can rightly make on the goodwill and commitment of nurses, about the difference between giving people what they want and giving them what is genuinely good and right, and about how conflicting interests have to be balanced in a context of finite resources. These questions force us to think about justice in a non-utopian world without undermining the importance of being open to the precious experience of caring for others in that world. In other words, these questions take us back to the ethic I sketched in Chapter 2.

Conclusion

The moral sense of care is not the sole basis of either the "ethic of transpersonal caring" or the "ethic of advocacy". Both ethics are based on a subjective sense of care and neither has a sufficiently developed understanding of respect for persons and justice. Moreover, neither Gadow nor Watson give a credible account of nurses' moral responsibilities to anyone other than their immediate patients.

Many of the weaknesses in the ethics of Gadow and Watson parallel the problems that were detected in Chapter 3

in Noddings's ethic of care, even though there are significant difference in the three scholars' conception of care. The relevant weaknesses are too substantial to be corrected through any fine-tuning of the theories. In particular, the general idea that care rather than justice is the foundational concept for ethics in nursing or anywhere else is one we have many strong reasons to doubt.

Notes

1. Over two decades ago Gaut (1983) detailed the lack of clarity and precision in how "care" was being used in nursing. Morse et al. (1990, 1991) found the word "care" being used in five different ways in nursing and concluded that the concept had been "poorly developed" (1991, p. 125). Similar claims are made by Fry (1991), Curzer (1993a, 1993b), Thomasma (1994), Kuhse (1995), and (Marks-Maran 1994, p. 43).

2. Benner's claim that "caring means people, interpersonal concerns, and things matter" serves to illustrate how the thin sense of the word "care" is used to support the claim that caring is "central" to nursing (1994a, p. 44). Kuhse's designation of "dispositional care" (1995, p. 212) is similar to what I refer to as an openness to care.

3. Gaut referred to "caring as respect for persons" (1983, pp. 318-321).

4. This has been argued at length in Chapter 2.

5. This is similar to Gaut's claim that caring involves meeting "a need" and the action must result in a "positive change" that was "intended" to occur, with the change being that of "growth or maturation, fulfilment, movement, or any term that designates "some kind of positive alternation or progression" (1983, p. 321). Gaut also claims the "context" of moral responsiveness needs to be based on objective criteria or "norms" rather than on "whim or wishes" of anyone (1983, p. 322); Benner & Wrubel delineate the concept of care as based on the specific relational connection that includes an emotional connection with the other's good. While they suggest that context is needed to determine whether caring has occurred or not, they do not specify how context is relevant (1989, pp. 2-4; See also Benner 1991, p. 17). Griffin also does not ground her concept in an objective moral context (1983, pp. 289, 291-294).

6. Gaut refers to this kind of response as "questionable caring" (1983, p. 321). Benner claims clinical judgments cannot be "sound" without knowing the patient's/family's situation and moral concern (1994a, p. 49). By implication, Benner is claiming that nurses working in emergency situations where this kind of knowledge cannot be feasiblely expected cannot make sound moral judgments. Alternatively, I argue the judgments can be morally sound so far as the nurse is morally sensitive to the patient as a person and sensitive to the vulnerability the patient is likely experiencing, even when there is relatively little knowledge of the patient. However, I would support the idea that a certain kind of knowing of the

patient is likely necessary for a nurse to come to care-for a patient.

7. Gadow's conception of existential advocacy has strong similarities to Curtin's conception of "human advocacy", with the exception that Curtin does not claim care as the foundation of her conception of nursing practice (1979, p. 4).

8. Recently, Gadow has been inclined to refer to patients as clients (Gadow & Schroeder 1996). There is uncertainty whether the term patient or client is the appropriate way to refer to those receiving health professional services. The worry here is perhaps that referring to a person as a patient reduces the person to the status of an object. In light of my arguments in Chapter 3, I suggest that referring to a person as a patient is only problematic when the ethical dimension of nursing or medicine is occluded by the practitioner only seeing the patient through the lens of traditional science. Moreover, the language of "client" is at least as morally dangerous since it is a term that belongs primarily in the marketplace.

9. In opposition to Gadow, Benner claim "effective" nursing, as "caring", fosters mutuality (1994a, p. 45).

10. Gadow describes empathic regard as involving empathic imagination (1988, p. 12). Gadow is not clear what exactly she means by empathic imagination. It is possible she is using the term to refer to a nurse's ability to perceptively imagine how a patient is experiencing a situation by attending to the patient's feelings. If this is her meaning, I agree this is a valuable perceptive ability that needs to be developed in nursing education. But it is not a response that is exclusive to caring, as justice also depends on the empathic imagination.

11. Gadow also refers to alleviating distress as alleviating vulnerability (1988, p. 7).

12. Gadow previously referred to the "self-body" as the "lived/body" (Gadow 1980, p. 96).

13. Gadow defines relational ethics as "the practice of engagement, the coauthoring of a narrative expressing the participants' views of the situation, including their imagined alternative - their view of the good, toward which they want to move" (1995a, p. 243). This is similar to Noddings's claim that in relational ethics "all deliberations focus on the human beings involved in the situation under consideration and their relation to each other (1988, p. 218). Churchill argues that "relationship-centred practice" is "wrongheaded" since

the relationship is to be understood as a means to meeting the central focus - namely the patient's needs (1997, p. 115).

14. There are two constituent parts to Gadow's and Watson's similar conception of patient dignity. First, the nurse is to assist the patient find meaning in the experience and not impose meanings onto the patient's experience (Gadow & Schroeder 1996, p. 131; Watson 1988, pp. 54, 57). Nurses are "not permitted to define the patient's interest in any way" (Gadow 1980, p. 84; Gadow 1990, p. 34; Gadow & Schroeder 1996, pp. 130-131), since it is claimed for a patient to experience integrity there must be "a presence of coherence" between the meaning given to an experience and the person who originates the meaning (Gadow 1985, p. 33; Watson 1988, p. 66). Second, a patient's self-determined decisions are not "to be infringed upon, even in the interests of health", since self-determination is claimed to be the "most fundamental and valuable human right" (Gadow 1980, p. 84; Gadow 1990a, p. 34). This means, nurses are "obligated to act" on patient self-determined decisions, regardless of the decision (Ibid; Gadow & Schroeder 1996, p. 131; Watson 1988, pp. 54, 57).

15. Gadow and Watson both enlist the criterion that a patient must be at the level of a "new self-unity" before decisions can be deemed as self-determined and patient decisions are developed through the nurse and patient "co-authoring" a mutually satisfactory relational narrative (Gadow 1980, p. 96; Gadow & Schroeder 1996, pp. 130-131; Watson 1988, pp. 66, 71). However, being at the level of "self-unity" and the process of co-authoring provides no assurance the patient's decisions that derive from the narrative will be morally defensible.

16. Carter claims actions guided by personal views and beliefs can constitute "moral senility" (1984, p. 58).

17. Nussbaum describes how women have been socialized into believing that what they need for flourishing is very limited and results in socialized oppression. Therefore, she claims we need to raise questions about "ethical objectivity" and cultural differences (1988, p. 154: See also James 1994). For example, female circumcision still remains a legal and socially sanctioned practice in Egypt, as passed by the Egyptian Government (Toronto Globe and Mail newspaper, June 25, 1997, p. A17).

18. Even though the objective moral context of human flourishing, that has been detailed in Chapter 2, cannot prevent moral conflicts from occurring, it can prevent responses from being unnecessarily restrictive or devoid of a substantial moral context.

Chapter V

FROM MEDICAL SCIENCE TO MORAL AUTHORITY

In the health system, the moral dimension of life has been somewhat overshadowed by an emphasis on the physical sciences (Bishop 1990, p. 69; Benner 1991, p. 8; Benner & Wrubel 1989, p. 402; Carper 1979, p. 12; See also Aroskar 1985; and Gadow 1985). This situation exists even though, as McInerny has pointed out, science is only one element that needs to be considered in helping patients flourish (1987, p. 271). The relative neglect of ethical considerations in a conception of medical practice dominated by science is one powerful obstacle to morally responsible decision-making on the part of nurses (Yarling & McElmurray 1986, p. 71; Tadd 1994, p. 9). The experience of being required to act against one's best moral judgment "is all too common in the day-to day practice of nursing and has become the predominant form of ethical conflict for the nurse in recent years" (Fry 1989c, p. 490). Regrettably, problematic patterns of practice that affect nursing have deep roots in tradition (Benner & Wrubel 1989, p. 369), even though medical and nursing scholars have tried to unearth the roots that feed these practices.

This chapter develops a moral critique of the institutional context of nursing. I begin the chapter by delineating two morally problematic practices that derive

from misplacing the authority of medical science. Then, the harm of these practices is addressed. I show how these practices negatively influence nursing and how nurses might try to mitigate the ill effects of such practices on patients. The chapter concludes with some suggestions about how the institutional context of nursing might be reformed on the basis of the ethic proposed in Chapter 2.

Misplaced Authority

Engelhardt (1985) and Aroskar (1985) both claim medical science and its practitioners have been established as the ultimate source of authority in the health system. This in turn has legitimated the establishment of asymmetrical relations among different professionals within the system and also between professionals and patients. Of course the intellectual authority of medical science and its practitioners might be readily conceded. But when that intellectual authority is directly translated into hierarchical social authority, two problematic patterns of practice develop - namely, medical science paternalism and authoritarianism.

