

**Virtue in Client Centred Care:
A Philosophical Investigation of Virtue and Nursing
in Canadian Healthcare**

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ABSTRACT

Virtue in Client Centred Care: A Philosophical Investigation of Virtue and Nursing in Canadian Healthcare

Isabelle Mercier

Part of the mandate of the Canadian Nursing Association is to develop and maintain a 'code of ethics'. Provincial professional nursing associations have largely based their own ethical frameworks on this code. However, as Mitchell and Benner have argued, ethical codes fail to capture some essential elements of the ethical life of nurses. This signals a need for a more accurate and experience based ethical framework for nurses. One such attempt is a document published by the Registered Nurses Association of Ontario entitled 'Client Centred Care' that presents an ethical framework that relies on a nurses' practical wisdom and that emphasizes individual experiences of ethical situations based on close relationships with patients. Some traditional ethical frameworks in the philosophical field have come under attack by Neo-Aristotelian Virtue Ethicists for the same reasons. These philosophers, including Wiggins, MacIntyre, Hursthouse, Zagzebski, and MacDowell, have supplemented unsatisfactory, traditional ethical frameworks with one that emphasizes perception of salience, practical wisdom, and practice. Because they are similar in their approaches to ethical life, and in their criticisms of traditional ethical frameworks, 'Client Centred Care' lends itself well to the vocabulary and conceptual structure of Virtue Ethics.

However, for all its merits, 'Client Centred Care' does not provide us with the rigor of a serious ethical text, leaving terms inadequately defined and many questions unanswered. This work is an effort to clarify the ethical claims of this text through the lens of Virtue Ethics. In doing so, I will expose some of the deficiencies of this ethical framework for nurses and propose a curative solution by examining the work of Narrative Ethicists such as Martha Nussbaum.

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To my daughter Anastasia:

who held my hand and led me through her recovery from cancer

and, in doing so, showed me the meaning of courage.

Table of Contents

| | |
|----------------------------------------------------|----|
| Introduction | 1 |
| 1 Virtue Theory | 5 |
| 1.1 What is Virtue Theory | 6 |
| 1.2 A Further Development of the Concept of Virtue | 16 |
| 1.3 The Difference Between Virtue and Skill | 26 |
| 1.4 Moral Education | 31 |
| 1.5 Virtue and the Emotions | 34 |
| 1.6 Conclusion to Chapter 1 | 36 |
| 2 Client Centred Care | 36 |
| 2.1 Best Practice Guidelines of the CCC | 39 |
| 2.2 Why We Need 'Relational Care' | 42 |
| 2.3 Recommendation 1 | 47 |
| 2.3a Human Dignity and Identity | 47 |
| 2.3b The Structure of Illness | 49 |
| 2.3c Authorship | 52 |
| 2.2d Perception of Salience and Practical Wisdom | 58 |
| 2.4 Recommendations 2 & 3 | 61 |
| 2.5 Recommendation 4 | 65 |
| 2.6 Recommendation 5 | 68 |
| 3 Difficulties of Caring Practice | 69 |
| 3.1 Self-Abnegation and Nursing | 74 |

| | |
|--------------------------------------------------|----|
| 3.2 Emotional Responses in Nursing | 80 |
| 3.3 The Public/Private Nature of Human Suffering | 85 |
| 4 Narrative as Curative | 87 |
| Conclusion | 95 |
| Bibliography | 97 |

The Canadian Nurses Association (CNA) is responsible for the maintenance of the profession of nursing in Canada. The CNA describes nursing practice in Canada as a 'self-regulating profession'. As a practice, the CNA reminds us that "one of the characteristics of a self-regulating profession is the development of standards of practice, based on the values of the profession [and] for nurses in Canada, these values are articulated in the Code of Ethics for Registered Nurses" (CNA). The Code of Ethics is a set of moral commitments guided by eight core values. They are: 1 - safe, competent and ethical care, 2 - health and well-being, 3 - choice, 4 - dignity, 5 - confidentiality, 6 - justice, 7 - accountability, and finally, 8 - quality practice environments (CNA). These concepts act both as a reference for the specific rules of conduct indicated in the Code of Ethics, and as a model of behavior for individual nurses in their day-to-day activities. Within the cadre of the CNA and the Registered Nurses Association of Ontario (RNAO), the Nursing Best Practice Guidelines (NBPG) — a province of Ontario project that promotes the advancement and development of nursing practice -- has developed an articulation of nursing practice within the scope of the CNA Code of Ethics.

In July of 2002, the NBPA in association with the RNAO published an 80 page guideline entitled 'Client Centred Care' (CCC). The document's intended purpose is the "development and utilization of 'client centred' best practice for all health care sectors, which empowers the client, improves client satisfaction, and enhances quality of care and quality of work life" (RNAO, 12). The document's guidelines include five summary recommendations that encompass the purpose of client centred care and whose scope reaches various levels of care including relationship development, valuation, decision making, workplace environment, and education.

My present purpose is to work through these guidelines and recommendations in an effort to inject a philosophical analysis of the ethical claims that are made in the document. To do so, I will provide an appropriate theoretical context of 'practice' and 'care' with talk of virtue that will serve as a background to both clarify and criticize the findings of the document. I will show that the CCC document can be illuminated through the theory of Virtue Ethics. Virtue Ethics provides a richer understanding of the ideals embedded in CCC. I will also extend my discussion of Virtue Ethics to clarify the relationship between Virtue Ethics and an Ethic of Care. I will show that both Virtue Ethics and an Ethic of Care richly articulate the context of CCC. Frequently the Ethic of Care in nursing practice involves institutional structures that can put women in a vulnerable position and can further burden women with the load of illness, dependency, and emotional investment. This feminist concern is that an Ethic of Care that expresses the ideals of nursing risks trapping nurses in roles that are disempowering. I will show that narrative creates a common bond and a sharing of experience which can be used to counter the institutional limitations of nursing so as to make space for, and support the best practices of caring.

I hope that this thesis will provide insight into my experience of nursing and client centred care. My daughter, Anastasia, was diagnosed with *adrenal cortical carcinoma* shortly after her first birthday. Anastasia is now a healthy and happy little girl, and has been in complete remission for over three years. As a mother, I found that the care and support that nurses offered my family was very important and often went beyond the basic administration of procedures. Many nurses became friends, and essential members of our extended family. As an academic, I wondered about what kind of ethical structure

supported nurses in their taxing role as caregiver and friend. How could these men and women, who clearly cared so much about people, choose a profession that put them into contact with so much suffering? What was the structure of the personal relationship between nurses and patients? How did this relationship affect both patients and nurses? How did nurses balance their personal commitments, values and beliefs with the values of nursing practice? How did nurses know *how* to care? I started thinking about this thesis with these questions in mind. What follows is more than an academic exercise. It is, for me, an answer to these questions, and it captures my experience of nursing care.

In Chapter 1, I begin my exploration of virtue and Nursing Ethics by providing a clear and succinct definition of virtue and Virtue Theory. Alisdair MacIntyre describes the role of virtue in practices. Virtue is essential in that it both enables practitioners to attain goods that are internal to a practice, and helps practitioners attain and even stretch standards of excellence within a practice.

Rosalind Hursthouse clarifies some key points about virtue. She explains that virtue is acquired, that it provides people with guidance, and finally, that virtue can be understood as being part of one's character. John McDowell further refines this description of virtue with his explanation on the motivational structures of virtue. Linda Zagzebski makes an important distinction between virtue and skill. Sabina Lovibond describes how a virtuous person learns how to be virtuous. Virtuous people learn how to be virtuous by a process of habituation that shapes their perception so that they respond appropriately to ethical situations. Part of this appropriateness is found in the emotional response. Virtuous people not only behave in ethically appropriate ways, they also *feel*

the right way. Virtue is a rich and complex concept and refining our understanding of virtue contributes to our understanding of moral life.

In Chapter 2, I argue that care is a virtue and is essential in understanding the role of virtue in nursing. CCC outlines recommendations that focus on the personal relationships with patients. The thinking behind this document signals a shift in healthcare from a model of healthcare that values impersonal and detached administration of procedures, to a more dynamic, personal, and situation-based model of nursing. Peta Bowden examines this shift and discusses the key issues that are involved in nursing care. Though CCC does a good job of touching on some key issues in Nursing Ethics, I supplement these issues with the vocabulary of Virtue Ethics and thereby clarify and expand upon some of these points.

I note in Chapter 2 that CCC describes the nurse-patient relationship as personal and essential to a patient's wellbeing. The personal relationship described by CCC, however, places serious demands on nurses who are systematically undervalued in our society. In Chapter 3, I argue that in institutions that do not provide nurses with the support they need to enact the recommendations of the CCC, the burden of nursing care falls squarely on the shoulders of nurses -- who are typically women. This is, therefore, a feminist concern and one that Ellen Fox deals with in her tracing of the problem of self-abnegation in an Ethic of Care.

Part of the problem of an Ethic of Care is that it may sometimes require women to divest themselves of their own concerns while adopting the concerns of another. This has led to emotional burn-out in many nurses. Hannah Arendt explores the theme of self-abnegation in her discussion of co-suffering. She argues that the only appropriate reaction

to suffering is co-suffering and that this excludes possibilities of articulating suffering. According to Arendt, once we talk about suffering, we are no longer reacting to suffering in an appropriate way.

Despite Arendt's insight into co-suffering, the sharing of stories is a powerful teaching tool in nursing. It has been my experience that the sharing of stories makes up a large part of nursing practice. In Chapter 4, I argue that stories can be used by nurses to share their experience with co-workers, comfort patients, learn from other nurses, and even learn from their patients.

Patients also share their stories of suffering with other patients. Martha Nussbaum argues that narrative is an important part of moral life because it draws on moral imagination and attention and extends our understanding of essential characteristics of moral experience. Because the sharing of stories extends a nurse's experience of suffering, of illness and of a patient's world, it is an important part of caring. But, beyond that, storytelling can be used to alleviate the problem of co-suffering described by Arendt. When nurses engage in storytelling, they can draw on their moral imagination to remove themselves from co-suffering and imagine possibilities of a positive future for both themselves and their patients.

1 Virtue Theory

Virtue Theory can be used to illuminate key points of CCC guidelines which run the risk of failing if they are explained with utilitarian or Kantian notions of duty. This is because Utilitarian and Kantian theories fail to capture something essential about the moral experience of nurses. In the following chapter, I will describe MacIntyre's notion

of a practice and show why virtues are necessary for the development of practices. I appeal to virtue theorists, Rosalind Hursthouse, David Wiggins, John McDowell, and Linda Zagzebski, to refine my concept of virtue. This concept will provide the theoretical background to understand and elaborate the recommendations of the CCC guidelines.

1.1 *What is Virtue Theory?*

Virtue is a reliable sensitivity¹ to moral landscape. A virtuous person discerns particulars about a situation. A kind person, for example sees opportunities for kindness, and acts kindly. A courageous person sees opportunities for courage and acts courageously. Virtuous people do not ‘choose’ to act virtuously; instead, they perceive the world in a way that is different from non-virtuous people.

Unlike ethical theories (like Kantian ethics and Utilitarianism) that seek to extract general moral lessons from particular situations, virtue theory embraces the complexity and uniqueness of particular morally significant situations. Since Iris Murdoch and Elizabeth Anscombe complained about the dryness of philosophy and the difficulties of both Kantian ethics and Utilitarianism, many philosophers have turned to Aristotle for a more satisfactory way of understanding moral life. One such author is Alisdair MacIntyre.

In 1981, Alisdair MacIntyre published After Virtue – an influential and important text in the development of Virtue Theory. In it, MacIntyre grapples with the complex concept of virtue. In chapter 14, MacIntyre lists wildly different catalogues of virtue and

¹ In *Virtue and Reason*, John McDowell introduces the term ‘reliable sensitivity’. Virtue, he argues, is a “*reliable sensitivity* to a certain sort of requirement that situations impose on behaviour” (51) (italics are my own).

virtue theories found or implied in various key Western writers. What is striking to MacIntyre is that these lists fail to provide us with any single coherent account of virtue. MacIntyre provides an outline for a more compelling and coherent account of virtue than any one of these single authors. One of his valuable insights is that we can understand a good deal about virtue by situating virtues in the context of what he calls a practice. Making use of the notion of practice as the context within which people exercise virtue, MacIntyre has linked virtue with excellence to show that the cultivation of virtue is necessary for the pursuit of goods internal to practices. Without virtue, practices degenerate into the pursuit of external goods such as fame, money, and power which breed competitiveness, greed and loss of meaning.

The efforts of the NBPG can be understood properly only with the understanding that practices involve the combination of: 1 - formal access to skill, and 2 - concepts of self-scrutiny and excellence. The challenge of maintaining and advancing a practice must touch on these two elements. When nurses want to improve the practice of nursing, then, they must include efforts to promote excellence while valuing the positive historical development of the practice. The articulation of what counts as 'excellence' and 'positive historical development' is the responsibility of the members of a practice. Alisdair MacIntyre argues that this articulation is inextricably tied to virtue. The following is an outline of MacIntyre's discussion, in chapter's 14 and 15 of After Virtue, of practices and virtue.

Our concept of virtue – both what qualifies as virtue, and what exactly virtue *is* -- is made intelligible by the social and historical background in which it has developed. In his discussion of virtue in After Virtue, MacIntyre develops the notion of practice insofar

as it is the first stage of a logical development of the background in which our modern conceptions of virtue emerge. What is central to the concept of a practice is the notion of goods internal to a practice. In what follows, I will explore what is meant by the phrase 'goods internal to a practice', and I will clarify how MacIntyre's discussion of practices contributes to an overarching conception of virtue.

MacIntyre defines a practice as:

any coherent and complex form of socially established cooperative human activity through which goods internal to that form of activity are realized in the course of trying to achieve those standards of excellence which are appropriate to, and partially definitive of, that form of activity, with the result that human powers to achieve excellence and human conceptions of the ends and goods involved, are systematically extended (187)

For the purposes of this thesis, two important claims are made here: 1 – that there is an important distinction between internal goods and external goods, and 2 – in striving to achieve excellence associated with a given practice, we extend our conception of these standards and also our power to achieve them.