Medical science paternalism.

Expertise in medical science is not a sufficient basis for decision-making in medical and health professions and health organizations (Pelligrino & Thomasma 1981, p. 172; Downie &

Calman 1987, p. 38; Curtin 1979, p. 6; Benner 1997, p. 51). This is because medical science must prescind from the moral context of patients' lives and the delicate judgments about human good which are intrinsic to that context. For example, only medical science can tell us about a patient's prospects for survival after severe brain injury. But medical science is necessarily silent on how good or bad the life will be that the survivor can enjoy. If it is assumed that medical science exhausts the knowledge relevant to difficult health related decisions, then it becomes tempting to infer that the authority to make the decisions properly belongs to the medical scientist, regardless of the reflective moral judgments of others.[1] Confusing medical science with moral authority results in the moral agency of all those involved being denied. This in turn creates patterns of moral insensitivity among many involved in the health system, blinding them to the reality of others as persons with different but perhaps legitimate moral views about how lives should be lived. In short, we get a morally noxious form of paternalism - which Pelligrino & Thomasma refer to as "scientism" (1981, p. 172).

Medical science authoritarianism.

Medical science authoritarianism is the assumption that the important decisions in the health organization require no more than the knowledge and abilities of medical science.

Therefore, all authority is monopolised by those with medical scientific knowledge, and others (e.g., nurses and patients) must exhibit unthinking loyalty to the scientific expert.[2] However, medical science is only one of the specialized forms of knowledge that enables the work in health organizations to be accomplished and medical practitioners comprise only one of the specialized working groups. Therefore, medical science authoritarianism is morally untenable because it treats one source of relevant knowledge for medical decisions as superior.

Moreover, medical science authoritarianism fails at a more fundamental level by assuming that disparities in specialized knowledge, whatever their source, can supplant the basic norms of mutual respect that are intrinsic to justice. Having specialized knowledge can result in one party in a relation being in a more dependent position than the other. However, the specialized knowledge of any social group does not change the moral fact that every human encounter is based on the symmetrical relation of persons living in a shared community. This does not mean a person who occupies a specialized social position cannot have authority over another person. The point is rather that the person with the specialized expertise must be sensitive to the other's position of vulnerability and not use authority as leverage to oppress and exploit the other.[3]

Medical science paternalism and authoritarianism are common features of contemporary health organizations. A closer look at their harmful consequences will enable us to bring into clearer detail why re-establishing moral authority in health practices and health organizations is so urgently important (Gaita 1992, p. 74).

The Medical Science Model and Harm

Benner & Wrubel claim that science without ethics is "frightening" (1989, p. 372).[4] Socializing health professionals in an institutional context that exalts science and neglects ethics is especially frightening. Indifference to the task of moral education, as Nel Noddings reminds us, runs the risk of creating "monsters" (1984, p. 179). But the risk is especially great for health professions, since their patients' vulnerability magnifies the harm caused by the ethical failing of the professional. Ethical problems are pervasive in professional health practices and professionals are continuously involved in making moral decisions that cannot be reduced to their scientific components (Wilkinson 1989; Blustein 1993; Tadd 1994).

To be a competent health professional, a person must integrate the specific knowledge, skills, and abilities for moral sensitivity, empathic regard and promoting the patient's good (Curzer 1993a, p. 177; Downie & Calman 1987,

pp. 38, 58).[5] This ethical component of professional competence must be integrated with other specialized knowledge domains (AARN 1997, p. 19). So, being able to perform technical activities that are specific to the professional's domain of work - i.e., curing disease, treating illness, alleviating needless suffering, and promoting comfort - is insufficient for addressing the complexity of ethical practice. I shall say more about the moral education of health professionals in the next chapter. What must be stressed here is that the exercise of moral competence may be thwarted more or less completely when medical science paternalism and authoritarianism are established patterns of practice in the organization where the professional works.

Patients, nurses, and physicians can all be harmed by practices based on misplaced medical authority. The harm caused by amoral practice is not some impenetrable inner state, rather, it is often obvious to a morally alert and sensitive onlooker.[6] Being harmed is often experienced as a pain that occurs at the core of a person's being. It is experienced in this way because the person's humanness has been insulted. In a broad sense, morally problematic practices are an insult against humanity. The harm is sometimes expressed through physical manifestations - e.g. headaches, depression, intestinal disorders, insomnia. So, people develop observable symptoms of being harmed by a lack

of ethical competence just as they develop observable indications of being harmed through a lack of competence in the science dimension of professional practices.[7] Moreover, the pain of being morally harmed can endure a life-time. Sarvimarki's claim that ethical practice is essential to well-being is correct (1995, p.348), even though she was only making the claim specific to patient well-being.

It is tragic that a patient can be harmed, since the social mandate of the health organization is to assist patients in having their good realized. The harm incurred from a lack of competence in ethics can often be seen by attending to the patient's body language and tone of voice, since it is through these means that a patient's attempts to fight against a professional's lack of ethical competence is often made evident (Rieman 1986, p. 34). However, without ethical sensitivity, the professional will likely notice none of this (e.g., Millette 1994, p. 666). Therefore, it is not uncommon for professionals not to see the harm they are inflicting. Worse yet, professionals who are aware of this harm can dismiss its significance by claiming that its infliction is "scientifically" justified. Physicians, nurses, and patients are all harmed when these problematic patterns of practice become the established way of working in health organizations. Consider the following example of a physician's response to being questioned regarding her interactions with a patient:

> What really matters is that I stopped the bleeding, I don't really care if she is upset with how I treated her or if you are. After all, being nice is not part of my job and besides, I think she should be happy I could stop the bleeding -- the rest of my actions don't really matter when it comes right down to it (personal experience).

These comments are a typical example of medical science authoritarianism. They illustrate a compartmentalized view of knowledge and a hierarchical valuing of medical science knowledge over ethics. The patient and nurse's distress caused by the physician's conduct is dismissed as irrelevant. The patient and nurse are thereby dehumanized, but so too is the physician who is rendered callous and indifferent to the suffering caused by the exclusively "scientific" conception of her role.[8]

Tragically, nurses are placed in the untenable position of inflicting harm on patients when medical science paternalism and authoritarianism shape the nurses' working conditions (Potter 1996). Nurses become the harming agent when they engage in nursing therapeutics that uphold a medical science treatment strategy that is against the patient's morally legitimate conception of his or her good. On the one hand, the medical science model tells the nurse that she must obey those orders based on medical science knowledge, and the model discourages the nurse from taking moral misgivings seriously. On the other hand, any morally sensitive nurse will suffer acutely in this predicament.

Both nurses and patients are thus victims of the medical science model.

The ongoing experience of being used as a harming agent can result in nurses becoming morally blunted or paralysed. If a nurse's moral sensitivity is not developed to begin with, the nurse may only experience a sense of unease with how a patient, a colleague, or the self is abused under the medical science model, and she or he may thus be unable to identify the cause of this "dis-ease".[9] In a health system that encourages moral insensitivity, a nurse will often be socialized to suppress the "dis-ease". In other words, the nurse becomes somewhat oblivious and hardened to unethical practice. In this way, a nurse may not consciously experience the "transforming" harm of moral wrongdoing. Chambliss's sociological account of nursing practice in the hospital health system environment (1982, 1996), Growe's journalistic depiction of nursing (1991), and Wilkinson's account of a nurse experiencing "moral distress" (1989) all attest to the harm that can happen to nurses when they work in an environment that is paternalistic and oppressive (See also Benner 1991; and Hoopfer 1988).

The morally sensitive nurse may try to establish a "buffer zone" around patients to protect their interests in a system that is often indifferent to them. Chambliss describes how aspects of nursing practice often pertain to the "practical, often political issues of cajoling, tricking

or badgering a recalcitrant system into doing what ought to be done" (1996, p. 7). For example, some nurses working in obstetrics try to obstruct unnecessary birthing procedures by not availing the physician enough time to do them. Morally exemplary conduct is sometimes socially subversive conduct. That is one of the realities that nurses encounter, and nursing education can and must prepare future nurses for that experience (Hutchinson 1990). However, often nurses cannot prevent patients from suffering the pain and harm of being morally wronged, and so, the morally sensitive nurse is left "cleaning up" after another's unethical practices (Chambliss 1996, p. 74).

Trying to manoeuvre around the obstacles to ethical practice requires an expenditure of personal energy that can exhaust the nurse's personal resources (Leininger 1990, p. 63).[10] It is also personally debilitating to be unable to counter moral wrongdoing (Aroskar 1985, p. 53; Fromm 1947, p. 144). Therefore, while it may be morally necessary for nurses to try to circumvent the "illegitimate" use of medical authority in the health system (Benner & Wrubel 1989, p. 369), this cannot be a sufficient solution to the problems of medical science authoritarianism and paternalism. Nurses cannot reasonably be expected to undo all the damage that flows from these practices.

In fact, among the harms that flow from the medical science model is the possible erosion over time of the

nurse's own ethical integrity. When nurses are sensitive to moral wrongdoing and unable to redress wrongdoing, their moral sensitivity can become blunted to the point of it being extinguished (Hutchinson 1990, p. 15). For example, signs of blunting are evident when the nurse is heard saying, "what does it matter - I can't do anything about it anyway - I'll just do my job - no one really cares anyway - it is just unfair - no one should be treated like that - it's just not right - I give up". Accordingly, nurses become "disillusioned" and experience "distress" at being impeded from engaging in ethical practice (Benner 1991, p. 12; Oberle & Davis 1993, pp. 73-74; Cameron 1986, p. 42b). The ability and determination to resist the pressures of a system that is often amoral are progressively undermined by daily exposure to those pressures.[11]

Nurses experiencing moral blunting may still have the moral sensitivity to realize there is a "right" thing to do. But the nurse may also try to desensitize herself to her distress by trying to rationalize the practice to the self, to patients, and to others, as a regrettable situation that must be coped with. Additionally, the nurse may try to "compensate" the patient for having to endure actions that goes against what the nurse knows is the "right" thing to do (Wilkinson 1989, p. 516). Yet, being unable to prevent harm to the patient is apt to be experienced as a personal failing. The sense of failure is heightened when the nurse

actually participates in the moral wrong (Ibid). The nurse may cope with this situation by becoming hardened, self-denying, or merely repressively passive. The following actual case illustrates the process of moral blunting; how nurses are harmed and the practice of nursing is impeded when medical science authority is misplaced in a health organization:

> A premature 900 gram neonate is experiencing severe physical degeneration and has been resuscitated eight times in 24 hours. The parents have been kept abreast of the infant's fragile state. After discussing and reflecting on the information provided they have requested that resuscitation no longer take place. However, the attending physician has verbally ordered the nurses to initiate resuscitation measures and refuses to write "Do not resuscitate" doctor's orders. The nursing supervisor is supportive of the physician's practice and claims the nurses are obligated to follow the doctor's orders. The other nurses are hoping the baby will not Code and need to be resuscitated again, but, he does. The nurse initiating the resuscitation activities is heard apologizing to the neonate, and tears begin to quietly flow as the nurse performs the resuscitation tenderly and skilfully. The physician and nursing supervisor commend the nurses involved on their successful efforts (personal experience).

This example serves to support Chambliss's claim that ethical issues are often "embedded in the complexities of routines and emergencies" and are often seen differently by nurses than others (1996, p. 10). It needs to be considered that having a doctor write "Do not resuscitate" orders is a pattern of practice that places the doctor in the position

of having exclusive moral authority in an area where moral conflict is likely to exist. In addition, using the instrument of "doctor's orders" eschews the moral dimension of the situation by dealing with the situation as a medical science issue. For although the physician may be more knowledgeable than the parents or nurses regarding certain scientific aspects of resuscitation, the physician cannot reasonably claim exclusive authority on whether it is right to resuscitate in these circumstances.

A dysfunctional response to moral wrongdoing that nurses sometime engage in is what Benner & Wrubel refer to as "moral outrage" (1989, p. 381; See also Benner 1991, p. 12). The nurse's way of interacting can become that of chronic outrage when the nurse is continually thwarted in her or his attempts to address moral problems. Nurses who have come to experience nursing in a state of chronic moral outrage are deprived of the energy needed to take therapeutic steps to change the situation and create an environment that supports ethical practice. Additionally, nurses who have come to experience nursing through this affective pattern can gradually become callous and irascible in their interactions with others, even though they still have some moral sensitivity to the other's needs.

Another outcome of moral blunting is that nurses can gradually lose confidence in their moral judgments, lose respect for themselves as nurses, and lose trust in those

who work in the health system. An additional outcome is when the nurse becomes disabled from countering authoritarian and paternalistic practices and feels compelled to engage in them, regardless of the harm caused to themselves and others. The culminating tragedy of moral blunting is the paralysis of the nurse qua moral agent - the virtual cessation of the ability to think, feel and choose morally. Nurses who suffer from moral paralysis are often robotic and indifferent in their demeanour. Gadow's description of "disembodiment" may in fact be indicative of such paralysis (1989, p. 540). When the moral dimension is extinguished or severely repressed the nurse does not act as a whole person, and ends up disregarding others as whole selves too. The patient exists only as the location of some illness or injury to be treated by mindless obedience to the dictates of medical science authority.

The main implication of the medical science model for nurses is that it reduces them to the role of an instrument of medical science, and the medical practitioner's will, and hence, deprives them of genuine moral responsibility (Tadd 1994, p. 11; Curtin & Flagerty 1982, p. 137; Schattschneider 1990, p. 197; Cochran 1985, p. 36; Alderman 1985, p. 142; Aroskar 1985, p. 53). On the other hand, other social expectations continue to be foisted on nurses, and this can create severe conflicts for nurses. Chambliss describes how the social structuring of nursing, in the hospital division

of the health system, has resulted in nurses being caught in the untenable position of being a professional, a provider of medical treatment, and a servile employee (1996, pp. 2-3; See also Krizinofski 1984, pp. 137-151; and Daiski 1996). He claims an "intolerable tension" is created when a nurse wants to engage in morally responsible professional practice (Ibid., p. 1) and others expect the nurse to be subservient (Hardimon 1994, p. 344; Wilkinson 1989, p. 515; Davis 1986, p. 19).[12] Moreover, in wanting to act as morally responsible agents, nurses are not merely indulging some eccentric desire. They are embracing the widely held assumption that nurses are indeed medical professionals with onerous moral obligations that pertain to the well-being of their patients (Curtin 1979, p. 3; Curtin & Flagerty 1982, p. 162; Packard & Ferrara 1988, pp. 62, 69; Davis 1986, p. 20). However, the medical science model supplants these obligations with a simple requirement of obedience. Nurses who maintain a strong commitment to those obligations in defiance of the demand for obedience run the risk of "recrimination and possibly job loss" which Curtin correctly claims is "wrong" (1979, p. 9; See also Wilkinson 1989, p. 515; Appleton 1994, p. 24; Hutchinson 1990, p. 15).

Alternatively, others will experience "the cost" of trying as "too high" a price to pay (Wilkinson, p. 516; See also Kowalski 1985, p. 199; Curtin 1979, p.9; Gaul 1995, p. 54; AARN 1998, p. 3), and will either leave nursing or

continue in the profession in an ethically blunted or paralysed state. The drain on their energy is often conveyed by the expression, "I just got tired of beating my head against the wall".

Pierce et al. has shown that moral wrongdoing was implicated in 7 of the 15 factors that resulted in nurses being dissatisfied with nursing and leaving nursing (1991; See also AARN 1993, p. 3).[13] Nurses in the study left nursing, after a minimum of 8 years of practice, because they saw that obstacles to conducting themselves in a morally responsible manner would take much more time and energy than they were willing to spend. These nurses decided to pursue a different career which would hopefully not involve such personal conflict and inner turmoil. It was noteworthy that 87% of these former nurses were satisfied with the respect they received in their present employment compared to only 49% and 41% of them having felt satisfied with the respect they received from physicians and employer administrators in their last nursing job.

The problems I have sketched in the role of the nurse working within the medical science model reveal the need for concerted organizational change (Benner & Wrubel 1989, p. 384; Potter 1996, p. 345). Without such change, conditions cannot be created in which the dignity of nurses is protected and they are free to discharge their moral obligations to patients. The typical "band-aid" solutions

cannot work here. Merely providing nurses with the opportunity to participate in stress reduction programs and workshops, for example, cannot be more than a distraction until intolerable working conditions are addressed (Benner & Wrubel 1989, p. 388).

The lack of attention given to the influence of organizational patterns of practice on nurses experiencing stress tends to send the message that the incidence of stress shows that something is wrong with the nurse rather than the environment. This in turn suggests the stress will be resolved when the nurse has achieved the "proper" degree of professional development or has faced the fact that she or he is not "cut out" to be a nurse. While to some degree this may be true, it is not the whole story. It is damaging, to everyone, to assume that the stress experienced by nurses in the health system is to be explained exclusively by personal factors. Instead, we need to address systemic features of practices which in many cases are the deepest source of stress (Sherwin 1996).

Altering Patterns of Practice

Tronto claims that a spur to social reform is often provided by viewing moral concepts as political concepts (1993). Alternatively, I suggest social reform in the health system might be better served by addressing the medical science paradigm of authority and its derivative conception of the

nurse's servile role as "moral and political" issues. Engelhardt has opened the door to possible social reform in health organizations by his call for a new conception of medical authority that is not exclusively scientific and that can "cross communities of people" (1996, p. 114). But beyond the suggestions that this must be a form of moral authority that is more socially inclusive than the medical science model, he gives no clear indication of what that alternative authority would be. In what follows I shall sketch some elements of an alternative conception of medical authority, drawing on the arguments of Chapter 2 regarding the ethical basis of nursing and other professional health orientated practices.

The focus of health organizational practices must be human flourishing and as I argued in Chapter 2, the only tenable construct of human flourishing is objectivist. Medical science is relevant here insofar as it enriches our understanding of various elements of life, and helps us to develop strategies for promoting health through scientifically informed measures. Medical science knowledge is thus critically important to medical practice (Pelligrino & Thomasma 1981). But the nature of a flourishing life, and the virtues of justice and care that link the moral agent to the good of others, cannot be determined merely on the basis of scientific expertise. That being so, it becomes irrational to equate medical science authority, which

pertains only to one facet of human flourishing, with the wider moral authority that is proper to health organizations.