The first claim distinguishes internal goods from external goods. MacIntyre illustrates the difference between the two kinds of goods in the following way. Imagine wanting to teach a child chess. The child, who has no particular interest in playing chess (but considerable interest in candy), is offered candy for playing. Furthermore, the child is offered candy if she wins. The child's motivation and purpose for playing chess is candy, and not the joy of playing chess itself. The goods of playing chess are external. But, in time, the hope is that the child will "find the goods specific to chess, in the achievement of a certain highly particular kind of analytic skill, strategic imagination, and competitive intensity, a new set of reasons now not just for winning [but] for trying to excel" (MacIntyre, 188). The shift from wanting to play chess for candy, to wanting to

play chess for the particular joys associated with just playing the game illustrate the differences between internal and external goods. More specifically, internal goods can be distinguished from external goods in the following ways:

- 1 – external goods can be attained through a variety of means whereas internal goods can only be attained through participation in practices
- 2 – external goods can be specified by everyone whereas internal goods can be specified only within the context of the particular practice in which it evolved
- 3 – external goods can be recognized by everyone whereas internal goods can be recognized only by those who are familiar with the particular practice under which that good arises
- 4 – external goods are good only for the person receiving that good whereas internal goods are good for everybody who participates in that practice

We can gain insight about the first distinguishing factor between internal and external goods by referring to our chess example. Candy can be acquired through a variety of means – which might include stealing, doing chores, working, asking Grandma. The competitive intensity of playing chess – the satisfaction of having successfully maneuvered the pieces across a board, and to be able to say “check – mate” – can be acquired only by playing chess. In a similar way, we can understand the second distinguishing factor. All children can appreciate the lure of candy (whether we like candy or not). On the other hand, only people who have become enchanted with the game of chess can understand the particular satisfaction of winning a game. Patricia Benner and Suzanne Gordon give a concrete example of the third distinguishing feature when they explain that,

it only makes sense to talk about being a good doctor, nurse, father, or mother because we have concrete practices and culturally transmitted visions that help us recognize and acknowledge excellence in these practices. Even though we may not be able completely to spell out the formal criteria for such roles, we can recognize another good practitioner, if we are ourselves practitioners, or appreciate and participate in caregiving with that practitioner because we are recipients of care (44)

To recognize a good nurse, one must be familiar with the underlying standards that define and describe excellence in nursing. This is because participation in a practice requires “the [acceptance of] the authority of standards and the inadequacy of [one’s] own performance as judged by them” (MacIntyre, 190). The final distinguishing feature explains how we are able to receive care from a good practitioner, even though we may not participate in the practice. External goods are not shared. If one person gets the prize or wins the money, others lose out. Whereas, when one person achieves the goods internal to a practice -- excellent performance -- all benefit. Good nursing according to high standards benefits the whole community.

External goods have a place in practices in our society. In recent years, the practice of Yoga, for example, has seen an economic boom. For evidence of its widespread economic success, one need only look in a variety of ‘women’s fashion’ magazines. One such magazine called Ottawa City (an monthly insert for the Ottawa Citizen) follows the growing Yoga ‘trend’ in the Ottawa area. An article lists various facts about the practice in Ottawa including its growth in number of schools from 4 in 1994 to the present count of 14 (Ottawa City, 10). Yoga, once a fringe practice in Canada, has enjoyed recent economic success in its popularization and has contributed to the development of an ever-expanding derivative market not excluding yoga clothing, equipment, and food. Once again, in the trend section of the magazine article, we learn of the various products that have arisen from the trend including body lotions, colourful Yoga mats, and \$125 Yoga bags (Ottawa City, 10-11). Though some may argue that the external goods of yoga in its modern Canadian inception may overshadow or downgrade the importance of the internal goods, many of those who practice yoga continue to do so

for the access to internal goods, such as spiritual well-being, improved health, and serenity². By the continued participation of the activities found in a practice, the emergence of internal goods may supercede the importance of external goods. In this way, yoga becomes more than an arbitrary stretching of one's limbs, or a trendy phenomenon. Yoga provides its practitioners with internal goods. Our understanding of the goods internal to a practice is tied to historical developments in the practice as well as to the performances of exemplary people.

The second feature of MacIntyre's definition of a practice is supported by his discussion of virtue. Virtues, argues MacIntyre, are necessary if we are to maintain both a concept of the goods internal to practices and the power to maintain the motivation to pursue those goods in the face of temptations to settle for external goods.

MacIntyre argues that virtues are necessary for the attainment of goods internal to a practice. He explains, "a virtue is an acquired human quality the possession and exercise of which tends to enable us to achieve those goods which are internal to practices and the lack of which effectively prevents us from achieving any such good" (178). MacIntyre is not arguing for a loose and rather uninformative interpretation of virtues that sees that *all* virtues, *in some way or another*, contribute to the attainment of internal goods. This may or may not be the case. There are, however, virtues that are *de facto* necessary in development and attainment of internal goods in a practice as we understand it. They include three key virtues: justice, courage and honesty.

² See following discussion of the corrupting influence of institutions for an extended discussion of the corrupting influence of external goods. For the present discussion, we need only ascertain that practices include both internal and external goods.

The three key virtues of justice, courage and honesty function to maintain the appropriate relation to standards within a practice and the tradition in which these standards evolve. When a person enters a practice, they both enter into a relationship with other practitioners *and* with those practitioners who have established current standards of excellence within the practice. Virtue is the kind of perception that enables practitioners to have appropriate relationships between standards of excellence and goods internal to a practice. Virtue enables practitioners to recognize model performers and to be willing to submit to their authority and to the authority of the best standards of excellence.

Every practice is maintained by the participation of its members. This continued participation demands of its members both the maintenance of the traditional and historical establishment of the rules and standards of excellence, and the development of new standards of excellence through innovation within this pre-established framework. This balance of maintenance and progress occurs through the cooperative efforts of the participating members of a practice. People who congregate because they have common goals share a vision of what is good. In the case of practices, they share the goals associated with the internal goods of a given practice. Practices flourish when they provide genuine opportunities for the advancement, attainment, and specification of a certain kind of good – when they create a milieu for those people in pursuit of a common goal. These opportunities or ‘milieus’ arise because of virtue. Practitioners further specify internal goods by exercising virtue in action and in the development of relationships between fellow practitioners.

“We define our relationships,” says MacIntyre, “by reference to the standards of truthfulness and trust” (179). We also define them by reference to justice and courage.

When we participate in a practice, we must presume that our opportunities for the achievement of excellence are justly parsed out. Justice demands that all people are treated “according to uniform and impersonal standards” (179). If a nurse dotes on patient A who has a broken leg, giving them careful and particular attention, and hurries through her care of patient B whose leg is also broken, her relationship to patient A and patient B is different. The relationships formed and defined within practices are always realized with reference to justice since justice is definitive of all human relationships. Trustworthiness or justice are virtues that define relationships between people. Unlike honesty or justice, however, courage may also define relationships a person has to a certain cause or ideal. It takes courage to risk one’s life, reputation, or livelihood for a given goal.

Practices flourish in societies where the virtues of justice, honesty, and courage are exercised. Because they are essential to the relationships that are defined within a practice, these virtues (or indeed, virtue itself) is necessary to make a practice thrive. Furthermore, a practice thrives when its practitioners are able to trust that the standards of excellence and achievement are just and that the people involved in the practice are genuinely committed to the achievement of excellence within that practice.

Practices are also inextricably linked with institutions. In our society, practices are supported by institutions. There is a concern that institutions, because they are primarily involved with the distribution of power, money and status, are often antithetical to the interest in internal goods inherent in practices. External goods can have a corrupting influence on practices. However, corrupting as they may be, institutions provide our society with the practical ‘raw space’ and governing laws necessary for the emergence of

practices. Martha Nussbaum, in a recent talk at Carleton University, entitled *Global Governance*, touted the importance of institutions in the effective redistribution of wealth in modern liberal societies. Institutions, she argued, are the most efficient way³ to redistribute resources in a morally neutral way. From this moral neutrality, she said, justice emerges. But, in a modern liberal society, the presumed moral neutrality of laws and governance makes presence of virtue in practices is ever more necessary. If we are to see justice emerge from morally neutral institutions whose main concern is with the redistribution of resources, it must find its origin within practices – those complex human relationships entrenched in historically developed standards of excellence. Moral and ethical concerns find their place within the virtues that maintain the integrity of practices. And if practices are to continue to develop, the exercise of virtue tempers the corrupting influence of institutions that are typically interested in external goods.

Another characteristic of a practice is that institutions are formally defined whereas practices are not. Benner and Gordon explain that “a practice [like caregiving] cannot be completely objectified or formalized [because] the practice must be carried out in constantly evolving, living relationships that allow feelings and attitudes to guide meaningful human interactions” (45). In this sense, practices are said to be living. Constant re-evaluation and re-defining means that practices are in a constant state of change.

Why is this important for nursing practice? Though I will explain in more detail what role virtue has in nursing practice in the following chapter, there are a few important details in this current discussion that are important to highlight at this stage. As with

³ As opposed to selective philanthropy common in wealthier nations, especially the U.S.

nursing practice, nursing requires that one distinguish between internal and external goods. We can picture a nurse who enters the profession of nursing because she is aware of the shortage of nurses in Canada and expects to get solid work once she has completed her education. When she does find work, she is concerned only with her paycheck – her habit of doing the minimum amount of work to improve her skills and the minimum amount of commitment to the wellbeing of her patients reflects a primary motivation – maintaining employment. On the other hand, we can picture a nurse who enters the profession of nursing because of a passion for caring for people. She constantly seeks opportunities for professional development as a way to increase her skills and understanding of the profession. She is committed to her patients and takes risks to uphold and defend the wellbeing of her patients when needed. Though she requires a paycheck, her motivations for being a nurse are internal to the practice. In her participation in the practice she reflects on the best standards of the practice and reflects on those who have exercised honesty, courage and justice in the pursuit of those standards: honesty in self-assessment and the praise of others, courage in taking risks, and justice in awarding recognition to those who have exemplified excellence.

MacIntyre describes a place for virtues in modern liberal societies. He shows that the concept of virtue is inextricably linked with practices which, in turn, are logically connected to the notion of internal and external goods. Virtue is also linked with recognizing standards of excellence that define the practice as it has evolved through time in particular traditions with exemplary performers and performances that have become authoritative for those learning the practice. He also lists the key virtues that are most important in the maintenance and advancement of practices. MacIntyre shows how

virtues enable us to aim for excellence by giving us a vivid concept of the particular form of excellence, a capacity to recognize those who do enact these standards, and the motivation to do so as well. We must now turn to Rosalind Hursthouse to refine our concept of virtue and how virtues function.

1.2 A Further Development of the Concept of Virtue

In On Virtue Ethics, Rosalind Hursthouse offers an excellent overview of the modern, neo-Aristotlean version of what virtue is. In her book, Hursthouse traces the Aristotlean roots of virtue in modern theory. I will provide an outline of three key points from Hursthouse that clarify my description of virtue. They are: 1 - virtue is acquired, 2. - virtue provides people with guidance through 'v-rules', 3 - virtue is a reliable feature of someone's character.

Virtue is a kind of knowledge that is learned by experience. Hursthouse borrows this concept of virtue from Aristotle. She writes,

moral knowledge, unlike mathematical knowledge, cannot be acquired merely by attending lectures, and is not characteristically to be found in people too young to have much experience in life ... we do not think of moral [wisdom] – of knowledge of what one should do – as easily come by (59)

Learning how to be virtuous is not about learning a series of guidelines about how to behave. Virtue theorists, like Hursthouse, support the notion that virtue is learned through a process of habituation where moral landscapes become apparent to the actor. Like MacIntyre's young chess player who learned how to appreciate the internal goods of chess by playing the game, a person becomes virtuous by being exposed to morally significant situations. We can imagine a young nurse who has never been exposed to death. How does she react when she is confronted with this situation for the first time?

Her reaction will, in part, depend on her ability to recognize that this counts as a morally significant situation – that a patient’s death *matters*. If she does this, she is already partway there since virtue starts with what a person takes to be meaningful. But, she is not there yet. She asks herself, ‘when should I allow my grief for the patient to be expressed by crying with the family?’, or ‘Is this a moment in which I must discretely act as though I am not there as a person who might make the patient’s family embarrassed?’. Nurses have to be able to perceive the salient features in each situation. Often times, for nurses, excellence in the perception of the salient features of a situation – virtue – arises from appreciating the accomplishments of ‘expert’ nurses. In nursing practice, this appreciation is accomplished by engaging with expert nurses and reflecting on the goods internal to that practice and by watching expert nurses as they maneuver difficult moral landscapes. Teaching virtue to nurses consists in occasions to reflect on the internal goods and the ways in which individuals manifested excellence in practice. Only after exposure to excellence in nursing, and the opportunity to reflect on these excellences can our young nurse become virtuous.

The second key point I will discuss about virtue is ‘v-rules’. The concept of a ‘v-rule’ represents Hursthouse’s attempt to address the criticism that virtue does not provide us with any helpful guidance about how to act. Hursthouse makes sense of the problem of non-codifiability by suggesting that virtue theory is non-codifiable only in the traditional moral sense. This traditional sense relates the capacity for a theory to provide guidance directly to its ability to generate a series of rules about specific conduct in not-yet-specified situations. These traditional moral theories want rules to function prescriptively in what is admittedly a world of generalities. In doing so, these moral theories attempt to

block the sensitive reasoning that moral situations tend to call for. Hursthouse argues that any moral reasoning of any significance – even in traditional moral theories – does not take place in the generalized, pre-situational, stage of moral deliberation. If, for example, the rule is ‘do not lie’, moral deliberation does not end here. Interesting moral deliberation occurs when an actor is trying to determine which situation counts as one of lying. Traditional moral theories, then, are unsuccessful at giving us rules that could be applied by just anyone. Her point is (and it is one that is echoed by other Virtue Theorists) that being a good person requires more than the blind application of rules – it requires a sensitivity to the salient features of the situation. Hursthouse provides us with a concept of v-rules as a challenge to the criticisms of virtue theories’ non-codifiability. V-rules, however, only guide the already morally sensitive actor. Moral theory, then, must extend itself to talk of moral education and the shaping of moral sensitivity.

Hursthouse’s sense of the purpose of moral rules salvages the codifiability of virtue and highlights a prescriptive component of virtue that often remains latent in Virtue Theory.

Her insight is that Virtue Theory does provide us with guidance in the form of rules. V-rules, like ‘do what is honest, do not do what is uncharitable’, tell us to act virtuously. An honest person knows what to do in the kind of situations that call on someone to enact the rule. This explanation seems simple enough but can be unsatisfactory to people who want an answer to the question – how do we know when a person is applying a v-rule correctly? The answer to that kind of question has to do with reasons for action.