As Martin Benjamin has noted, it is in collaborative settings where participants are alive to the moral significance of medical decisions that searching questions about the good of patients can be pursued by professionals in a way that is empowering for all. Benjamin claims a "mutually respectful give-and-take discussion" enables people to see the strengths and limitations in one's own and in other's views so that a morally laudable decision can be reached (1990, p. 7; See also Sherwin 1996, p. 196; Aroskar 1985, pp. 58-60). The point of this inclusive discourse and the shared authority it presupposes is not to accommodate divergent subjective preferences; it is rather to arrive at a fuller, more reliable understanding of the patient's good and professional obligations than anyone - including physicians - could reach in solitude. Yet, the relevant scientific knowledge and the legitimate moral views of patients and professionals could all be recognized and respectfully considered. Of course, decisions sometimes have to be made in circumstances that make inclusive deliberation impossible. My point is only that even when such deliberation is feasible, it commonly does not occur, and when it does occur, it tends significantly to enhance the moral quality of decisions.

To be sure, inclusive decision-making that explicitly recognizes the moral character of medical decisions would not necessarily eliminate all intrapersonal moral conflict experienced by professionals (Chambliss 1996, p. 96; Benjamin 1990, p. 20; Blustein 1993, p. 296), or the incidence of legitimate moral conflicts occurring between professionals and patients (Blustein 1993, p. 289). However, it would have the positive effect of blocking much of the harm that flows from the medical science model, with its disregard of all considerations except those that can be scientifically discerned and measured. For example, under the expanded model of moral authority, criteria used for determining efficiency and effectiveness in professional practice would be altered to include a fuller picture of the patient's flourishing, rather than merely technically orientated medical science markers.

Blustein claims when a person is "under pressure" they may act against what they know is the right thing to do, and so, experience a self-betrayal and a loss of self-respect (1993, p. 296). Creating an environment that does not eschew the moral dimension of life and is supportive of ethical practice in providing services to others can be instrumental in helping all professionals stay healthy and maintain self-respect (Davis et al. 1997, p. 39). However, establishing the authority of the moral dimension of life in health organizations may be met with some resistance. The

task will be unsettling for some individuals, since raising awareness of established wrongdoing "threatens the control and power" of those who maintain illegitimate authority (Schattschneider 1990, p. 199; See also Erlen & Frost 1991). However, if ethical responsibility is considered as essential to ensuring quality services are provided by professionals, then it becomes a priority since it is a part of the "service contract" that a health organization has with society (Tadd 1994, p. 35).

One way for nurses to maintain ethical sensitivity and awaken others to the moral dimension of their practice is to continually address the essential importance of the patient's good in guiding health service orientated practices. This helps nurses stay away from becoming embroiled in discussion that are tangential to the issue of ethical practice. Alternatively, some people may argue that nurses should forsake ethics to survive in an organization where ethical responsibility is commonly an obstacle to the unthinking obedience demanded by others (Crowden 1995). On the other hand, side-lining the moral dimension of what we do creates an impoverished life for everyone associated with nursing and nurses. Moreover, it serves to insulate patterns of practice (in health organizations) from the moral scrutiny that they urgently need (See also Sherwin 1996, p. 192).

Creating environments that support ethical responsibility will not occur overnight and will not occur without heartache, frustration, and setbacks. However, the present will never be improved if continual actions are not taken to keep the importance of ethical practice salient and to awaken people to the unnecessary harm that is experienced when moral wrongdoing and impediments to ethical practice are tolerated and accepted as part of health organization environments.

Conclusion

Moral wrongdoing occurs when the authority of medical science is misplaced in health organizations. Medical science paternalism and authoritarianism result in patients, nurses, and physicians becoming victims and agents of harm. Professionals can have their moral sensibility blunted by eschewing the moral dimension of their practice. Tragically, this can result in the professional becoming ethically incompetent, even though, scientific competence is maintained. Re-establishing moral authority in health organizations will require the continuous use of a moral lens in guiding professional decision-making and practices. A more collaborative and inclusive approach to professional practice, in which science figures as but one element among others in discerning patients' good and professionals'

responsibilities, is endorsed as an alternative to the medical science model.

Notes

1. Benjamin details how a narrow technical and scientific approach to problem-solving can pre-empt serious ethical considerations (1990). See also Tadd (1994). Additionally, Evers claims there is a "myopic" view of the good used in Western health systems that is based on a "white Protestant ethic" (1984, p. 1984).

2. See Cochran (1985, pp. 37-40) for the demand that nurses be loyal to medical science practitioners; and Dunn (1994, pp. 137-138) for a vivid example of how medical science authoritarianism is endorsed in some publications.

3. Bubeck delineates the "irreducible power differential" that exists when a person is able to meet certain basic needs that the other cannot meet alone. She further claims the context of dependency requires the person who is able to meet the basic needs to evince "receptivity and responsiveness" to the other's vulnerability and needs in order to "counteract" the power differential (1995, pp. 141-143, 221). The need for this receptivity and responsiveness in human relations is systematically obscured by medical science paternalism and authoritarianism.

4. Similarly, May claims that the "greatest peril" to human beings is having science accepted as having "power over nature and over human beings" (1960, p. 3).

5. Downie provides a good detailed account of the nature of professional responsibilities that includes ethical practice (1990).

6. Gaita claims people experience pain from seeing and experiencing evil that is done by others (1992). Gaita's reference to evil has similarities to Noddings's (1989) categories of moral and cultural evil.

7. Even though Appleton's (1994) research was not aimed specifically at addressing moral distress, it describes how nurses experience moral wrongdoing. The stress was displayed through fatigue, insomnia, headaches, nausea, diarrhea, crying, nervousness, decreased concentration, agitation. It also included feelings of anger, disappointment, frustration, disgust, fear, anxiety, and worry (1994, p. 25). See also Cullen (1995).

8. Blustein claims a medical practitioner is engaged in either "self-deception" or has a "misunderstanding of the nature of agency" when they try to block their moral responsibility for professional activities by selectively focusing on "technical

proficiency" (1993, p. 292).

9. Zablow found that nurses could not often identify the morally relevant features of nursing situations (1984).

10. Nurses pursuing further education have described their loss of personal energy and reduced self-concept in being morally wronged in the health system (Hoopfer 1988). Similarly, Hughes et al. found that students felt "drained" by experiencing the "uncaringness of staff nurses" and by trying to "make up for" how the patients were being treated (1992, p. 66).

11. Packard & Ferrara claim that sometimes the nurse's "job" actually "interferes with and misdirects" their work as nurses (1988, p. 68).

12. Aroskar claims authoritarian and bureaucratic power often require nurses to act in a way that is immoral (1994). Similarly, Benner & Wrubel claim that the "stresses of nursing become intolerable when the demands of the situation prevent the nurse from performing with a maximum level of skill and compassion" (1989, p. 369).

13. Similarly, medical students have voiced concerns about being mistreated in the clinical arena (Baldwin et al. 1991).

Chapter VI

AN INTEGRATED SCHEMA FOR ETHICS EDUCATION IN NURSING

In an influential paper published twenty years ago, Carper argued that ethics is a specific dimension of knowledge that differs from other forms of knowledge (1978). Since then, scholars have claimed that ethics education needs to be based on moral theory, not solely on science and established therapeutic practices (Scott 1996; Tschudin 1994; Cartwright et al. 1992; Evers 1984). However, ethics education in nursing remains overshadowed by an emphasis on the traditional sciences (Bishop 1990, p. 69), suffers from a fragmented educational approach (Tadd 1994), and tends to use educational methods that stress institutional compliance rather than critical thought (Cartwright et al. 1992, p. 227).[1]

In this Chapter a schema is proposed for the integration of ethics through the entire educational program for nurses. Other scholars (e.g., Ryden et al. 1989; Bergum 1993; Tadd 1994; Krawczyk 1997; Durgahee 1997) have proposed strategies for integrating ethics into nursing education. Thus the proposed model is not presented as a radical departure from nursing education, but rather it involves a distillation of trends that have recently become influential in the field and advances arguments for why an environment that attends to and supports ethical practice is necessary

for ethics education to occur. It is argued that the challenge of ethics education for nurses cannot be adequately addressed through discrete, time-limited courses or by only focusing on the moral development and practices of students. Rather it requires an ongoing attention to ethical practice by all involved. The proposed schema is presented in four parts. First, a general overview is provided and the integrated approach is defended as necessary to enable students to become morally competent practitioners. Second, I describe a specific kind of learning environment that is needed to support this approach to ethics education. It is argued every educator needs to continuously integrate ethics in the nursing curriculum and to shape an environment for students that is morally enabling. Some methods that are central to the educator's task are also discussed. The inclusion of Schon's reflection-in-action approach (1991) within each of Noddings's four methods for ethics education - i.e., modelling, dialogue, practice, and confirmation (1984, 1992, 1995) - are shown to be powerful means of furthering the ethical ends of nursing education. Lastly, it is argued that ethical practice will need to become one necessary benchmark of student progress in nursing education programs.

Ethics Education in Nursing

Ethics is pervasive in daily nursing practice (Wilkinson 1989; Evers 1984; Tadd 1994; Bishop & Scudder 1996; Davis et al. 1997; Bottorff 1991, p. 33). Additionally, it is pervasive in the activities of teachers - including nursing instructors - and prominent in much of the subject matter we teach. Nursing is like many other professions in these respects. Therefore, Carter's claim that it is insufficient for ethics to be presented as a discrete element in professional curricula, isolated from other areas of knowledge and skill, is applicable to nursing (1984, p. 139). In the integrated ethics education schema, ethics is a horizontal, interwoven curriculum thread. This does not preclude specific courses in ethics being offered at various stages (Tadd 1994, p. 26). Rather, it means specific courses in ethics will need to be systematically integrated with other courses and experiences in formal and continuing education programs. The point is to help nurses understand ethics as an ubiquitous constraint on responsible practice rather than an isolated element of expertise.[2]

Ethical practice is of considerable importance in nursing since patients experience a high degree of vulnerability when they need nursing (Hurley et al. 1982, p. 163; Bishop & Scudder 1996, p. 24; Curtin & Flagerty 1982, p. 163; Pask 1991, p. 6). That vulnerability means the patient is exposed to harm when nurses lack moral

competence. Moreover, the vulnerability of patients often dissuades them from defending their own dignity, and thus the ethical competence and assertiveness of nurses can be a necessary bulwark against abuse.

As I argued in Chapter 5, competence in the traditional sciences and the associated technical skills is insufficient for ethical practice. I agree with Sarvimaki that moral knowledge is necessary since a decent person can end up doing harm when the person has limited moral knowledge (1995, pp. 346-348; See also Packard & Ferrara 1988, p. 63). However, moral knowledge is also insufficient. Hurley et al. suggest ethical practice occurs from making "integrated clinical and ethical judgements" (1995, p.42). The emphasis here is on cognitive components of ethical competence, and without supporting attitudes and motivation, that cannot be a satisfactory basis for virtue (Shogan 1988, p. 87; Packard & Ferrara 1988, p. 63; Pelligrino & Thomasma 1996, pp. 18-19).

What is missing in so many accounts of moral education for professionals and others is the necessary element of practice. In fact, Benner claims that practice is the "final lesson" in ethics education (1991, p. 10). However, it is not merely practice that is needed, rather it is supportive practice that is needed (Davis et al. 1997, p. 39). By "supportive" practice I mean experience of nursing that gives the student nurses ongoing support in making

moral sense of that experience. Supportive practice is needed for students to gain a foundation and confidence in being able to contend with the moral complexities of their profession and resist the pressures of moral blunting to which they will be subject.[3] Additionally, a practice-oriented approach will help nurses to see moral conflicts of their daily lives as more than mere "conflicts of interest" or worse yet, as "trivial" distractions from the application of science (Benjamin 1990, pp. 15-20).

One important goal of the integrated ethics education schema is to assist students to consider morally legitimate alternative solutions to problems that are offered by other professionals and patients (Friedman 1993, p. 140; and Evers 1984). This is necessary since nurses work in the context of pluralism and uncertainty (Benjamin 1990, p. 81). To cope with the demands of that environment, they will need to develop "moral imagination" (Griffin 1983, p. 292; Benner 1991, p. 7; Bubeck 1995, p. 221). It is all too easy for people to close the self off from considering alternative legitimate moral views and then suffer from what Carter calls "moral senility" (1984, p. 58). Nurses who have developed the imagination and open-mindedness to discern the merit in contending views will be disposed to compromise where compromise is morally fitting (Carter 1984, p. 58).[4]

Additionally, nurses will occasionally have to forgo the ideal and settle on the "best possible" solution for

nursing others, and their ethical education must prepare them for this as well. Nursing is practised in an imperfect world and in social contexts that cannot feasibly provide unlimited resources for meeting every specific health related need of every person (Sparshott 1968; Tourtillot 1982; Benjamin 1990). And yet, an integrated approach to ethics education can lay the foundation for enabling nurses to participate in the life-long endeavour of ethics education, to practice nursing ethically, and to actively participate in creating social contexts that support just and caring human relations.

The Student - Nursing Educator Relationship

Thompson claims only some nursing educators need to be responsible for ethics education in nursing programs (1991, p. 20). Alternatively, Noddings suggests each educator has a "special responsibility" to enhance the "ethical ideal", and shape a person so they can engage in ethical practice (1984, p. 178; 1988, p. 223). Although Noddings is talking about moral education in general, her point is certainly applicable to nursing education in particular. The pervasiveness of ethical questions in nursing practice means that <u>every</u> nursing educator must be responsible for participating in the process of ethics education. However, this means that some nursing educators will need to engage in continuing ethics education, since some have indicated

they "feel unprepared" to assist students deal with ethics in the clinical setting (Patterson & Crawford 1992, p. 169; See also Green-Hernandez 1991).[5]

Ethics education in nursing will not necessarily make the student into a virtuous nurse. However, the process can help students to "internalize" moral concepts and develop moral responsiveness to the issues that characteristically arise in their profession (O'Hear 1981, p. 122; Fry 1989c; Hunt 1997).

Benjamin suggests ethical growth is enabled by people engaging in "respectful" inquiry that is reflective and open (1990, pp. 5-7). Similarly, various nursing scholars claim that nursing educators "empower" students by being respectful toward students and recognizing their individual needs.[6] I suggest this kind of inquiry and interaction with students can be further clarified through the ethic proposed in Chapter 2.[7] That is to say, student nurses should be able to discern in their dealings with nursing educators the justice as well as the openness to care that befits the ethically competent nurse. Therefore, if nursing educators fail in this regard, they can be criticized in two ways - for failing in their ethical responsibilities as nurses and for failing in their educational responsibilities as exemplars of ethical competence.

Any successful relation between the educator and the student nurse involves a rich experience of trust.[8] Nursing

educators have been criticized by students for being unjust, disrespectful, and uncaring. Students have explained how unethical practices by educators can instill a sense of distrust in the educational environment and deplete a student's energy for learning (Hoopfer 1988, p. 94).[9] Nursing educators are not super-human; they are susceptible to moral lapses. But, these moral lapses need to be addressed. The educator needs to take timely actions to reduce the harm inflicted by such lapses and participate in activities to reduce the likelihood of the lapse recurring (Becker 1986, p. 4).

Educators who are morally self-critical and welcome responsible moral criticism from students and others help to create and maintain a relation of trust with students.[10] This kind of respectful open interaction, which has similarities to what Arnett has described as "dialogic teaching" (1992, pp. 206-226), enables real moral growth to occur without anyone being judged in a threatening or demeaning way.[11] Welcoming inquiry and questioning of each other's practices helps reform the paradigm of authoritarian power that often exists or is perceived to exist in nursing practice.[12]

Trust enables students to disclose their learning needs, as they are reasonably assured their self-disclosure will result in a supportive rather than a demeaning response. This does not mean all students who engage in

self-disclosure must be successful in their educational pursuits in order for trust to be maintained. Instead, it means that even when a student's progress is disappointing, he or she can maintain faith in both the educator's fairness and commitment to helping the student to learn (e.g., Diekelmann 1990). Of course, students will often exercise self-protection in disclosure, given the educator's role in evaluating students' progress. My point is only that the appropriate ethical presence on the part of the nursing educator can in general create a relation of trust in which respectful mutual criticism and a candid acknowledgement of personal lapses is possible.

Another rich learning opportunity is presented when a student commends an educator on his or her interactions with others or on the educator's way of dealing with a difficult moral problem. There are times when simply accepting student compliments is the apt response. There are also times when the situation presents itself as a "learning moment". The educator's focus on enabling student development, coupled with an openness to share the educator's approach to the situation, enables the student to appreciate the complexity of responsible decision-making and responsiveness.

Education in an Ethical Learning Environment

Stenberg claims that in order for ethics to be integrated throughout a nursing curriculum nursing faculty must have a strong "unified commitment" to integration (1979, p. 57). However, as Shogan points out, ethics education will be insufficient when the learning environment is not given moral attention (1988, p. 89; Starratt 1991, p. 187). The commitment of each individual educator to uphold moral standards will be undermined if the overall institutional environment in which nurses are educated and practice does not support justice and the openness to care.[13]

As Aroskar claims, nursing is still practised in a patriarchal system that retains the idea that good nursing is reducible to loyalty and obedience to "superiors" (1994, p. 11; See also Wilkinson 1989; Chambliss 1982 & 1996; Cochran 1985; Winslow 1984; Aroskar 1985; Allen 1990; Boon 1998). Of course, a judicious loyalty and obedience is sometimes appropriate. However, as I have argued in Chapter 5, an environment that expects students and nurses to conform uncritically is oppressive.[14] An institutional environment that is oppressive in this way is also inherently mis-educative. For students to become morally educated, they need to learn to think critically not just about the options they confront in their professional lives but also about the institutional norms that shape those options (Fry 1989c; Cook 1991). Just as morally responsible

nursing educators will exhibit justice and an openness to care in their own conduct and the way they discuss their conduct with students, they are equally responsible for exhibiting those virtues in their reflection on the institutional context of nursing and in dialogue with students about that context. Benner & Wrubel claim the reality of nursing is such that students will experience being "browbeaten" by others (1989, p. 379). Some nurses will also encounter environments in which they are expected, even required, to comply with morally problematic practices even when they know what they are doing is morally wrong.[15] Tadd claims clinical environments can be oppressive and unsuitable for nursing education (1994, p. 36). This means, students need to learn how to individually and collectively address professional practice as a "moral" and a "political" issue (Benjamin 1990, p. 23; See also Wehrwein 1996, p. 297; Boon 1998, p. 31).