In traditional moral theories, rules provide both guidance and motivation for action. So, when asked, ‘Children, why did you refrain from littering’, they can answer

‘because it is wrong to litter’. That answer is intelligible because the children’s reasons for acting in such-and-such a way require judgment only insofar as they determine that this is a situation that would count as littering. Once that judgment is made, the rule provides the motivation for action. Motivation for acting in the virtuous person, however, is of an entirely different sort. Consider Hursthouse’s description of a virtuous person’s reasons for acting.

Thinking of the sorts of reasons a courageous agent might have for performing a courageous act, we can come up with such things as ‘I could probably save him if I climbed up there’, ‘Someone had to volunteer’, ‘One can’t give in to tyrants’, ‘It’s worth the risk’ (128)

The reasons here do not consider the possibility of either acting or not. Courageous people simply act when they have to act courageously. Reasons for acting identify the possible ways in a virtuous person’s capabilities that can best express the virtue. For the virtuous person, reasons, “indicate what [is taken] as relevant or salient, advantageous or disadvantageous, good or evil, decisive or compelling” (Hursthouse, 129). These kinds of reasons can be understood only by someone who is in a position to appreciate them already.

The third key point from Hursthouse is the notion that virtue is a reliability of character. Virtuous people care about virtue. We expect that someone who is honest will abhor dishonesty, that a courageous person will dislike cowardice or deeds or that a kind person will be disapproving of malevolence. We expect that virtuous people will have “a reliability in [actions] that reflect their attitudes [to virtue]” (Hursthouse, 11). Virtue resonates within virtuous people so that their whole perception of the world is illuminated by virtue.

The concept of virtue as a reliability of character is further developed with a notion of virtue being linked to an overarching concept of the good life, or *eudaimonia*. David Wiggins describes how Aristotle might want *eudaimonia* to be articulated. In his essay, *Deliberation and Practical Reason*, Wiggins explains that Aristotle might object to the claim that deliberation, specifically deliberation about ‘a man’s ends’, is strictly technical. The following is a description of deliberation (action-syllogism):

- 1 – One should use an umbrella when it rains
- 2 – It is raining outside
- 3 – I should use an umbrella

The correct picture, according to Wiggins, identifies the first statement (the major premise) as saying “something that can be the subject of desire, *oxexis*, transmissible to some practical conclusion” (227). In this case, the subject of desire is ‘remaining dry’. The second statement (the minor premise), “details a circumstance pertaining to the feasibility, in the particular situation to which the syllogism is applied, of what must be done if the claim of the major premise is to be heeded” (Wiggins, 227). Essentially, of these two statements, only the first can be said to pertain to ‘the good’, and the second pertain to ‘the possible’ (Wiggins, 227). Wiggins remarks that this is not particularly informative about the ‘good’ on its own. We can imagine a scenario where a nurse is trying to decide what to do with an elderly patient who is afraid of needles. Her action syllogism may look something like this:

- 1 – Nurses should comfort elderly patients
- 2 – This patient needs comfort
- 3 – I should comfort this patient

One way we could look at this is as a technical (rule-case) solution to an ethical problem. In these cases, the major premise identifies a statement about the world; the major

premise is applied to a particular case in the minor premise followed by an action. However, the technical (rule-case) paradigm interpretation of the action-syllogism does not provide a valuable and vital solution to ethical deliberations. The nurse is still left asking herself – ‘what does it *mean* to comfort my patient?’, and ‘how do I go about comforting her?’. This is the same complaint that Hursthouse broaches in her discussion about v-rules. This way of approaching action syllogisms, or indeed moral life, incorrectly supposes that ethical/practical deliberation has to do with determining what rules generate ethically sound acts. Wiggins argues that Aristotle defends the position that much interesting ethical work is found in ethical perception and deliberative specification. That is, the articulation of the good is where interesting moral work happens. Interesting moral work happens when our nurse seeks to answer her questions about what counts as comforting and when and in what way a particular patient needs comfort. In all action syllogisms, this answering is directed towards articulating the good. However, the picture of the good – this articulation – is not like the articulations of a general good of a rule-case approach, rather it belongs to the deliberative methodology belonging to practical wisdom.

If we are looking for a solidified articulation of the ‘good’, Aristotle’s picture will look nothing like it. This is because the practical is “indefinite and unforeseeable” (Wiggins, 229). But, we still deliberate about the good. We do not deliberate about wanting the good – of course, everyone wants *that*. Our human value structure is indeterminate because it reflects our vulnerability as finite beings in a world of infinite options. Our overarching concept of the good is never a solidified articulation -- instead it is voiced by the deliverances of practical wisdom (*phronesis*). We can recognize that

practical wisdom delivers true judgments in part because such judgments are themselves, constitutive of the good.

What is meant by the claim that the deliverances of practical wisdom are constitutive of the good? Let us consider our nurse again. Let us suppose, now, that she has acquired virtue. When she is confronted with her elderly patient who is afraid of needles, she immediately sees what she needs to do to provide comfort to her patient. We can picture our nurse sitting down with the patient and calming her by talking, or suggests to bring in a family member to hold the patient's hand, or whatever. Our nurse provides comfort. Because of her practical wisdom she is able to identify what is needed in that particular situation. She is able to discern the particulars of the situation that make *this* a situation where she comforts in *such-and-such a way*. The nurse may have entered the room with an overarching commitment to 'comforting patients', and a vague sense of what that may mean. The good (or comforting), however, is crystallized in the nurse's perceptions, sensitivities, and actions.

We are now approaching a more complete picture of virtue. I will further refine this picture by elaborating on the concept of virtue as a kind of 'reliable sensitivity' to a moral landscape. I will also further explain the reasons a virtuous person has for acting.

John McDowell, in his essay, *Virtue and Reason*, describes what is meant when we say that virtue is a 'reliable sensitivity'. The following is a description of a kind person:

a kind person can be relied on to behave kindly when that is what the situation requires...moreover his reliably kind behaviour is not the outcome of a blind, non-rational habit or instinct, like the courageous behaviour of a lioness defending her cubs...rather, that the situation requires a certain sort of behaviour is (one way of formulating) his reason for behaving in that way...a kind person knows what it is

like to be confronted with a requirement of kindness. The sensitivity is, we might say, a sort of perceptual capacity (McDowell, 51)

There are two key features about this description. The first is that the kind person's sensitivity to situations indicates a particular sort of perception. Kind people see opportunities for kindness. A non-virtuous person, on the other hand, does not see those situations. Take the case of courage. Imagine a scenario where a child has fallen into the bear pit at the zoo. Erin, a courageous person, calls 9-1-1, or jumps in the pit, or acts in some way. Alternatively, when a non-virtuous person participates in the same scenario, the reaction is something quite different. Perhaps the non-virtuous person gasps in horror, turns-away, or watches, eagerly anticipating a dramatic rescue. In any case, the non-courageous person does not see this scenario as an opportunity for courage. To be clear, when asked why they did nothing, the response would not be 'I realized that someone had already called 9-1-1', or 'I didn't want to jump into the pit and wake the bears'. Instead, the non-virtuous person would say something more like 'I didn't consider doing anything myself'. For, to act courageously requires a perception of the world as presenting opportunities for courage.

The reasons for the courageous person's action would look something like 'I called 9-1-1 because I had a phone at my disposal', or 'I jumped into the pit because I noticed that I could use the ladder to climb back out'. This brings us to the second key feature of the passage: that situations, when perceived with the appropriate sensitivity, provide reasons for behaving in certain ways. Moreover, these reasons are exhausted by the deliverances of perception. "On each of the relevant occasions," explains McDowell, "the requirement imposed by the situation and detected by the agent's sensitivity to such requirements, must exhaust his reason for acting [...] the sensitivity fully accounts for its

deliverances, the sensitivity fully accounts for the actions” (52). When a virtuous person is confronted with a situation that calls on virtuous action, motivation for action goes no further than the immediate deliverances of this sensitivity alone.

One of McDowell’s significant contributions to Virtue Theory is a clarification of this point – that virtue is perception and it is this perception alone that provides reasons for action. “It is not,” says McDowell, “that some extra explanatory fact, over and above the deliverances of the sensitivity, conspires with them to elicit action from the virtuous person” (15). Furthermore, McDowell argues that the motivational quality of the perception of moral salience is absolute. That is, not only does this refined perception provide reason enough for acting (as in the ‘ultimate’ reason for acting), it silences other reasons. Concerning this, McDowell writes,

the view of a situation that [a virtuous person] arrives at by exercising his [/her] sensitivity is one in which some aspect of the situation is seen as constituting a reason for acting in some way; this reason is apprehended, not as outweighing or overriding any reasons for acting in other ways, which would otherwise be constituted by other aspects of the situation (the present danger, say), but as *silencing them* (56) (italics are my own)

According to McDowell, the ability to be sensitive to moral salience is, at the same time, the ability to cultivate appropriate responses to moral facts. Motivational structures do not exist apart from moral facts and the fine-tuned perception of those facts. Virtue, then, is not a matter of deciding to let certain motivations hold sway over others. Instead, virtue is the cultivated ability to perceive the moral salience of facts.

One of the most obvious difficulties with McDowell’s insight is the phenomenon of *akrasia* which is when “a person can act intentionally, and even voluntarily, without articulating either his [her] preferred judgment or his [or her] immediate intention” (Rorty, 246). The fact that some, even virtuous people, act un-virtuously challenges the

motivational quality of virtuous perception. I will briefly address this issue because I think that it illuminates the complexity and richness of moral life.

The issue of *akrasia* is complex because it suggests that there can be a break in the argument for the immutability of the motivational structures in place in Virtue Theory. In general, there can only be said to be a case of true *akrasia*: when the actor is truly conflicted. That is, when our actor is fully aware of the demands of the perception of moral salience, but fails to act. What is at play here is the conflicting demands of the varied interests (even varied moral interests or personal concepts of *eudaimonia*) present in a full, thoughtful, and involved human life. The occurrence of *akrasia* cannot be used as an argument against the immutability of moral fact and motivation, but rather it indicates that life is rich and complex and our navigation through such ground may be challenging (Rorty, 239-245).

Having clarified some key points about virtue, we are now in a good position to understand the following sketch of Arthur Mercier – a virtuous man -- from his widow, Mariette Mercier (my grandmother):

He started working as a lumberjack at 13. He later recalled that he didn't like the work – "it was hard work for a boy", he said, though he rarely complained about it. In fact, he rarely complained about much. We married when he was 29 – I was 21 -- and had six children. He awoke every weekday at 6:00 am and worked at the local grocer as the head butcher – he came home for lunch and again for dinner, providing (delicious) meat scraps that I would prepare for the next day's meal. These rather unremarkable markings of a man, however, don't explain why when any man about town had any problems – any whatsoever – they planned a trip to the local grocer to seek his advice. Certainly, his grade 4 education, did not certify him to give financial or learned advice, but they came nonetheless – he did not go to them mind you. He seemed to balance humor with understanding, caring and sympathy with an acute sense of what needed to be done. But perhaps what made him so respected was that the advice he gave always had a ring of truth in it. To do what he suggested seemed right. Whatever wisdom we can attribute to matters of everyday decision making, when right, is recognizably so. And in his

own life, never was there a better husband – a man who cried by his wife's side while she endured the pains of difficult labors – a man who fathered six remarkable children who walk this world with hearts of gold – a man who would be unnecessarily humbled by the moral hole (yet unfilled) experienced by his hometown even years after his death.

What is striking about this description is the ability that my grandfather had to deal with the unexpected in predictable ways. This is not to say that he had blanket solutions to problems – indeed, the opposite was true. What was predictable was that the solution always “had a ring of truth to it”. This kind of truth is accessed by the deliverances of practical wisdom.

We now have a picture of the virtuous person. Instead of starting from a morally neutral point of view (one, for example, that stands outside of social and historical commitments and experiences), virtue theory starts from the socially embedded and historically developed virtuous person. When we want to know what to do, Virtue Theory points its finger in the direction of the already virtuous person.

1.3 The Difference Between Virtue and Skill

Linda Zagzebski looks at the problem of the acquisition of virtue. She contrasts the notion of virtue as an acquired trait of a personality versus the notion of virtue as a kind of a habit. She warns, though virtue is a ‘kind of habit’ “it would be hasty to conclude that virtue is *identical* with a habit” (Zagzebski, 117). For, like habit, virtue is relatively permanent and formed through repetition, however, unlike habit, virtue exhibits ‘intelligence’ in its operation.

Zagzebski contrasts her notion of virtue against Nozick’s ‘experience’ machine whereby a person is endowed with virtue through a machine. The experience machine

thought experiment asks us to imagine a machine that could make someone virtuous by providing someone with the 'right' sort of experiences. There is something displeasing about this proposal. Zagzebski, like other virtue theorists, recognizes that virtue is not only about acting in a morally right way. This is because part of what it means to *be* virtuous is to have come to an understanding through one's habits, training in practices, and experience. It is the gradual habituation of virtue through experience that gives virtuous persons the ability to function in the way they does.

Robert Nozick, with his 'experience machine' thought experiment, asks the question whether someone who wanted to do good but (for some reason) lacked the motivation to do so would benefit from entering into an 'experience' machine that would somehow supply her with an extra motivation boost she needs to act morally. Zagzebski argues against the 'Nozick experience machine' example by suggesting the experience machine (or drug, or other such formulation) would not transform a non-virtuous person into a virtuous one. There is a difference between the virtuous and the merely morally strong. This point is one Aristotle sheds light on with his examination of continence.

Morally strong, or continent, people are able to do the right thing though they might be tempted to do otherwise. Presumably, the experience machine would give a person this added 'motivation'. Virtuous people, are also motivated to do good, however, unlike the simply morally strong, good action is accompanied by a feeling of wanting to do good. The virtuous person wants to do good. And, furthermore, as Zagzebski points out, this wanting to do good comes from "a superior form of moral knowledge" (119). The virtuous person has access to a moral wisdom that gives them the ability to 'tap into' their experience and use that to discern morally salient features in new and novel

situations. "A human person's moral identity," explains Zagzebski, "is intrinsically connected with a series of experiences of interaction with the world around her" (120). As we will see with McDowell's discussion of second nature, moral reasoning requires the ability both to see moral salience and to apply what one has learned to the creative process of moral reasoning. No machine can supply a person with the kind and quality of experience one needs to be virtuous since 'learning from experience' is as essential to virtue as is the experience itself.

Zagzebski addresses the problem of the experience machine by further examining the famous thought experiment. Imagine, as Nozick has, that there is a machine for all possible stages of the moral process. We have, then, an experience machine that provides the appropriate 'background experience' for moral reasoning. We have a result machine that handles the 'correctness' of the response. And, we have a transformation machine that corrects 'feeling' associated with moral behavior by blocking out temptation from other sources. On the face of it, Nozick has all bases covered. However, as I have pointed out, what is important about virtue is that it is a learned experience from habit.