The moral critique of established practices is sometimes an energizing experience, but it would be utopian to assume that it is always so. Addressing injustice at the systemic or individual level commonly involves some degree of risk and fear. But to acknowledge this is merely to register a truth that is widely applicable to the moral life outside as well as inside nursing: sometimes justice can only be served through acts of courage. Nevertheless, it is unrealistic to suppose that ethics education can proceed

successfully in a setting where the personal risks of speaking out against wrongdoing are in general prohibitive - i.e., an act of professional suicide. In these conditions, nothing short of institutional change can create propitious conditions for moral growth (See also Potter 1996, p. 345).

Ethics Education Methods for Nursing

Watson (1989) and Crowley (1994) claim that Noddings's processes of modelling, dialogue, practice, and confirmation are essential means by which the correct ends of moral education can be pursued in nursing (1984, 1992, 1995, 1996). The argument of Chapter 3 highlighted some important limitations in Noddings's ethical theory and these are evident in her approach to the methods of moral education. For example, her emphasis on maintaining relationship puts a brake on the process of critical reflection through which student nurses might learn that opposing moral wrongdoing sometimes requires the disruption of personal relationships. Evers rightly claims that educational methods need to counter instructional approaches that have "discouraged self-reflection, critical reasoning, and independent assessments of the ethical nature of nursing situations" (1984, p.15; See also Cartwright et al. 1992, p. 228; Laschinger 1992, p. 113). Therefore, Noddings's methods for implementing moral education in a curriculum can be enriched by integrating Schon's education method of "reflection-in-

action" so that the critical capability of the moral agent is nurtured rather than impeded (1991, p. xii).

Tadd claims that reflective thought involves a willingness to suspend judgments, to maintain a healthy scepticism, and exercise an open mind (1994, p. 10; See also Dewey 1916, 1938; and Downie & Calman 1987, p. 95). Similarly, Schon claims that reflective learning enables development of "new habits of thought and action" (1991, p. xii).[16] This describes what students often have to undergo in order to engage in ethical nursing practice. Some students have to be introduced to new ways of looking at the world, especially when previous socialization has been harmful (Patterson & Crawford 1994, p. 169; e.g., Cartwright et al. 1992; Evers 1984; Wilkinson 1989; Hoopfer 1988). In what follows I address how methods of modelling, practice, dialogue and confirmation can be employed in ways that are duly sensitive to the development of nurses' critical capabilities in moral responsiveness. The methods are best viewed not as discrete strategies serving common educational ends but as different facets of a unitary educational process. For as my discussion will show, specifying the role of any one of these methods in moral education involves an appeal to the others as well.

Modelling.

Modelling is widely endorsed in ethics education (Evers 1984; Patterson & Crawford 1994; Forest 1989; Benner & Wrubel 1989; Watson 1989; Wehrwein 1996). Carter describes the process as teaching morality by "lesson and example all day long" (1984, p. 55). Even though the effectiveness of modelling has not been extensively studied, the research conducted by Hughes et al. suggests instructor modelling does not "directly" enable ethical behaviour toward patients (1992, p. 64). Through modelling alone students do not gain an understanding into the complex processes that underlie what the educator has modelled, regardless of whether the student emulates the modelled behaviour. Therefore, modelling needs to be accompanied by dialogue with students in which the psychological processes underlying modelled behaviour is both explained and held up for critical scrutiny. Such dialogue is also the setting in which elements of moral theory are introduced in ways that make their application to practice clear to the learner.[17]

Modelling enables students to observe ethical responsibility as it is enacted in the daily lives of exemplary professional practice, where that process is combined with theoretically informed dialogue about the significance of what is modelled, modelling becomes a powerful vehicle of reflective moral practice (Davis 1995; Sarvimaki 1995).

Practice.

Practice sessions enable students to openly display their ways of listening, thinking, assimilating information, and responding to the quandaries of professional life.[18] This is important since the student's personal views are often "the first to operate in the clinical decision process" (Evers 1984, p. 16). By being with students in practice sessions, an educator can identify areas where a student is having difficulty with theoretical content, the perceptive rationality delineated in Chapter 2, and the ethical conduct that is the fruit of such rationality. The educator can assist students to reflect on their views, as well as their conduct, to identify difficulties, and finally, to approach subsequent practice in a more thoughtful fashion (Durgahee 1997; Johns 1993).[19] In this way, educational assistance can help students learn from their ethical mistakes (Benner & Wrubel 1989, p. 38; Benner 1991). Additionally, when practice is accompanied by the sharing of experiences among student nurses, educators can help students learn from situations where students have been exposed to the moral mistakes of others. Analyzing mistakes can help develop a consciousness of the wrongness of actions that seem innocent at the time they occur. Oser aptly calls this morally "protective knowledge", since it protects the practitioner from some of the hazards of unreflective wrongdoing (1996, p. 69).

Simulated practice experiences provide opportunities for students to develop competence in ethics without being inhibited by fear of harming patients or being harmed by others.[20] However, simulated practice without theoretical reflection is insufficient because practice by itself does not necessarily reveal the mistakes that are made or the successes that are achieved. Moreover, within the process of ethics education, student nurses must make the difficult transition from merely simulated practice to performance in unscripted, real situations that involve a progressive degree of accountability.

Actual practice experiences require students to more fully attend to the context of the patient's situation. A combination of various practice strategies, like those detailed by Fry (1989c, p. 494; See also Carmack 1997), will be necessary for assisting students experience all the personal and external factors that a student has to become sensitive to in order to engage with sufficient competence in the ethical aspects of nursing. Chambliss is correct in claiming that actual situations provide a richer learning experience than "hypothetical" cases (1996, p. 6; See also Wilkinson 1989; and Lickona 1996). But educators have to ensure that students are not plunged into that richer experience before they are ready for its onerous emotional burdens. As Brandt suggests, a person may experience stress because of not knowing how to implement job requirements in

morally acceptable ways (1996, p. 63). Since stress can impede competence in ethics and elsewhere, it is important that students be assisted to develop the abilities to engage in ethical practice without experiencing debilitating stress.

As they gain in experience, nursing students need to be increasingly involved in devising and implementing health plans for patients and making decisions regarding the actual delivery of nursing and health services. But as students are drawn further into decision-making, their need to cope with intrapersonal and interpersonal moral conflicts and complexity becomes increasingly urgent. For example, actual practice experiences will quickly show students that the relational context of nursing is far more complex than the nurse-patient dyadic structure or the nurse-patient-physician triad that Bishop & Scudder discuss (1996, p. 48). The importance of responding justly to the needs of many different patients and of exhibiting moral responsibility in dealing with others, such as patients' families, can only be adequately appreciated in the context of actual as opposed to simulated practice.

A final aspect of practice is worth stressing in circumstances where student nurses find themselves working in a very imperfect moral environment. In that environment, they must learn how to express anger, disbelief, and frustration in ways that are respectful of others (Benner

1991).[21] Sequential practice sessions can help students become aware of how they frequently respond when experiencing moral wrongdoing and how honesty can be combined with tact, and self-righteousness avoided.

Dialogue.

Dialogue is a necessary method for developing students' moral sensitivity and understanding of the complexity of ethical practice (Evers 1984; Benner 1991; Watson 1989; Diekelmann 1990). Without dialogue, modelling and practice can degenerate into the thoughtless mimicry of established patterns of practice. Dialogue is critical to exploring the cognitive underpinnings of the moral life and aligning good conduct with authentic moral understanding. On the other hand, moral dialogue without modelling and practice becomes no more than idle talk, disengaged from the sphere of conduct and real life.

To avoid the pathology of idle talk, dialogue should be closely tied to practice sessions. Evers claims it is very important that students have the opportunity to express their feelings about their education and "the difficulties they are experiencing in being socialized into the practice of nursing", especially issues related to "role conflict, competence, autonomy, coercion, and accountability" (1984, p. 17). Timely dialogue provides the opportunity to consolidate and deepen the learning that has occurred in

simulated and actual practice sessions. Moreover, the collective deliberation of many participants at clinical meetings or conferences provides rich opportunities for a sharing of insights into the complexity of nursing practice, the exchange of theoretical understanding, identification of gaps in theory, and mutual aid in a process of moral growth. Through such dialogue, participating parties become "enlightened" (Noddings 1988, p. 223; See also Buber 1964, pp. 1-33). The use of practice logs and learning diaries are invaluable learning tools in providing fruitful material for dialogue and self-reflection.

The dialogue which can serve as a powerful educational method in modelling and practice cannot take the form of the values clarification which is still sometimes used in ethics education for nurses (Bandman and Bandman 1995). As Carter has shown, values clarification is "deceptively and dangerously superficial" as it does little more "than look at opinions or feeling" rather than subjecting moral convictions to serious rational scrutiny and exploring their relation to choice and conduct (1984, p. 52). By itself, values clarification does not provide anything like a satisfactory basis for morally educational dialogue (Bandman & Bandman 1995, p. 78; Higgins 1989, p. 203). Values clarification can be a valuable first step in bringing students values to light before they are subject to critical assessment in mutually respectful dialogue. But if the

first step is the last, values clarification will merely confirm students' moral prejudices and blindspots.

When the values of participants in dialogue are clarified, they often turn out to be in conflict, and this is where another educational sub-task is brought into focus - learning to be open to alternative, legitimate moral views and engaging in moral compromise. Fry (1989c, 1989e), Evers (1984), and Hurley et al. (1995) all claim nurses need to learn how to compromise, and sometimes the compromise has a moral content. This is because individuals and groups will often have different but equally reasonable moral views. That being so, even when everyone reasons with due concern for the interests of others, their views are likely to remain "irreducibly plural, diverse, and resistant" to harmonization (Benjamin 1990, p. 81; See also Blustein 1993). Circumstances involving factual uncertainty, moral complexity, and scarce resources, combined with the need to be in a continuing cooperative relationship and the need for a non-deferrable decision to be made, necessitate compromise among mutually respectful people (Benjamin 1990, p. 32). Since these circumstances are encountered daily by nurses, student nurses need to learn about how to distinguish between morally principled compromise, in which one settles for the feasiblely best solution, and unprincipled compromise, in which self-interest and other extraneous factors contaminate common deliberation. Dialogue tied to

simulated and actual practice in which divergent moral perspectives are sympathetically but critically explored is the ideal vehicle for this particular sub-task of ethic education for nurses.[22]

Story-telling has been espoused as a dialogue strategy in ethics education for nurses (Diekelmann 1990; Benner 1991). Smith (1992), Parker (1990), and Benner (1991) have used story-telling in a way that is similar to values clarification, as their approaches involved a somewhat shallow analysis of nurses' stories (See also Benner & Wrubel 1989). But stories can be a powerful source of emotionally engaged moral reflection (Durgahee 1997). Some forms of story-telling have the potential to allow students and others to examine the "practical moral reasoning" that the individual has worked through at critical moments in her or his life (Benner 1994a, p. 59). The personal story is something that cannot be dismissed; it has to be dealt with, learned from, and lived through. A personal story has a tone of responsibility and reality that hypothetical cases do not contain.[23] Additionally, I agree with Parker that some of the "rudiments" of an ethic for nursing are "embedded" in nursing practice and can be uncovered through story-telling (1990, p. 34; See also Benner 1991). But in order for story-telling to be an effective educational strategy, the narratives need to be subjected to serious, theoretical informed scrutiny rather than uncritically

celebrated as expressions of morally laudable nursing practice.

A significant limitation of using story-telling in ethics education is that students may be inclined to describe what they wish they could do or what they wanted to do instead of describing what actually occurred (See also Pelligrino & Thomasma 1996, p. 24). This is not a limitation that negates the use of story-telling; rather it further highlights why an environment of trust is necessary to enable ethics education to occur in nursing and why stories are properly the beginning rather than the end of reflective moral dialogue (Halldorsdottir 1989). When students are not honest about their own experience, the ethical lapses and omissions that mar their professional lives will become blurred by habitual self-deception. Here again, the critical thrust of dialogue is essential to storytelling's potential as an arena for moral education.

Confirmation.

Confirmation is bestowed by the educator on the student when the educator contributes to responsible self-affirmation (Noddings 1988, pp. 223- 224). Like induction into any other profession, the process of becoming a nurse will put strains on personal confidence and provoke doubts about the ability of the self to cope with the ethical and technical demands of the role. If students are to become competent,

trustworthy professionals, they must be able to affirm their own abilities to meet these demands. On the other hand, the self-affirmation that is achieved must be responsible, grounded in a realistic confidence in one's abilities. Students inevitably look to admired teachers for both encouragement and constructive criticism as they struggle toward responsible self-affirmation, and that is why confirmation becomes a critical part of the relationship between educator and student.

Confirmation in ethics education is a complex process. It requires the educator to assist students to progressively grow in confidence and ability during the educational enterprise while at the same time remaining duly sensitive to the limits of his or her abilities (Noddings 1988, p. 224).[24] I suggest this process is unlikely to succeed unless the educator is sensitive to the many factors that influence a student's life and abilities to achieve and realize their aspirations. A relationship of trust and mutual understanding thus becomes critically important. As Noddings suggest, "confirmation" requires a certain kind of "knowing" of the student that enables confirmation to occur, and the student to reach for an ideal that is laudable and attainable (1988, p. 224; 1984, p. 112).

Evaluating Student Progress

Integrating ethics into the nursing education requires fresh thought about how we should evaluate the progress of student nurses. If moral competence is critical to professional competence, we must find ways of assessing its development. Superficially appealing ways of solving this problem must be rejected. For example, performance on a critical thinking or ethical decision-making test cannot be a defensible evaluative criterion in ethics education (Shogan 1988, p. 87; Evers 1984; Emler 1996). Such a test would merely address a few cognitive skills that may have little application in actual moral practice. They do not begin to tell us how well the student is prepared to evince justice and an openness to care in practice settings.

Nursing educators will need to establish credible evaluative markers for determining student progress and failure in ethical practice. I suggest the evaluation system needs to be based on a progressive determination of the student's development throughout the complete educational program. For example, when a student exhibits the confidence and ability to engage in constructive moral criticism of others or the institutional context in which he or she works, this should be documented as a positive assessment of the student's ethical progress. This is opposite to the traditional, derogatory designation of

"whistle-blowing", which labels the critical student as a troublemaker (Fry 1989d).[25]

In nursing as elsewhere, not every student has to progress in the same way at the same rate. But it is reasonable to insist that students be expected to achieve certain thresholds of ethical competence before they move to more advanced stages of professional education. For example, students who have shown little moral awareness or concern in the context of simulated practice should not be thrust into actual practice sessions where they will be responsible for real patients, regardless of how sophisticated their science-based skills are. This approach will necessitate a more fluid approach to student evaluation than is offered by rigid, arbitrary time-imposed deadlines for learning. Additionally, when ethics is fully integrated into a nursing program, the traditional structure of student evaluation in which different instructors are responsible only for what is learned in "their" course must be abandoned. If every nursing educator is responsible for ethics education, then every educator must be responsible for its assessment. Every educator involved with the student will be responsible for providing on-going feedback to the student and assisting student progress in ethics education.

Noddings claims that combining the roles of teacher and evaluator of student progress is contrary to the trust that

good teaching requires (1984, pp. 193-195). Alternatively, I argue evaluation of student progress is more reliable and credible if it involves educators who have been involved with the student. Without the intimate knowledge of another's moral learning that only teaching can afford, one is in no position to make reasonable judgements about moral growth. Having student evaluations conducted by an objective other, as Noddings suggests, would result in the education enterprise being de-contextualized, and a rich understanding of the student's progress, strengths, limitations, and perceived possibilities being denied expression.

A far-reaching implication of integrating ethics in nursing, using the proposed approach, is the need to de-emphasize academic competence in the assessment of student nurses. Frequently, academic achievement is used as virtually the sole indicator of success for accomplishments in nursing education. This is insufficient, as academic achievement does not accommodate ethical practice. Progress in ethical practice needs to form a major component of evaluation in nursing education. For example, nursing educators need to reconsider if it is appropriate for a student to hold first class standing based on academic performance when their conduct toward patients and others is indifferent, callous, or otherwise morally immature.

The lack of a significant positive correlation between academic performance and professional competence has long been noted (Marquis & Worth 1992; Maynard 1996; Hilton 1996). Nurses have often criticized educational programs for graduating students who have lots of knowledge but who do not have the sensitivity that is associated with professional nursing practice (Thayer-Bacon 1993, p. 323; While 1994). While occasionally these complaints have been directed at the performance of technical skills, there is also the deeper concern which is about the moral dimension of the profession (Scott 1996). It is now urgent that nursing educators address that concern.

Conclusion

Nursing education requires the integration of ethics throughout the complete program. All nursing educators, regardless of their specific expertise, must be committed to helping students become nurses who are just and open to care. That commitment is expressed through mutually supporting processes of modelling, practice, dialogue and confirmation which are emphasized throughout the necessary interdependence of critical, theoretically informed reflection and ethically responsible practices. The centrality of moral development to nursing education can only be taken seriously when assessment criteria in nursing education are changed accordingly.

Notes

1. Similarly, Evers claims the limited understanding of how ethics applies to nursing has been a factor in nursing education programs more or less imposing ethical values on nursing students and "abandoning moral inquiry and the development of the student's moral consciousness" (1984, p. 15).

2. See also Tadd (1994); Cartwright et al. (1992). I argue O'Hear's claim that the aim of ethics education is to enable students to have "moral insight and sensibility" is too restrictive for nursing (1981, p. 131), since nurses must be able to actually engage in ethical practice.