If that argument isn't convincing – that is, if we can suppose that machines actually *can* supply a person with the necessary background for moral reasoning – there is still something terribly displeasing about the idea. If a person could push a button to become virtuous, all that is required of that person for becoming virtuous is a 'single act of will'. Virtue is praised, however, because it is the result of a lifetime of learning and experience. Virtue is also governed by an overarching *telos* which answers the question 'What is a good life?'. The answer to this question is reflected in the choices that are made – and in a truly good life, the choice is virtue – throughout the course of one's life.

This is, at least in part, a question of accountability and reliability. We praise virtuous behavior, partially, because the behavior is indicative of the kind of praiseworthy training and struggle that has gone into becoming virtuous. A single act of will – such as pushing the button on a machine – does not draw the kind of praise that comes with virtue. If we don't accept the former argument about the experience machine's inability to causally transform a person into a virtuous one, we must accept the argument that a single act of will that is required by the experience machine is "logically insufficient" to bring about any change that would be as praiseworthy as a lifetime of choosing to be morally serious. So much for the experience machine's ability to produce virtue.

What we are learning here is that virtue must come from a lifetime of learning, experiencing, evaluating and re-evaluating moral situations. In an effort to further clarify our concept of virtue it is worthwhile examining Zagzebski's distinction between virtue and skill. Discussions of virtue and skill often overlap. Practices are often highly technical and proficient practitioners are often highly skilled. I will show, however, that virtue and skills are different.

It might be tempting to regard virtue as a specialized kind of moral skill – an ability of being skillful at recognizing and acting morally. This is a particularly pertinent distinction within the nursing profession. 'Care' has the knotty role of being both commonly referred to as a skill *and* as a virtue (most often it is synonymous with compassion). To care for a patient may mean to have certain skills that contribute to the improvement of that person's health. It may also mean to have a particular emotive stance towards that person. To be 'care-ful' or 'caring' can also mean to exercise a particular attention to a person. This latter version sounds more like a virtue and less like

a skill for the reasons that Zagzebski has mentioned. Part of the difficulty in discussing nursing care is that the many concepts evoked by the word 'care' are not parsed out in this way.

Zagzebski suggests that the confusion between virtue and skill comes from a linguistic confusion between the two. Also the confusion is likely due to the actual conflation of the two. Virtuous people require skills to be virtuous – the skills of courage, for example, may include “knowing *how* to stand up to a tormentor” (Zagzebski, 113)(emphasis added). Conversely, some skills may be acquired with the help of virtue. Patience, for example, helps in learning a language. Despite the association between the two, virtue and skills are different. Zagzebski considers the ten following distinguishing features between virtue and skill:

- 1 – Skills are capacities and don't need to be exercised whereas virtues do (on the appropriate occasions)
- 2 – All virtues are worth having whereas not all skills are
- 3 – Skills are closely associated with technique whereas virtue is not
- 4 – One can forget a skill but not a virtue (though this does not exclude the possibility that a once virtuous person may not act virtuously⁴)
- 5 – A virtue is never given up voluntarily whereas a skill might be
- 6 – It is possible for a non-virtuous person to exhibit fully virtuous behavior whereas this is not so with skill, though...
- 7 – The final outcome resulting from a skill may come about by accident and that is just as good as if the outcome was produced by a skilled person. But, with virtue, the *doing* matters just as much as the outcome
- 8 – The exercising of a skill says nothing of the person's character whereas the exercising of virtue does

⁴ As Zagzebski points out, this distinguishing feature is a little complicated. Some skills once mastered, (like riding a bike) are arguably never really forgotten. And, in some sense, if one's life circumstances are changed considerably, one can become 'rusty' in the exercise of a virtue. Notwithstanding, the point is important given that the following distinguishing feature suggests that a virtue is not something that one would willfully give up. For, the point of 'giving up' a virtue bears significance only if it is, at least in part, *possible* for us to become less virtuous after having been more virtuous.

9 – Virtue has two contraries (every virtue is sandwiched by two extremes – the contraries of courage, for example, are cowardliness and foolhardiness) whereas there are no contraries to skill

10 – Virtue is always connected to something good in itself whereas skills are not (106 – 114)

Practices involve both the honing of specific skills and virtue. MacIntyre, we remember, argued that virtue finds its place in a practice by assuring the continued improved development of excellence within that practice. Clearly, virtue in a practice, is not necessarily a skill. Virtue in a practice is a kind of knowledge that is a reliable sensitivity to morally salient features of a situation and that sensitivity exhausts the reasons for action. However, as we will see in nursing, some skills and virtue remain closely linked.

1.4 *Moral Education*

We have started with MacIntyre's notion of virtue as understanding of goods internal to 'practices' and moved to the notion of virtue as a form of knowledge characterized as a reliable sensitivity to the salient features of situations.

I have briefly outlined the acquisition of virtue when I explained Hursthouse's claim that virtue is acquired. McDowell has a more developed idea of this notion with his discussion of second nature. I will now turn to McDowell's distinction between first and second nature.

The world provides considerable and legitimate reasons for action. Hunger drives us to eat; fatigue encourages sleep; thirst leads us to water. McDowell refers to this unmediated navigation through the world as first nature. But, once we acquire reason (or *logos*) – the ability to verbalize and give reasons for action – we are compelled to do so.

That is, along with the very ability of providing reasons comes the requirement of self-scrutiny. When asked to consider the question ‘why did you do *that*?’, we question our reasons for behaving in such-and-such a way. Providing reasons is an exercise in self-scrutiny. It is the ability we have to step back and provide reasons for what we do that indicates the emergence of what McDowell refers to as ‘second nature’.

Self-scrutiny places the agent in the world. The agent of second nature no longer simply follows one’s first nature impulses. “A possessor of *logos*”, McDowell explains,

cannot be just a knower, but must be an agent too; and we cannot make sense of *logos* as manifesting itself in agency without seeing it as selecting between options, rather than simply going along with what is going to happen anyways (170)

The structure of reason and rationality gives rise to an ability of self-scrutiny that signals an ethical impulse. Reason provides second nature with the kind of grip on reality that allows for practical concerns to be motivational.

Along with second nature comes the freedom and imagination necessary for virtue. McDowell explains that “freedom is essential to conceptual thought” (171). The capacity to conceptualize and to provide reasons for action is brought about by the imaginative, free-flow of perceptions and thought that allows the agent of second nature to see opportunities for action. Acknowledgement of these reasons brings us closer to the ability to be influenced by ethical reasons.

One sense in which second nature is ‘natural’ is that, like first nature, it provides the agent with an ability to be motivated by the world. The human world is one that is ethical in the sense that the reasons for action that are ethical do provide legitimate reasons for action. Practical considerations do indeed motivate human behavior. One

need only look at a person of character to see that. In moral education, the goal is to replace one's first nature motivational impulses by second nature impulses. But this replacement is not a simple substitution of the same kind – the kind of impulses we want from a moral education are not the kind of mechanical motivations of first nature. The development of a second nature is also the development of appropriate methods of self-scrutiny. Ethical self-scrutiny means that the asking of certain questions (the right questions) and criticisms becomes explicit and natural in the evaluation of what one should do. McDowell explains,

In acquiring one's second nature [one] learned to take a distinctive pleasure in acting in certain ways, and one acquired conceptual equipment suited to characterize a distinctive worthwhileness one learned to see in such actions, that is, a distinctive range of reasons one learned to see for acting in those ways (188)

Moral education is, then, inextricably linked to a sense of *telos*. The point here is that a virtuous perspective is needed to make sense of a virtuous person's reasons for action. Teaching virtue is about teaching a person to value virtue and appreciate the deliverances of a virtuous outlook.

If someone is virtuous, they act according to the ends and goals that they see as particularly valuable. These ends and goals are reflective of a sensitivity to a moral landscape that is available throughout the course and development of one's moral life. It may be misleading here to think 'one's moral life' to be a continuous progression from first nature to the ultimate adoption of a fixed and immutable second nature. This is not the picture that McDowell has in mind. Just as human life is dynamic, so too is the development of moral character. If we are to take seriously the notion that the structure of ethics is participatory we should also accept that the structure of the mechanisms we use to navigate our ethical lives is as dynamic as the life it serves to reflect. What we

communicate in our moral lives – through action and through communication – is reflective of our integrated and developed moral character.

1.5 *Virtue and the Emotions*

The final development of our concept of virtue is an elaboration of the role of emotions in virtue. Virtuous action must be accompanied by appropriate emotion. This means that we expect kind people will enjoy being kind, courageous people will feel brave in the face of oncoming enemy fire, caring nurses will like talking to their patients and comforting them. In their introduction to What is an Emotion?, Cheshire Calhoun and Robert C.

Solomon describe Aristotle's position on emotion:

Central to Aristotle's concept of moral virtue, is the notion that our emotions should be appropriate to the situation – felt toward the right individual, under the right circumstances, and in the right amount, being neither too violent nor too calm (7)

Adding to this explanation of the role of emotions in Aristotle's virtue theory is

Hursthouse with the claims that:

- 1 – The virtues (and vices) are morally significant
- 2 – The virtues (and vices) are all dispositions not only to act, but to feel emotions, as reactions as well as impulses to action. (Aristotle says again and again that the virtues are concerned with actions *and* feelings.) (108)

These claims indicate that emotions are intrinsically morally significant. They are interesting claims because they seem rather obvious but at the same time, have challenged the traditional ethical impulse to void ethics of emotion.

On the surface, it seems any ethical model would be missing something essential if it did not include in it a description of emotions. Some virtues – like sympathy for example-- are exclusively about appropriate emotional responses. It seems that Aristotle has done what others after him have been reluctant to do – that is, to acknowledge a place in ethics for both rational deliberation and emotions. Hursthouse describes the reluctance

of Ethical Theorists to combine both reason and emotion in an overly rigid picture of human nature as being divided into rational and non-rational components. Aristotle's division of the 'soul' leaves a space for the interplay of reason and emotion. "The Aristotelian picture of human nature", she explains, "creates a space for the emotions – in what is said to be, shall we say, Janus-faced; animal and/or non-rational one face; rational the other" (110). Humans, then share a class of emotions with animals, and also enjoy a class all their own. What is interesting about this conception of human nature is that the interplay between reason and emotion explains both why emotions have a place in moral life – that reason can shape emotion -- *and* that emotions reflect human reason fixes the place of emotions in moral life.

It was the ability that some nurses had to manage emotions that first sparked my interest in nursing ethics. I once asked a young student nurse how she thought she would fare in such an emotionally charged atmosphere as the Montreal Children's Hospital Oncology Ward. She responded that it didn't bother her too much. This was surprising to me. The young student nurse had yet to be fully initiated into nursing practice – she had much to learn from the Head of the Oncology Nurses Department. I later asked a similar question to a veteran nurse and her response was long and profound. She talked about the need to balance her fears, the fears of her patients and their families, with hope; to taper her own emotions and perform her task; to use her emotions to guide her in her role in the healing process. She also talked about the community of healthcare professionals, about financial cuts to healthcare, about the Nurses' Code of Ethics, about emotional burnout, and about the deep and personal commitment she, and others like her, had to her profession. Virtue Theory embraces the complexity of emotional life and the fact that

emotions are informative. These theorists hold that moral theories that cut out emotional life fail to capture something essential about human experience.

1.6 Conclusion to Chapter 1

In chapter 1, I traced the complex ideas of virtue theory and showed that virtue theory brings to life the following features of moral life which are absent or muted in alternative theories: virtue is a kind of knowledge informed by emotion; virtue is the result of training and education so that the person shaped by virtue acts virtuously without a sense of sacrifice or loss, but takes pleasure in enacting a vision of the good in particular situations. The vision of the good is greatly enhanced by exposure to practices and the standards of excellence that constitute practices. It risks being underdeveloped in societies and institutions that focus primarily on external goods and view human beings as capable only of satisfying the desires of 'first nature'. All of this argues well for an illumination of nursing practice and that best practice guidelines of the CCC presuppose much of this but have no means of spelling it out in the language of Virtue Theory, relying instead on the culturally embedded language of utilitarianism and Kantian notions of duty.

2 Client Centred Care

The practice of nursing in Canada is regulated and licensed by the Canadian Nurses Association. Membership in the CNA is exclusive to and encompasses all registered nurses in Canada. The CNA is responsible for setting out the parameters of standards in the practice by identifying exactly what skills a nurse is required to know, and what employers and patients can expect of nurses. Both the ethical and technical aspects of a nurse's role are regulated by the CNA. Individual nurses, however, are hired

by institutions or private companies that place unique demands on nurses. Institutions (hospitals and community health care centers) for the large part, manage the bulk of the nursing workforce in Canada. The role of the institution is to parse out tasks, money and the order and structure of the health related workforce. Nursing clearly fits into the cadre of MacIntyre's 'practice' insofar as nursing is a historically developed, socially embedded, technically unique, and self-regulated workforce. Furthermore, nurses learn about excellence in nursing by submitting to the authority of a community of expert nurses who have achieved standards of excellence.

While the virtues of justice, honesty and courage are imbedded in the structure of all practices, care is also a part of nursing practice. Nursing is also based on the delivery of care. Care, then, it can be said, is the central focus of nursing. 'Care' is a complex cluster term that involves skills but, most importantly, a moral perspective that, in nursing, is aimed towards two goods, respect for human dignity and respect for human relationships. The structure of virtue – insofar as care is a virtue – is central to the functioning and development of the practice of nursing.

Before I begin my discussion of nursing care, I think it is necessary to clarify the scope of nursing 'care'. Unlike some other practices, like chess, hockey, or mountaineering, etc., the activity itself is grounded in the practice of a virtue – care. There are many uses of the word, 'care'. Here are some examples of the use of the word 'care' that lead me to think that this clarification about the scope of 'care' is necessary:

- 1 – I care about my children
- 2 – I care about my neighbor
- 3 – I care about my work
- 4 – I care about my car

In all these four cases, I've used 'care' to mean very different things. To say 'I care about' something outlines a relationship that I have towards that thing. Clearly, even if I meant the same thing by 'care', *what* I care about requires a different set of responsibilities, obligations, roles and tasks. To care about my children might mean that I take seriously their future goals and plans independently of my own. If, for example, my daughter wants to become a doctor – I may be impelled to worry about (and want to change) the present state of healthcare so that she may find a satisfying and fulfilling career as a doctor. If my neighbor says to me that she wants to be a doctor, my caring thoughts about my neighbor may extend only to the present thoughts about how a taxing work schedule may affect her health and wellbeing. Similarly, to say 'I care' about my work is different from saying 'I care' about my car. To care about my work means that I am concerned about accomplishing my tasks that my work demands of me but also how that work contributes to my sense of personal identity. To care about my car means that I fill it with the appropriate fluids and bring it to the appropriate mechanics at appropriate times – to care about my car is wholly mechanical and instrumental. But, these differences are apparent and relatively clear.