3. I suggest Benner's reference to "moral courage" may have some relationship to having the confidence necessary to engage in dialogue pertaining to the moral dimension of nursing practice (1991, p. 8). Moral blunting is more specific than what Maslach (1982) has referred to as "burnout" - defined as the loss of caring. Being morally blunted results from being morally harmed (e.g., treated disrespectfully) by others without sufficient abilities and support to redress the wrongdoing. But it does not necessarily result in the morally blunted being unable to care for anyone. However, the morally blunted person is at risk of losing their moral resolve to engage in morally laudable responses (of either justice or caring) and have moral wrongdoing addressed.

4. Moral senility has similarities to a person who claims the maintenance of their integrity provides sufficient justification for their actions even though their integrity is based on values and beliefs that have an insular rather than moral quality.

5. Carter's following claim regarding moral education is transferable to lifelong moral education in nursing. He claims, moral education is "necessary to give the young and the not-so-developed a place to stand from which to act and respond as moral citizens and secure persons. It also provides a basis of intellectual integrity for searching out, qualifying and polishing positions. A person can be less than certain and still act - as being less than certain is part of life - and keeps a person open to how one lives their life and improving it and each other" (1984, p. 201).

6. See also Miller et al. (1990); Tanner (1990); Halldorsdottir (1989); Benner & Wrubel (1989); Patterson & Crawford (1994). All of these scholars claim that this kind

of approach with students is caring and it empowers students to be caring. I do not deny that students are enabled to care for patient when nursing educators are caring with patients and students. However, their claims that an educator's moral responsiveness is caring and needs to be caring is suspect, since none of the claims have been based on a critical attention to the concept of care. For example, Patterson & Crawford claim "caring" attributes of teachers are "respect for, interest and confidence in the student" (1994, p. 167). These attributes are also characteristic of the moral responsiveness of justice. Therefore, I suggest these scholars may be engaged in the "talk of caring" which, as I have argued in Chapter 2 & 4, does not suffice to establish a distinct ethic of care for nursing.

7. This proposal is in accord with Wehrwein's position that an ethic for nursing education should be explicit in the ethic for nursing practice (1996, p. 301).

8. Carse & Nelson concur with the position that any relationship where one person is dependent on another "must by necessity be bound by trust" (1996, p. 28).

9. Similarly, a study by Baldwin et al. found that 581 responding medical students experienced being mistreated - 84.6% by medical residents and 79.1% by clinical faculty and to a lesser degree by nurses. The mistreatment included being shouted or yelled at, being publicly humiliated, or having others take credit for their work (1991).

10. Alternatively, Noddings claims students and educators must know each other "well enough" for trust to develop (1988, p. 223). I suggest a degree of trust is often present when an educator and student come together and provisional trust in the other is confirmed or negated by subsequent responses. In this way, trust can be created and maintained without a very substantial "knowing" of the other. Similarly, Thomas claims trust occurs when people are prepared to be vulnerable to each other because each has reason to believe they can be counted on not to harm or be harmed, even when there is the opportunity for harm to occur that may go undetected (1993, p. 13).

11. Thomas claims trust and affirmation by someone we value are essential to human flourishing (1993, p. 15).

12. Hughes et al. found that student anxiety was reduced and confidence was bolstered when instructors treated students like colleagues (1992, p. 68).

13. See also Cartwright el al. (1990); Evers (1984); O'Neill (1996, p. 192).

14. Gilbert explains that being a member of a group still allows for individuals to make decisions, as it is individuals who form the collective. However, there is a risk that a person will "subordinate" judgments to the collective (1991, p. 114). This can involve a shift away from the moral dimension that results in the person experiencing an "alienation of the self" (Ibid., p. 115). See also Wilkinson (1989).

15. Wilkinson details how actual forces do threaten nurses who "presume they can oppose sources of power" (1989, p. 515). It is of interest that "doctor's order" can be a force that impedes ethical nursing practice (Benner 1991, p. 14; Wilkinson 1989, p. 515). See also Sparshott (1968).

16. Evers claims the "reflective thinking" is the "only way" to enable nurses to "fuse the need to be objective with the requirements to be ethical" (1984, p. 17). It may not be the only way but it is one way that needs to be more fully integrated and investigated in nursing education.

17. This position is based on personal experience of students requesting to "get inside my head" or just "down load the thinking" I used, so they could better understand how I came to do what I did with patients.

18. Duraghee reports that by learning to listen to others and "make room for" others' views students gradually became more alert and receptive to others and developed discipline and self-restraint in their responses with others (1997, p. 142).

19. Benner refers to this as students learning to take responsibility for their judgments (1991, p. 9).

20. Benner claims "fear" stands in the way of being open to others and being sensitive to the connections that exist between people (1991, p. 15).

21. A person's tone of voice, the words used, facial expressions, and body language can convey whether the person respects the other as a person and is open to care.

22. Higgins refers to this process as moral role-taking (1989, p. 209).

23. This can be understood by referring to the stories Benner (1991), Wilkinson (1989), and others have detailed in the nursing literature.

24. Durgahee claims that key factors to ethical practice "appear to be": confidence, ability to understand patients as rational people, support received while questioning decisions, and patients perceiving the students as persons (1997, p. 141).

25. I suggest when identification of morally problematic practice is labelled whistle-blowing the operating context is more likely that of authoritarian control rather than ethical practice.

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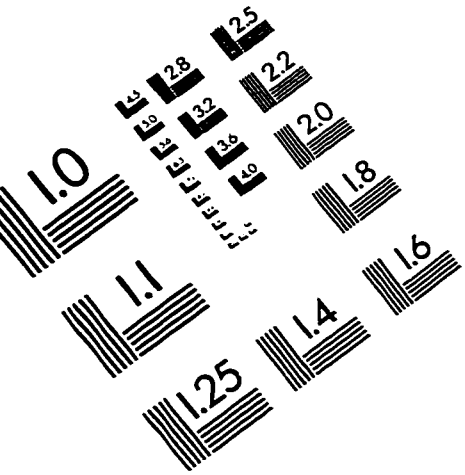

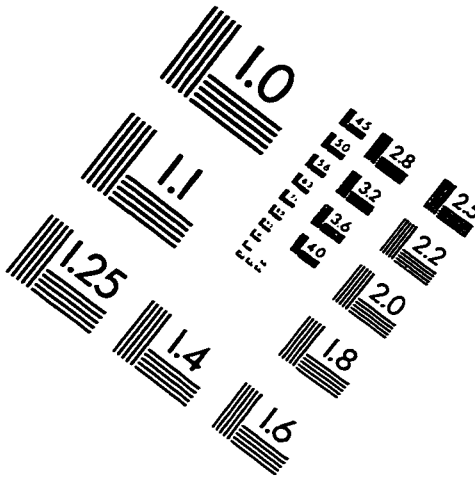

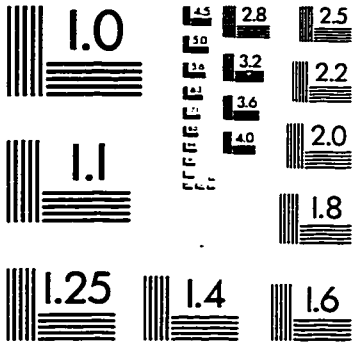

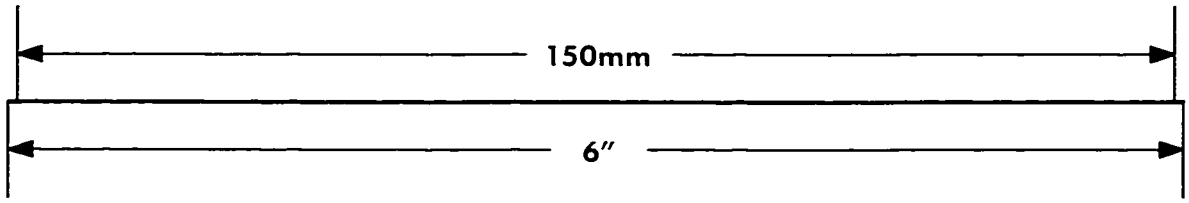

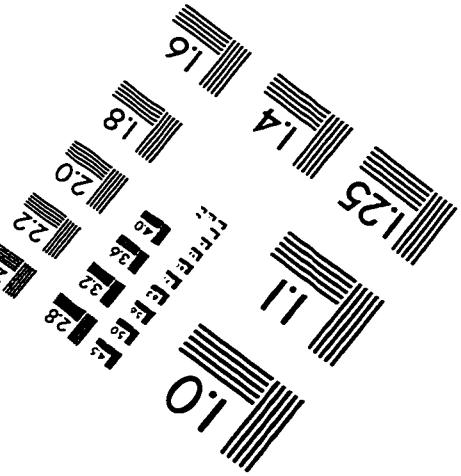

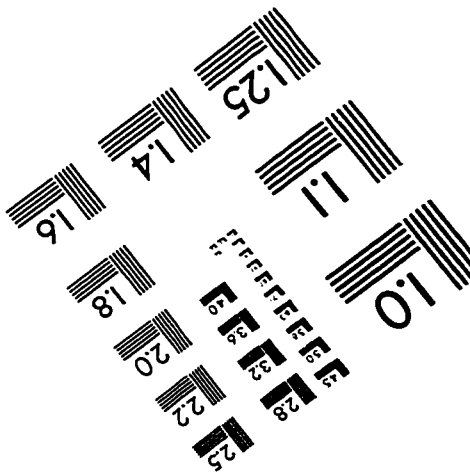

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