There is another, more subtle sense of care that is illuminated by these examples. To care about 'something' can mean, 'to care *about* (worry about)', to care *for*, or a combination of the two. Traditionally, the simple meaning of the former is considered emotive. To care about something is a feeling – one that may or may not necessitate action. To say I care about my children (emotively) means that I love them. The latter, on the other hand, is more often associated with skill. What is meant by saying 'I cared for some *thing* well' usually implies that the technical (or even physical) aspects of the cared

for thing are accounted for – to have cared well for my car means that I’ve kept it running well, to have cared well for my children means that they are kept clean, well-fed, healthy and dressed appropriately. However, I intend to make a case for the thesis that if care is a virtue, its meaning is neither captured exclusively by one meaning or the other. Its meaning will find its place in the framework of virtue that I refined in Chapter 1.

The virtue of care is knowledge and an enduring part of character. It involves both an emotive and technical element. Care is a particular perspective of the ethically salient features of a given situation. Nurses care about their patients’ wellbeing. But nurses care about other things too. Virtuous nurses care about virtue in their practice – loving honesty, fairness, and having the courage to submit oneself to demanding standards. Therefore, caring practice, for nurses, will mean having a caring perception that will touch on all aspects of their practice. In the following chapter, I elaborate on the virtue of care and use this concept to explain and illuminate the best practice guidelines of CCC.

2.1 Best Practice Guidelines of the CCC

The NBPG’s Client Centred Care report defines care as follows:

Caring can be considered the behaviors, actions, and attributes of nurses. Caring nurses listen to and are empathetic with clients’ points of views. Generally, caring requires recognition of clients as unique individuals whose goals nurses facilitate. Clients’ values and choices are of primary consideration when planning and providing care and the nurses’ own personal values must never interfere with clients’ right to receive care” (RNAO, 3-4)

Clearly, this definition is written with the intention of guiding nurses into client centred care (CCC). The rest of the document is an effort to elaborate on this definition and guide nurses into ‘caring’ in a client centred way.

There are two layers of this ethical dimension that I wish to explore⁵. I will explore these particular aspects since they have, thus far, been on the fringe of academic talk of the ethical experience in nursing. The first layer is located in the tension between nursing practice and medical institutions. MacIntyre argues that though institutions maintain practices, because institutions are primarily concerned with external goods, they can be, in their structure, antithetical to the development and maintenance of practices. However, when they function well, institutions “provide that degree of order which makes [the] self-determined activity [of practices] possible” (MacIntyre, 182).

Healthcare, in Canada, is in principle available to all citizens. Our success at achieving our goals (most personal goals require some degree of health and wellbeing) will, in large part, depend on the quality of health care⁶. Furthermore, our definitions of health and wellbeing depend, at least in part, on the way in which health and wellbeing is defined in the institutional cadre. What we can expect from our health care system is affected by what we are told is possible – factors such as life expectancy, quality of life, diagnosis, and pain management, are established by protocol. These protocols shape not only the actual outcome of our wellbeing, but also the way in which we assess how successful we are at attaining our goal *and* how successful nurses are in their delivery of care.

Institutions exert an influence on a vast array of morally significant and personally meaningful descriptions, settings and expectations. Peta Bowden, in her extended account

⁵ In her article, *Nursing Diagnosis: An Ethical Analysis*, Gail Mitchell argues for an inclusive plurality of ethical paradigms to suit the diverging and varied needs of the nurses and the situations they encounter. No one model, she explains, is able to ‘fit’ within it, the multitude of views, attitudes and experiences generated by the medical community.

⁶ With health, as with many other human goods or ends, luck has much to do with our success.

of nursing care in Caring: Gender-sensitive ethics, suggests that the structure of institutions shapes the ethical systems that are carried out within a practice. "Public organization and accountability," she says, "directly influence the nature of caring and [our] understanding [of] the ethical possibilities of [an] impersonally administered relationship of person-to-person care" (102). What a nurse can be expected to do is a function of the structure of medical institutions. The opportunity for ethical care is defined, defended and carried out within an institutional setting. Any account of nursing care must take seriously the structures of the medical institution in which any opportunity for ethical care is enacted. The account I will give considers the unique role of nurse as public caregiver. This account sees the nurse as representative of a medical community that helps define what it is to be healthy and helps give structure and meaning to the physical suffering of the ill. I will also give an account that takes seriously the limits that institutions place on a nurse's role and ability to care.

The second layer where nurses encounter an ethical dimension in their practice is in the personal relationships between patients and nurses. Peta Bowden argues that nursing care is distinct from other forms of care for two reasons. First, illness imposes unique demands on patients and caregivers. "The loss and incapacity of illness", she explains, "expose our intrinsic limits and dependency with respect to relations with others" (103). Illness creates vulnerability in a patient which is observed by the nurse as caregiver. Secondly, illness has an impact on notions of identity. Bowden describes illness as introducing the moniker of objectivity. "Taken-for-granted subjective experience", she says, "is transformed by illness into experience of the concrete objectness of oneself for oneself" (Bowden, 103). Once again, the nurse finds herself at

the forefront of shifts in personal structures of meaning and understanding. The nurse-patient relationship is inextricably linked to the development and definitions of agency, autonomy and human dignity. The nurse must understand that the position she occupies in the self-revaluation of the life of a patient is one that is particularly influential given that her experience of illness is approached from the clinical and non-personal side of things.

2.2 *Why We Need 'Relational Care':*

According to Quebec Provincial Law, I have access to my daughter's enormous medical file. Though I had never been terribly interested in looking through it, once during one of our overnight stays, I took a peek at her file. The first page gave some basic information: her name, date of birth, height, and weight. What I read seemed familiar but at the same time, alien. It was a series of test results and reports on the status of my daughter's health. Familiar were the names of the tests, the dates and the results. Alien were the descriptions in the reports. The kind and skilled surgeon who had spent over an hour playing with Anastasia before her surgery, who had honestly and patiently answered all of our questions about the surgery ranging in importance from 'Will she recover?' to 'Can she have her blanket with her when she is taken into the operating room?' in his description on the pre-op. report, simply wrote -- 'family prepped'. "But this," I commented to my husband, "is not *Anastasia's* file, it's not about *her* – it's about her disease!". What my daughter looked like in her file did not seem to capture some essential elements about our daughter's health, and experience of healthcare.

Given my experience, it seems unsurprising to me that nurses have claimed to feel a increasing gap between the institutional demands of healthcare (filing reports, charting

vital signs, and so on) and actually caring for a patient. Anne Boykin and Savina O. Schoenhofer, in their study entitled Nursing As Caring, support this claim. “What has become apparent through our practice”, they say, “is that it is increasingly difficult for nurses to conceptualize their service as caring” (27). Boykin and Schoenhofer attribute this sense of the increasing gap between nursing practice and care to the 1960’s trend towards a problem-solving process in nursing. The idea behind the problem-solving process is that the role of a nurse is to find and cure health problems in patients. The focus, then, of nursing turns away from nursing, towards a systematic administering of tests whose function is to reduce the scope of possible diagnoses by eliminating causes. “This focus on correction”, however “distracts the nurses from their primary mission of caring and therefore practice results in objectification, labeling, ritualism, and non-involvement” (Boykin and Schoenhofer, 28). This is why Boykin and Schoenhofer, in an effort to signal a change in current nursing practice, argue that the practice must put forth an effort to re-inject care into nursing.

This is the goal of the BNPG’s Client Centred Care document and it is welcomed by some nurses. One nurse comments “[helping in the development of the ‘CCC’ project] was like a little breath of fresh air...I mean health care right now is under great stress financially. This was like ‘oh my gosh, we’re not talking about finances, we’re talking about how we treat patients!’” (RNAO, 15). This sentiment is echoed in an account offered by Randy Spreen Parker, an RN, a teacher and an accomplished academic. Parker shares her experience with a patient – Mike – in an effort to articulate the need for what she calls ‘relational ethics’ in nursing. Mike was an ailing patient with aphasia who, because of advanced diabetes and a stroke, underwent a leg amputation that left him with

a large open wound. A stroke made Mike's speech sound more like "garbled utterances and guttural groans" (Parker, 33). However, as Parker and Mike's special relationship developed, Parker and Mike came to communicate and understand each other in a profound and important way. The following excerpt from *Nurses Stories: The Search for a Relational Ethic of Care*, describes the development of Parker and Mike's communication.

Everyone said Mike was disoriented and could not communicate, but his eyes spoke articulately. His whole being communicated volumes. Now before each dressing change I sat at eye level, grasping Mike's contracted hands, and we talked. At first Mike's attempts to communicate were very difficult to comprehend; however, over time I began to understand the subtle nuances of this strangely eloquent language [...] Over time his engaging eyes became windows into his life story – an unfolding autobiography filled with memories, struggles in the present, and hopes for the future (33)

The communications between Mike and Parker became a source of comfort for Mike.

When Mike conveyed his concerns about the imminent prospect of dying. "What would it be like to die?", he asked Parker (33). Parker "recalled past experiences with the death of family members" and "shared what it would be likely to happen if treatment were withdrawn" (33). Mike found comfort in her words – "at that point" explains Parker "the prospect of death did not seem quite so painful" (33).

Unfortunately for Mike, Parker was relieved of her position as his primary care nurse. Though Parker visited Mike, their relationship of caregiver/patient had suffered an insurmountable blow. The "human connection", writes Parker, "which sustained and nurtured hope in a seemingly hopeless situation, gave way to technological separation, creating a gulf that would never be traversed" (Parker, 34). Mike died a few weeks later "in pain, frightened and alone" (Parker, 34).

Parker wants to challenge the medical community that supports an ethical framework that devalues Parker and Mike's ability to communicate. Parker is devastated by the horror of Mike's lonely death. Parker shares her story in an effort to reshape the moral language of care. In caring for Mike, Parker finds herself having to question some of the traditional ethical models that previously guided her ethical life as a nurse and called for treatment in the preservation of life *above all else*. Instead, her relationship with Mike becomes one of sharing – where Mike teaches her about “powerlessness, suffering and fear, as well as patience, courage, and hope” (Parker, 33) and she teaches him about what it might mean to die. This exchange, and Parker's inability to express why and how this exchange is equally meaningful to her role as treatment nurse, casts doubt on the efficacy of ‘traditional moral language’ to express the full ethical experience of the nurse-patient relationship. After explaining how she refused to continue life-sustaining treatment because she had come to an understanding about Mike's acceptance of death, Parker has difficulty explaining the apparent abandonment of her duty of life-preservation to the rest of the medical community. She asks, “how could I translate my own moral experience into traditional moral language? The scripts were different” (33). It is my contention that traditional ethical models and vocabularies are indeed ill equipped to capture the kind of moral experience Parker is talking about. This kind of experience is one that is expressed in CCC. Parker calls for the need of a ‘relational ethic of care’ to describe a nurse's experience. The ethical model that Parker wants is one that gives a voice to the nurse as engaged, involved, and personally invested in her care of patients. The model of virtue ethics that I am proposing – one that is echoed in CCC, does just that. In what follows, I will reveal the links between virtue and care and nursing care. I

will introduce the vocabulary of care for which Parker is calling. And, in doing so, I will provide a paradigmatic vocabulary which can make nurse's insights more readily available.

If Parker's story about Mike is not enough to convince us of the necessity of a relational ethics of care, we can turn to the words of other nurses who complain that alternate methods of administering healthcare undermines the very practice of nursing itself.

As I mentioned, Boykin and Schoenhofer, both teachers of nursing, recommend a relational 'caring' model for nursing. Relational care refers to caring that starts from the nurse-patient relationship as opposed to an impersonal, non-relational viewpoint. Caring, they argue, is central to being human and a pure form of the expression of personhood. "Personhood", they say, "is the process of living grounded in caring...[and is] a process [that] is enhanced through participation in nurturing relationships with others" (4). Relationships, then, seem to be primary to the practice of nursing. Relational ethics take seriously these relationships.

There are problems associated with non-relational thinking. All too often bureaucratic talks about healthcare are "'language'd' in impersonal, aggregate, disembodied, and perhaps more importantly, economic terms" (Boykin and Schoenhofer, 30). The focus here is, in MacIntyre's language, on external goods. The caring role of nurses – one that is relational and emotionally involved – reminds us of the internal goal of helping the sick. The potential for the harm that non-emotional (non-relational) healthcare can cause is expressed by Jodi Halpern M.D:

missing important emotional cues from patients wastes time, leading to missed diagnoses, inadequate treatment adherence, and inadequate understanding of

patients' values in the face of tough medical decisions...since physicians' own unacknowledged emotions contribute to time consuming clinical difficulties, and a brief consultation acknowledging these emotions can make a big difference, teaching physicians to attend to emotions is more practical than teaching detachment (xiv)

Clearly, one of the concerns with the omission of relational care is that it has a corrupting influence on the practice of nursing – alienating a nurse from her purpose – and one that has the even broader disadvantage of limiting the possibilities of healing and health in the healthcare system. It is with this awareness of a need to change the current way in which health care is thought about and administered that we begin our investigation into nursing and CCC.

2.3 Recommendation 1

Nurses embrace as foundational to client centred care the following values and beliefs: respect; human dignity; clients are experts for their own lives; clients as leaders; clients' goals coordinate care of the health care team; continuity and consistency of care and caregiver; timeliness; responsiveness and universal access to care. These values and beliefs must be incorporated into, and demonstrated throughout, every aspect of client care and services (RNAO, 19)

2.3a Human Dignity and Identity

In her book, Caring, Peta Bowden draws largely on the work of Patricia Benner to articulate the kind of caring that should inform nursing. Benner's work is tethered to the notion that the nurse-patient relationship is a unique relationship and it is, therefore, a unique expression of care. A point that Bowden makes clear – and one that I have already touched on – is that the position of nurse as public administrator of care is one that places both ethical and non-ethical demands on nurses. If nursing practice is to continue with its present goal of *healthcare*, the need to articulate an ethic that reflects the everyday lived experience of nursing care is necessary.

The need for a nursing ethic of care is simply, but poignantly, articulated by Gail Mitchell in her paper, *Living With Diabetes: How Understanding Expands Theory for Professional Practice*. She writes, “if healthcare professionals want to be valued by members of our society, they must develop practice approaches that respect patients as partners in defining and leading their own healthcare” (1998: 30). The claim that patients *must* be involved in their own healthcare may seem a rather large task to ask of a patient. The increasingly complicated technology involved in modern healthcare actively alienates patients. This is why the nurse’s role as mediator is ever more necessary. Patricia Benner develops this theme in her examination of neonatal critical care nurses. “[These] nurses”, she explains,

work with the patients’ and families’ world, humanizing the technology and domesticating the alien environment....For these nurses the work-place technology is tempered by the centrality of their caring practices, though they are experts in intensive care technology and though the technical aspects of care take up much of their time (1994:145 - 146)

Caring for the human relationships that surround their patients remains a central activity of these highly technical nurses. For example, the role of care in neonatal intensive care units has an even more immediate implication in the day-to-day wellbeing of their patients. Benner describes the comforting practices of nurses. “The possibility”, she says, “is put forward of substituting comfort measures for sedation in instances where the carer has expert ability in comforting and handling the baby” (1994: 147). Comforting practices for premature babies are not rule based. Instead, they require the ‘expert sensitivity’ of a seasoned neonatal nurse. These practices involve the family of the baby by, in a particular case, “encouraging breast feeding, comforting touch, and explaining the value of the familiar parental voices to the infant’s developing sense of world”

(Benner, 1994: 146). The choice of the nurse to explore comforting practices over sedation only makes sense against an orientation concerned with respect for human dignity and human relationships that I claim is the focus of care.

2.3b *The Structure of Illness*

Peta Bowden describes the structure of illness by referring to Richard Zaner as follows:

Illness presents us with explicit and indisputable evidence of the pervasiveness of chance and vulnerability as inherent structures of our lives. As the sufferers of assaults of happenstance, we experience the inescapable 'objectness' of our bodies – or in more complicated ways, our minds: the defenceless, thing-like fragility of body or mind is experienced in opposition to our purposes and values (112)

Similar to the feeling of alienation I experienced from the clinical evaluation of my daughter, illness creates a feeling of loss. The once healthy, independent, and 'under control' individual, finds herself feeling uncertain about her body or what may happen to her. Technology, as I have discussed, does nothing to bridge this gap. Bowden explains,

the therapeutic response acts on the pure materiality of the patient, and in so doing, reduces the patient's whole world to an entirely negative, bodily sphere of existence [...] by contrast, the clinical nurse moves with ease [...] the clinical environment is familiar, both physically and culturally to her" (114)

The nurse is, at once, a source of the alienation and, in caring a source of the alleviation of this alienation. In her capacity to function with ease in the clinical environment, the nurse is an expert in the very cause of a patient's alienation. A nurses' ability to be comfortable with illness, medical technology, and scientific knowledge is at once a symbol of a patient's vulnerability *vis a vis* her own sense of personal identity, and a potential source of the re-establishment of a personal identity that is comfortable with illness and the clinical environment.

Bowden places the ethical significance of nursing in this unique role that nurses occupy in the life of a patient. She describes these two, interconnected, ethical dimensions as “on the one hand, the helping and healing activities of coping with the experience of rupture; on the other, the interwoven practice of breaching the relational chasm that those activities, in part, create” (Bowden, 116). Bowden cites Benner in her explanation of how the nursing relationship creates an opportunity for a patient to re-establish a positive sense of selfhood after illness. By exploring the practice of “present possibilities in the face of the apparently interminable distress of the moment”, by recognizing “meanings for the patient that arise out of cultural understandings of different illnesses”, and by understanding “each patient’s own personal involvements and commitments”, in Bowden’s view, nurses “transform the meaning of dependency and vulnerability from alienation and demoralization into a sense of personal integrity and dignity” (Bowden, 118). The CCC outlines these goals⁷ in its ‘Core Processes of Client Centred Care’.

The four core processes of CCC include: 1 - identifying concerns/needs, 2 - making decisions, 3 - caring and service, 4 - evaluating outcomes. One of the primary values identified in recommendation 1 is human dignity. The CCC document defines human dignity as “care for clients as whole and unique human beings, not as problems or diagnoses” (RNAO, 19). The core processes are aimed at expressing the value of human dignity – a value essential in the transformation of the patient from a fractured self to a whole self.

⁷ These are considered to be reflective of the values and beliefs of client centred care. (CCC, p. 20)

The first core process is one of recognition. To identify a patient's needs or concerns is to "accept the patient's whole phenomenal world" (Bowden, 118). In doing so, the nurse opens the door for the re-evaluation necessary to re-establish a complete self. The second core process is one of empowerment. To involve the patient in her own care shows a patient that clinical care is not just a process that 'happens' – instead it can be chosen. The third core process is one of involvement. This process accepts that the patient knows her own body best (or minimally, that she is most aware of a particular aspect of her body). This process makes the patient the expert on how she intends to contribute to her health. During this process, the capacity a nurse has to care for a patient is in her ability to "explore situations by listening, understanding, and responding; to be aware of the relevant legislation; and seek additional information and resources" (RNAO, 23). And, finally, the fourth core process establishes a continued commitment to improvement. This final core process helps define what was previously, an indefinite future. Complete personal identity, even in the face of death and illness, must take root in temporality. This final core process alleviates the punctured sense of time that accompanies illness.

The concept of authorship in the authenticity of self explains why the activity of re-establishing a complete sense of self is ethically relevant. Firstly, the caring relationship is based on human interactions. The four core processes are essentially a list of prompts/questions intended to be used to prompt conversations. The idea is that nurses guide these conversations to a state of self-realization. "Because [caring] practice is situated, particular, and responsive to another human being", explains Benner and Gordon, "it is always dialogical, existing in human interactions that demand responses"

(46). In this way, the nurse facilitates the re-establishing of selfhood in a patient. A nurse's personal values, and indeed, much of her personal sense of self outside of the context of nursing care, does not enter into the equation here⁸.

Sabina Lovibond argues that authorship of self (of one's actions) is what is essentially 'moral' about human experience. In the following section, I will explore in more detail Lovibond's notion of authorship. I will show that the concept of authorship is closely linked to the concept of perception of salience. Both these concepts secure caring practice as an essentially moral practice. And, in doing so, I show that the *moral* vocabulary I am deploying in my analysis of the CCC is not only adequate, but required.

2.3c Authorship

Lovibond argues that one of the distinctive results of moral upbringing is the ability to speak with complete authorship. The virtuous speaker is one whose utterances are "fully permeated by the conscious intention of the user" (Lovibond, 125). Authorship begins from an inside view of moral discourse, with the recognition that moral discourse emanates from a unique perspective.

The concept of authorship is one that Lovibond adopts from Austin. It is this – that there is a difference between being serious when we speak and being 'non-serious'.

⁸ This is not to say that caring practice is value neutral. Quite the opposite is true. The position that I am defending sees care as being guided by a *telos* of upholding human dignity and valuing human relationships. This is, in itself, moral. The relationship between the nurse and the patient is value-neutral only in the sense that it prohibits the imposition of a nurse's personal values *outside of the ultimate telos of care*. This is particularly relevant under those circumstances where a nurse's personal opinion about a particular patient's treatment conflicts with his/her opinions about the treatment *even after careful listening, understanding and attention*. In these cases – where presumably personal differences between nurse and patient cloud the ability to 'see' or understand – caring practice requires the clear articulation of the role of nurse as facilitator and not as advisor about life goals and plans.

This difference is similar to the difference between being an actor who is simply repeating lines and an author whose utterances aim to be a true reflection of her intentions, beliefs, and goals. In the case of moral authorship, a person can be truly an author of her moral utterances when she has both fine-tuned awareness of the meaning of her words *and* an honesty in the commitment to which the utterance can be said to bind. As with promises, statements that are authentic, reveal a commitment to what is being said.

However, Derrida reminds us that the nature of speech acts is public and he argues that one can never be said to be *fully* the author of one's own utterances. About this, Lovibond writes,

the particular sentences I construct, in speaking or in writing, represent what I as an individual have been able to accomplish in the way of 'self-expression' on the basis of the collective 'mindedness' embodied in English; but this 'mindedness' existed before me, and although I can draw upon it more or less creatively, I cannot wholly rid it of the alterity that consists in its being *available*, not just to me but to any English speaker, for the expression of meaning (103)

It seems a structural impossibility to be fully the author, then, of our moral utterances and thus to acknowledge the distinctive promise like character of such utterances. However, Lovibond is not deterred by this. In fact, this insight from Derrida allows us to take claims about discerning salience in particular situations even more seriously. Derrida is claiming that even the most 'sincere' of persons might not have access to all the reasons for action that come into play. That the world is not transparent even to the most virtuous of people is not a testament to the impossibility of moral life – it is a testament to the embedded and participatory character of human life and perception.

Benner and Gordon criticize the concept of authenticity as initially conceived by Lovibond. They suggest that a non-public concept of authenticity equates the impersonal with the separate and supports a picture of the self that is independent of his or her human relationships. For Benner and Gordon, the fact that illness so greatly fractures 'the self' is due to the demands of our 'highly individualistic society' of "the private self-constituted individual" (48). "Feeling dependent on another", they explain, "makes the individual who seeks unrealistic levels of control and autonomy feel vulnerable" (48). "Caring practices", they argue, "provide the necessary preconditions for the creation of a separate, unique, autonomous individual" (48). Benner and Gordon want to dispel the myth that authorship of the self is a self-directed process. Instead, authorship of the self can happen only when relationships that foster opportunities for choice and self-actualization are valued. Authorship, in their view, is possible and, because human experiences arise from participation in society, authorship must also begin from this point. Caring nurses seek to acknowledge the ultimate vulnerability of reliance that is created by illness and, within (and not despite) that vulnerability, outline the sources for choice that are always available.

However, another, rather obvious disappointment arises from Lovibond's discussion of the public nature of moral utterances. And, it is this: Derrida's insight into the 'seriousness' of speech acts – that speech acts, in the very structure of language, cannot be said to be under complete authorship – makes us question the appeal of moral discourse about a fully 'disenchanted nature'. If moral speech acts are not transparent to ourselves, then we are uncertain of the possibility of meaning what we say. Are we left to the possibility of never being able to know if we, or others, have indeed "gotten *it* right"?

This is a distressing possibility indeed. However, Lovibond wants to explain this distress – what she refers to as a “distinctive form of anxiety” (112) – by appealing to Wittgenstein’s conception of ‘metaphysical emphasis’. Wittgenstein’s insight allows us to distinguish the distinctive position we give to speech acts when we remove them from their context. When I say “I *know* I am sitting on a chair”, as a claim about the state of metaphysics, I am asserting something that is problematic. It is problematic because it gives an elevated notion to the word ‘I know’, which the human language game does not allow. However, when I utter the same sentence when asked ‘where are you sitting’, the ‘know’ is an indication of common parlance where grand claims about my mental state and the state of the world need not go beyond the functional significance the utterance was intended to uphold. ‘Know’ only makes sense in the context where the possibility of ‘knowing’ makes sense. Similarly, we explain authorship as being contextually limited to the ethics language game – where it is “sometimes not presumptuous to say that we hold certain beliefs” (Lovibond, 113). In this sense, Lovibond’s talk of authorship still provides us with some relief from anxiety.

However, this talk leaves us open to other questions. Lovibond has salvaged, or explained, a common sense meaning of ‘seriously meaning something’ as being still pertinent to moral discourse. But, if we admit that we are contextually limited, Lovibond notes that the “historical contingency” of all speech acts makes itself apparent. About ‘seriously meaning’ she writes,

this concept being one that we have to master in order to deliberate effectively in an environment containing other subjects who can, but are not guaranteed to, make their mental states apparent to use through language...yet as we learn the techniques of appraisal (and self-appraisal) demanded by this deliberative environment, we can hardly fail to notice the *historical contingency* of the circumstances in which any given moral personality is manifested (114)

If we are to have an ethics that is based on the reliability and predictability of one's character, the hope is that this character remain relatively stable *despite the circumstances under which it is tested* – that the circumstance of moral luck (or bad luck) is irrelevant to the predictability of a well formed ethical person. The hope is that ethical upbringing creates a 'second nature' that is immune to moral luck. Does the historical contingency of speech acts (including moral ones) presuppose moral luck?

Again, Lovibond looks towards Wittgenstein for an insight that may help appease this concern. Second nature can be (superficially) understood as a method of action that originates from a deep understanding and adoption of particular standards or virtues. In this way, the ethical person can be said to act in accordance with the virtues and that this act is an 'act of will' (Lovibond, 117). If I will to be just, for example, I act from this will in just ways. However, Lovibond reminds us of a lesson we have learned from Wittgenstein and it is this: that the will cannot be posited as a 'thing'. If we want to talk of will, we would do better (and avoid the traditional confusion surrounding 'will') if we "concentrate on the 'physiognomy' of those acts that are called 'voluntary' or 'intentional'" (Lovibond, 116). This shift in our thinking of 'will' has, for Lovibond, two major outcomes. The first is a reconsideration of our use of 'acts of will' in the explanation of how character works, and the second is an insight into the concept of authorship and predictability of moral speech utterances.

What we learn from Wittgenstein is that we need not posit the will as a 'thing', nor do we have to posit a 'God' to understand that we can still be immune to moral luck. It is enough to look at the voluntary act as something that is formed within a "normal

surrounding of intention, learning, trying and acting” and to have that act judged on what *actually happens* (Lovibond, 118). That is, if someone claims, “I want to be just”, we *can* judge her and the reliability or predictability of her utterance when we see what she actually goes on to do. In this way, we can salvage the seriousness of speech utterances by retrospectively determining, in the course of what happened, if the actor indeed meant what she said.

Caring practice helps patients assume authorship of their acts. The four core processes of CCC act as a guideline to set this process into motion. Caring practice is ethically significant, then, because it supports the possibility of authorship in patients. The nurse’s ethical impact, here, is in her ability to provide a forum for open discussion about the ongoing mechanization of a patient’s body caused by technology and illness. But, this is not where nursing ethics ends. The very process of caring is one that requires virtuous attention and perception of salience.

Without grounding the core processes listed in recommendation 1 in an overarching concept of virtue these processes run the risk of sounding like a series of techniques or skills rather than “a series of responsive relationships that create possibilities and constraints” (Benner and Gordon, 50). What is risky about this idea is that this vision of caring does not allow for the development of authorship. If caring practices are not anchored in virtue – in the perception of salience that outlines the unique and particular features of a circumstance – these practices become “a free choice made by human beings who are depicted as rational choicemakers ” and nothing more (Benner and Gordon, 50). These practices become nothing more than techniques focused on external goods. Authorship cannot flourish in this kind of instrumental environment because

“connectedness, responsiveness, and interdependence” are transformed into sources of dependence and not the platform for a project of self-identification (Benner and Gordon, 50). However, in the introduction to the CCC, in the section on ‘how to use this document’, “guidelines should not be applied in a ‘cookbook’ fashion but used as a framework to individualize client care” (CCC, 1). The framework of care is geared towards particular values and beliefs. This is why if caring practice is to function at all, it needs to be tethered to virtue and *telos*.

2.3d. *Perception of Salience and Practical Wisdom*

I have alluded to an image of the nurse as being entirely comfortable in a highly technological environment. Before my daughter was admitted for her chemotherapy sessions, she would undergo ‘prep’ in the hematology/oncology day clinic. After being weighed, measured and some blood drawn from a finger prick, she would have her ‘Port-a-Cath’ accessed. The port looked like a metal disk attached to a tube that had been inserted into one of my daughter’s arteries. It was accessed by a needle that was inserted into the subcutaneous disk in my daughter’s chest. The procedure was relatively painless (since I would numb the point of injection) but required special attention since any infection would spread rapidly to my daughter’s heart and lungs. The nurse would begin a long routine of sterilization and would often have to start the process over since my daughter’s young and wandering hands would sometimes invade the sterile space. On more than one occasion, the port was ‘blocked’ which meant that some blood had coagulated and this required a series of injections of blood thinner alternating with saline solution to push the blockage out. All this would happen while the nurse held conversation with me, and made funny faces to keep my daughter occupied and happy.

What was most incredible about these occasions was the expert way the nurse would deal with various levels of interaction, while maintaining the skilled application of highly technological equipment. The task required the spontaneous evaluation and re-evaluation of physical responses and the skilled know-how to work with these responses and finding immediate solutions. It seemed as though the nurse had an awareness of her body and a connection to my daughter's that went beyond a simple action-reaction scenario.

Following Benner, Bowden refers to this kind of phenomenon as 'embodied intelligence'. She describes it as follows,

the complex skills of nurse experts rely on a 'bodily takeover of the skill to some degree' such that the body is oriented appropriately in relation to the kind of activities the skills encompass. In the use of medical interventions, for example, perceptual 'takeover' transforms the instruments into extensions of the nurse's body: an intravenous catheter tip becomes an extension of the nurse's fingers; the regulation of an intravenous drip, the visualized responses in the patient's veins. This is not simply a matter of physical dexterity and co-ordination, but of bodily insight understanding how different resistances feel, and what the relationships between different responses are (107)

The structure of this kind of knowledge is analogous to the structure of caring practice. This kind of knowledge draws on skills and procedures but relies on a richer and more complex appreciation of the immediate situation. During a particularly long series of alternating blood thinner and saline, my daughter's nurse commented that she felt something else was wrong. She called over some other nurses and explained her difficulties – not only should the blood thinner have worked by now, but my daughter was complaining when she normally didn't, the port seemed to have moved, there seemed to be some 'puffiness' around the site. Though these things were minor and nothing seemed wrong, the nurse said that she "felt something was up". After some investigation, the nurse's concerns were confirmed – the port had slipped. Injection of

chemotherapy into a port that is not in its proper place can prove to be extremely damaging. The nurse's ability to pinpoint a problem in the absence of precise information indicated that she had a fine tuned awareness of a plurality of factors. This kind of example of nursing "[is] shown to illustrate capacities to cope with the ambiguities and complexities of real-life circumstances that defy the possibilities of analytical models or lists of context-free criteria" (Bowden, 106). Coupled with her experience and technical know-how, the nurse demonstrated an expert practical ability to unveil an existing problem.

Responsiveness in nursing care also relies on the discernment of salience in particular contexts and situations. As we saw with Randy Spreen Parker's experience with her patient, the relationship that she developed with 'Mike' opened up a new perspective that forced her to reconsider her values and beliefs about what exactly defined her role as a nurse. And too, with Jodi Halpern's insights about the inclusion of emotion in the practice of medicine – a change in perspective opens up new possibilities for the perception of salience. Excellence in caring, explains Bowden, "emerges through ... intuitive understanding that 'responds to the demands of a given situation rather than rigid principles and rules'" (106). The intuitive understanding associated with responsiveness describes the kind of nursing character that is able to engage patients without oppressing them and to identify with the cause of a patient with appropriate perspective and closeness. Virtue refers to this reliability of character. The level of quality of a relationship that is needed to bridge the gap between vulnerability and complete selfhood in a patient depends on the quality of trust the patient feels in her healthcare providers.

If the project of re-defining selfhood is to take root at all, nurses must be reliable and consistent in their ability to care and understand. In other words, for nurses to be reliable in the practice of care, the honesty that is required as a function of nursing being a practice must be transmitted to the practical aspects of the work as well. So too must the virtues of courage and justice. In the case of the former, we need look no further than Nurse Parker's story about 'Mike'. Parker's re-evaluation of her own values, her openness to Mike's suffering, her refusal to give up on Mike even after he was no longer her patient, required courage. Parker exemplifies virtues that define excellence in practice.

2.4 Recommendations 2 & 3

Education regarding the nursing best practice guideline for Client Centred Care should, wherever possible, be based on voluntary attendance by the nurse with organizations financially supporting this training (RNAO, 25)

The principles of client centred care should be included in the basic education of nurses in their core curriculum, be available as continuing education, be provided in orientation programs and be made available through professional development opportunities in the organization (RNAO, 25)

Both recommendations 2 and 3 are grouped together in the CCC document. This is because they both are concerned with the education of client centred caring practice. As I have established in the previous section, the guidelines of CCC are not intended to be used as procedures and rules that govern behavior. Rather, the guidelines are to be used as a framework for the development of a perception of salience and a fostering of key virtues involved in caring practice. This kind of education, then, is a moral education. It would, then, be fruitful to turn our attention to a more refined picture of moral education than the one I have previously described. This picture is offered by Sabina Lovibond.

In Ethical Formation, Lovibond seeks to examine and understand 'ethical upbringing'. Specifically, she seeks to develop the concept of a 'second nature' as reflecting a way of being-in-the-world that embodies specific commitments to goals and ends. This preoccupation with ethical upbringing starts from an interest in defining the possibilities of authorship in moral speech acts. CCC describes the process of learning about this second nature as follows:

the education program approaches teaching-learning about client centred care as a process of values clarification and individual and group discovery through ongoing dialogue. To this end, learners participate in a series of classes that are highly interactive and experiential and that foster *self-reflection*. Through dialogue and reflection, learners are supported to discover *meaningful* insights into the *linkages* among values, beliefs, language, and actions (25) (italics are mine)

The virtuous person *sees* moral reasons and these reasons motivate in such a way as to 'silence' external motivations (such as first nature responses to desire). In Lovibond's words, "when a virtuous person perceives a fact of the relevant kind, *action* (or inaction, as appropriate) *necessarily follows*" (91). This is not to say that the virtuous person is blind to other, perhaps first nature level reasons for action. Rather, it is that these reasons simply cannot be contemplated in a light that would have any motivational impact whatsoever. To be motivated by reasons requires a standing commitment to those reasons. Otherwise, those reasons do not stand out as being any more significant than others. In a very open and dynamic way, nurses are encouraged to examine and articulate the goals that guide them in their current practice. The process of articulation is not one of ultimate articulation of values. Instead, the above quotation is intended to show that what is meant by 'values clarification' is the 'linkages' among values. This is because ultimate ends, especially in practices, are broad and cannot be pinned down (unless they

are so broadly described as to lack any meaningful content whatsoever). Instead, the process of discovering linkages encourages a methodology of assessing ethically pertinent situations. It is in this kind of discovery that virtues are both needed and flourish.

In the discovery of linkages, we have a placement of the perception of salience within the context of ethical upbringing. The deliverances of a fine-tuned perception of salience are *there* to be accessed by people who share a particular faculty (in this case, a moral sensitivity). The placement of salience, here, can be seen as operating on two fronts. The first places seeing salience as a necessary condition of *becoming* virtuous. This is because it is the perception of the moral features in a situation that signal to the virtuous person that 'this is the way I should act'. In the truly virtuous, the deliverances of salience do not present a choice – rather they signal a clear path outlining 'what will happen'. If someone is virtuous, they act according to the ends and goals that they have discovered as being particularly valuable. But these ends and goals are not discovered without rhyme or reason. If the ethical upbringing is successful, the ends and goals are reflective of a sensitivity to a moral landscape that is available throughout the course and development of one's moral life. In this sense, the perception of salience allows a person to be justified in their moral utterances.

It may be misleading here to think of 'one's moral life' to be a continuous progression from first nature to the ultimate adoption of a fixed second nature. This is not the picture that Lovibond or McDowell have in mind. Just as human life is dynamic, so too is the development of moral character. This does not imply that second nature is unstable – indeed, when we are motivated by our second nature, we are able to reclaim

some degree of authorship of our utterances. But, second nature is not fixed in the sense of being the goal that can be achieved. This is not a lapse in the notion of second nature – it is simply reflective of the fact that “morality makes its demands upon the people we actually are – that is, upon natural beings who possess certain moral capacities and who can therefore be addressed [a]s members of a community of interest in the relevant forms of value” (127). If we are to take seriously the notion that the structure of ethics is participatory we should also accept that the structure of the mechanisms we use to navigate our ethical lives is as dynamic as the life it serves to reflect.

The perception of the salient features in a situation will provide the appropriate motivational structures for moral action in the virtuous person. We assume here also that nurses have the ability and willingness to learn from their experiences. This can be a long process of habituation and some nurses are better at it than others. The recommendation of learning client centred care is not dependant on external goods. The recommendations stress that this kind of education should remain voluntary, free, and readily available. The participation in the program indicates an original openness to this kind of knowledge.

A further way in which the perception of salience is connected to the context of ethical upbringing is extension of the first – that a person is, indeed, only able to become the full author of moral utterances if they are, first, capable of the perceptive faculty that sees the salience of given moral situations. Once again, this kind of education is part of an ongoing process of evaluation and re-evaluation. The idea here is that nurses already bring a sense of moral salience to their practice. The educational program is set to refine the methodologies that lead to the perception of moral salience.

We have already established that the perception of salience, minimally, presupposes that the virtuous person will get things right. This is because the salient features of moral circumstance become apparent to that person when a person is equipped with the proper moral upbringing and appropriate ends.

2.5 Recommendation 4

To foster client centred care consistently throughout an organization, health care services must be organized and administered in ways that ensure that all caregivers, regardless of their personal attributes, enact this practice successfully. This includes opportunities to gain the necessary knowledge and skills to really engage with clients from their standpoint, as well as organizational models of care delivery that allow nurses and clients to develop continuous, uninterrupted, and meaningful relationships. (RNAO, 27)

Given the personal nature of virtue, and the focus of client centred care on interpersonal relationships, the passage that implies an omission of a nurse's 'personal attributes' needs some explanation. The problem with the passage is that it is not terribly clear what is meant by 'personal attributes'. There are two ways in which this passage can be read. The first reads – 'health care services must be organized and administered in ways that ensure that all caregivers, regardless of *any specific* personal attribute, enact this practice successfully. In this reading, the nurse's delivering of care is independent of her personality which is presumably made up of her experiences and perceptions – and that *any* person can replace any nurse without disrupting health care services. The second reads – 'health care services must be organized and administered in ways that ensure that all caregivers, regardless of their personal attributes, *should be able to learn how to* enact this practice successfully'. In this second, the emphasis on the ability to learn nursing practice calls on the public nature of nursing – that all nurses should have access to the

moral training that contributes to caring practice. There are good reasons to think that the first reading is the correct one. However, I will argue that the second reading is also an appropriate reading. These reasons turn on what is meant by 'personal attribute' and require a formulation of how 'personal attributes' contribute to the notion of 'personal investment' in caring practice.

Following Benner, Peta Bowden suggests that the structure of the patient-nurse relationship is not reciprocal. "Nursing", she explains, "does not depend on receiving reciprocal attention from the patient to make the relationship valuable" (111). For Benner, nursing is not about the nurse, but rather, about the ability that nurse has to engage the patient in personal reflection and aid the patient in determining outcomes and defining values for herself. In a very important way then, nursing is about leaving out one's sense of self. "This perspective", writes Bowden, "gives rise to a more reflective, directed intensity of involvement" (111). Caring practice is geared towards the patient and a nurse's role is defined *only insofar as her practice contributes to the needs and goals of a patient*. The structure of the nurse-patient relationship is such that a nurse – as a complete self with her dreams, fears, and hopes apart from the dreams, fears, and hopes of the patient – matters very little. In this sense, the nurse must negate herself in caring practice. However, this does not mean that a nurse's personal attributes are *insignificant* in the face of caring practice. They matter. However, they matter only insofar as they are directed towards the goals of a patient and values of caring practice.

Some level of personal involvement is necessary for the initial relationship of nurse-patient is to be meaningful at all. However, the personal involvement is limited to the structures and social expectations that define nursing practice. However, "though

their role and the distance it entails are objectively prescribed”, warns Bowden, “[nurses’] orientations to these prescriptions [are] suffused with their personal endorsement of the ethical traditions of nursing” (111). The core process guidelines suggest the same. They recommend that nurses “introduce [themselves] and call clients by preferred name” (CCC, 22) in order to open a comfortable dialogue with patients. They all recommend that nurses “demonstrate an attitude of openness and a willingness to change” (CCC, 24). These indicate that a certain level of personal investment is necessary for caring practice to take hold. Indeed, recommendation 4 includes the recommendation that caring practice should foster relationships that are continuous, uninterrupted, and meaningful. “Client centred care,” as is explained in the preamble to recommendation 4, “gets expressed through individual practitioner’s behaviours and actions” (CCC, 27) Certainly, this is not painting the picture that the first reading would have us think – of a particular nurse (with her personal attributes) as ‘replaceable’. Instead, the kind of preferred relationship that CCC hopes to foster is the kind that Nurse Parker had with Mike. This was a relationship very much dependent on Parker’s patience, understanding, opening and changing values and beliefs all of which came from Parker’s unique personal attributes. Every situation is a unique mix of viewpoints, capabilities and experiences.

The second reading adds dimension to the first reading. Recommendation #4 falls under the title *Organization & Policy*. There are 12 key guidelines in place for the development of the recommendation. Two of these guidelines talk directly to the personal involvement of nurses in caring practice.

The first of these guidelines – “model of care delivery that ensures continuity of care and continuity of caregiver” – recognizes that relationships are fostered through time

(RNAO, 28). The ability of a patient to trust a nurse depends on the historical development of that relationship throughout the development of the services provided. A particular nurse's presence matters to the nurse-patient relationship. So too, does this commitment to living through the crisis of illness represent a nurse's engagement in the nurse-patient relationship.

The second of these guidelines calls on a nurse's "reflective practice" (RNAO, 30). This guideline acknowledges that a nurse's contribution to caring practice requires something of herself. What a nurse learns from her personal experiences is meaningful in the development of caring practice. Once again, what we have is a picture of the nurse-patient relationship in which the nurse is involved with a patient with all her capacities involved in the development of human relationships.

All of the ten remaining guidelines are geared to the development of client centred care environments in hospitals. This includes the ongoing opportunities for practitioners to learn, perceive, and implement caring practice in the day-to-day activities of healthcare services. The role of the institution is to provide the appropriate support to nurses such that their efforts are not thwarted by policies that undermine their efforts. The idea behind this recommendation is that caring practice can flourish only in environments where significant personal attributes (virtues involved in caring practice) are fostered.

2.6 Recommendation 5

Nursing best practice guidelines can be successfully implemented only where there are adequate planning, resources, organizational and administrative support, as well as the appropriate facilitation... that includes:

- *An assessment of organizational readiness and barriers to education.*
- *Involvement of all members who will contribute to the implementation process.*
- *Ongoing opportunities for discussion and education to reinforce the importance of best practices.*

- *Opportunities for reflection on personal and organization experience in implementing guidelines.* (RNAO, 31)

The last recommendation adds depth to the kind of support that practices demand of institutions. Institutions best function when they support the various ethical initiatives set forth by practices. One of the challenges in Canadian healthcare is to provide adequate funding necessary to ensure that this support is available. In Wasting Away: The Undermining of Canadian Health Care, Pat and Hugh Armstrong argue that the increasing privatization of healthcare in Canada has a detrimental effect on the quality and opportunities for caring in the providing of healthcare services. What they call the 'deinstitutionalizing' of healthcare in Canada shifts the focus of a practice's internal goods to a blended interest in the practice *as a source of* profit. This rupture in institutional and supportive structures of healthcare has had far reaching consequences for healthcare practice. "Work in institutions", they say, "has intensified, has become less collegial and less satisfying, and is more dangerous [and] the same thing has happened to caring work in the home" (144). Furthermore, as nursing practice becomes increasingly technical and requires more skills training, the funding for nursing practice has become highly geared to technical training. These issues with external goods are not, however, the only problems with the implementation of caring practice. The following chapter identifies some distinct problems that arise out of caring practice.

3 Difficulties of Caring Practice

Those who enjoy deep meaningful, attachments must ultimately pay for them in one form or another when they meet with profound loss, unless they deny and thereby dishonor these same attachments...(Cunningham, 137)

Institutions make it increasingly difficult for nurses to act virtuously. Virtue arises from extensive moral education and a commitment to the kind of caring that has traditionally been devalued in the medical profession. To be clear, caring is not difficult for nurses. According to Aristotle, virtue is not perceived as demanding by the virtuous person. "Just acts are pleasant to the lover of justice and in general virtuous acts to the lover of virtue" (NE 1099a). What makes virtue difficult for nurses is that the healthcare system, with structures that give inadequate resources, time or space, places limitations on the quality of care that nurses are able to deliver to each and every patient. Nurses' sensitivity to care can be clouded by the political and institutional structures that devalue this kind of sensitivity.

Some writers have suggested that the requirements that virtue theory places on nurses reflect women's burden to be the caregivers of society. Historically, nursing has grown from the foundation of oppressive associations between a woman's 'natural' ability to care and self-sacrificial devotion. Such a burden functions as a tool for women's oppression. Feminists warn of the abuses of power associated with women socialized to be caregivers. Training structures of nurses, in the absence of money, and the increasing demands of modern healthcare "compromise education in favour of long and heavy hours of mindless, repetitive work on the wards" (Bowden, 131). Nurses willingly accepted this work in exchange for training and unknowingly contributed to their own exploitation (Bowden, 131). Virtuous nurses must protect their profession and their roles carefully from these abuses, and not get it wrong by being politically naive. Part of a virtuous nurse's sensitivity, then, must include an awareness the oppressive structures in which nursing practice has developed.

Oppressive structures, however, remain. The feminist critique should be taken seriously since, even today, nursing remains largely a 'woman's' profession. It also remains highly hierarchical. This broad feminist critique, I think, reflects some concerns that result from the exercise of caring practice which I have thus far articulated. In this chapter, I will formulate three problems that arise from the basic standard of 'directed and intense personal investment' that I have claimed is necessary for caring practice.

Many writers have something to say about how compassion functions in caring relationships. Much of what is said warns of the dangers of accepting the personal investment (of the self) without restriction. Within this context of self-sacrifice, Ellen L. Fox, in *Seeing through Women's Eyes: The Role of Vision in Women's Moral Theory*, briefly outlines the positions of various authors, including Simone Weil, Iris Murdoch, Marilyn Frye, and Maria Lugones in an effort to make sense of this potential danger. She seeks to answer the question of just how much personal investment is required for compassion.

All of these authors formulate different and increasingly restricted senses of 'personal investment' in entering the moral life of another. I alluded to the appropriate personal investment in my analysis of recommendation #4 in the previous chapter. In that analysis, I claimed that at least some personal attributes of nurses – those that are defined by their personal dreams, hopes and fears outside of the scope of the nurse-patient relationship -- must take a backseat to both the dreams, hopes and fears of patients, *and* the values of caring practice. Though these personal attributes may not be in direct conflict with those expressed in the course of caring practice, part of a nurse's ability to enact caring practice is a function of how well she recognizes when to hold and when to

withhold them. What is prescribed, then, is an appropriate level of involvement that is a function of a nurse's ability to direct complete and total caring practice towards a patient, while at the same time, withholding the expression of those personal attributes that might conflict with the project of caring. The structure of the nurse-patient relationship requires that a nurse define her role (as nurse) entirely through her ability to enact caring practice. And, because nursing practice is unidirectional, in a very important sense, excellence in client centred care is a function of the level of personal investment they afford to their practice. My analysis of Fox (and those authors she looks at) will illustrate the potential dangers of an unrestricted requirement of personal investment in nursing care.

The first problem that arises from an unrestricted requirement of personal investment is primarily a social one. As I mentioned above, the feminist concern about care reflects a worry that care becomes burden-ful for women. If we accept an unrestricted requirement of personal investment in nursing, we might be in danger of maintaining the subordination of the self which has traditionally pushed women aside and left them to take on the role as incomplete members of society. Women who are not complete selves cannot occupy the same position of power in society as those who are.

A second, related problem sees the potential for personal harm in the requirement of personal investment. Virtue theorists accept the supposition that emotions play a role in the development of perception. Emotions enter the picture, however, in the 'right place, in the right way, at the right time'. This generally requires a sense of moderation in emotional responses. However, it is my claim that, at least sometimes, extreme emotional responses are indeed warranted. This problem leads to a possible practical crisis in nursing. Members of a practice should be concerned that their practice evolves and

flourishes. If we advocate a theory of nursing care and practice that requires the emotional upheaval of its members, we cannot at the same time, expect the psychological stability of its members. The burden of care, in this sense, becomes a psychological burden – one which, historically, has contributed to something called ‘emotional-burnout’ in nurses. In my analysis of this problem, I will explore the possibility that the requirement of personal investment leads to the practical problem of emotional-burnout.

In Fruits of Sorrow, Elizabeth Spelman discusses Hannah Arendt’s approach to suffering. Arendt’s writings look at the nature of political life. By looking at political life *phenomenologically*, Arendt hopes to uncover understandings about the human experience of political life. Part of Arendt’s writing seeks to uncover the nature of public and private discourse. Though Arendt does not address ‘care’, she does address compassion which, for her, is integral in understanding the nature of suffering. Arendt requires an unrestricted sense of personal investment for compassion. For Arendt, what this means is that the only *appropriate* response to another person’s suffering is that we enter into a co-suffering with that person. Sometimes, it seems as though the only important reaction to suffering is co-suffering. For Arendt, this is politically worrisome because compassionate relationships, then, do not maintain the kind of distance required for public discussion. If we expect compassion from nurses, on this view, we also have to expect them to be unable to articulate their responses in a public realm. But, institutions are public. The question, then, becomes one of articulation – if we expect personal relationships to be a part of nursing care, how can we discuss the insights we gain from personal relationships in a way that is meaningful and beneficial for other members of the

medical profession? If we follow Arendt, compassion fundamentally cuts off the nursing/patient relationship from public discourse.

3.1 *Self-Abnegation and Nursing*

In her account of excellence in nursing, Benner identifies the positive position that might be gained in the self-diminishing capacities of some nurses. This capacity is especially important when, in our culture we see that self-esteem is “based on individualism, self-control, independence and self-reliance” (Bowden, 123). A patient’s ability to maintain their sense of an independent self may be tied to a sense of obligation they feel towards their caregiver. Part of caring nursing practice, I have argued, requires the fostering of a patient’s sense of self -- that the obvious distinctions between a nurse’s capabilities and a patient’s incapacities are negated. This is accomplished, in part, in a nurse’s ability to educate a patient. It is, however, also in part accomplished by a nurse’s ability to make her role seamless and impersonal in the world of the patient. Often, this happens when a nurse administers embarrassing procedures. In these cases (and they make up a surprisingly large part of nursing work), a nurse’s role is best accomplished when the patient does not see her as fully human. The effacement of the self in these circumstances may serve to provide the patient with the kind of illusory comfort necessary for the patient’s maintenance of selfhood. This process effectively lets the patient see that nurses enter into their relationships without requiring the kind of obligation that might make them feel indebted to the nurse.

Nurses learn how to achieve this self-effacement in various ways. One of the ways which Benner suggests they do this is by “joking or assuming an air of unconcern” when asked for help (Bowden, 123). This has the more far-reaching outcome of

“establishing a domain of responses characteristic of being a ‘nurse’” (Bowden, 124). In this way, nurses call upon a tradition of caring that automatically signals to the patient that the nurse identifies with a role imbued with its own values and traditions. The nurse, in this sense, is no longer a person whose occupation puts them in the position of caregiver. Instead, nurses become *only* caregivers. This allows the patient to feel a sense of autonomy from the personal relationship – indeed it allows the patient to take her proper place in the nurse-patient relationship as the recipient of care without damaging her sense of self.

However, this form of self-effacement is indicative of a greater social construction that has continually placed nurses in a self-sacrificial role. Bowden criticizes Benner’s account of the positive outcomes of nurses’ self-effacement. She suggests that “in continuity with cultural devaluations of women’s caring, nursing care may conventionally be perceived as a right of service from inferiors” (Bowden, 124). Within the cultural context of women’s care -- a context that already devalues women’s role as independent selves – the self-effacement capacity of nurses may further the devalued role that women and caregivers are given in society. “Being a nurse”, says Bowden, “may be understood as a practice of self-effacement combined with the establishment of relationships that are worth little valuation from patients, or society” (124). This is particularly dangerous if, like Benner, we accept that the capacity of nurses to self-efface is necessarily a positive one. Without analyzing the negative social contexts that support nursing self-effacement, we are in danger of further diminishing the important role nurses have in our society.

This concept of self-effacement in caring contexts is not, however, a new one. Fox traces the development of the investment of the self in personal relationships by tracing this theme in the works of Simone Weil, Iris Murdoch, Marilyn Frye, and Maria Lugones. Many of these same authors have had much influence on the development of virtue theory. The historical development of virtue theory takes into account the position articulated by these authors – that the kind of perception necessary to see morally salient features in situations requires a closing of the distance between the self and the beheld. To be in an appropriate moral stance requires that we step out of ourselves and begin to see the world from a multitude of personal perspectives.

Fox identifies Simone Weil as articulating the prototype for this kind of thinking. For Weil, we should devote ourselves to ‘pure attention’ to receive God. This pure attention is marked by “a kind of open, receptive wanting, where the self does not intrude or try to take a more forceful, participatory role” (Fox, 112). To be attentive to God requires complete self-effacement. Though not appropriate for secular use, the concept of ‘pure attention’ was reworked by Iris Murdoch who has had much influence on virtue theory and nursing ethics.

Bowden identifies Murdoch’s work on ‘emotionally engaged attention’ as being particularly influential on Benner’s account of Nursing Ethics (109). Murdoch transforms Weil’s insights about God into insights about ‘Good’. The perception of the Good, Murdoch writes, requires “unsentimental, detached, unselfish, objective attention” (Murdoch, 66). She suggests that if we focus our attention on the Good, one’s self – in which all the concerns and pre-evaluations that come along with the ego – inevitably go unnoticed. She is not advocating, however, that the self should be entirely negated.

Murdoch's position is not "merely endorsing the abject selflessness of the slave; rather, she is concerned to advise us not to be greedy and consuming in our attention" (Fox, 113). What she is trying to do, instead, is show us the dangers of an unreflective ego in our moral lives. The proper moral perception of others requires that we are open to see from other perspectives. This can be done only if we engage with others with humility – the humility to let go of the ego and let 'the other' take on some of the lead.

Fox further identifies Marilyn Frye as being concerned with the selflessness of 'loving perception'. The term 'loving perception' indicates the kind of perception that takes seriously 'the other' without doing harm to him/her. Loving perception loosens the distance between the beholder and the beheld. In the previous chapter, I have advocated a role for nurses that narrows the gap between the patient and the nurse in an effort to gain from that relationship moral awareness. This moral awareness engages the nurse as translator between the patient and the institution. Furthermore, care heightens awareness of important salient features of situations that are lost when they are not considered within the scope of a close, minimally less distanced, personal relationship.

Unlike Weil and Murdoch, however, Frye does not see loving perception (or any perception) as simply passive. Perception is a more active moral endeavor. And, for this reason, incorrect perception can actually do harm. What is required for loving perception, however, is not the abnegation of the self. Frye's argument is more subtle. What she suggests is that loving perception is a 'kind of perception'. "The loving eye", Frye says, "is one that pays a certain sort of attention" (Frye, 75). The kind of attention that is paid by the loving eye is one that requires an awareness of the self. One must engage in loving relationships when one is aware of the 'contents of one's soul'. Loving perception, then,

begins with an assertion of the self as a self. It is “a matter of being able to tell one’s own interests from those of others and of knowing where one’s self leads off and another begins” (Frye, 75). This position is different from Weil and Murdoch, *and* from the kind of caring perception I have thus far advocated for an ethic of nursing care. The divestment of the self is not apparent here. Frye, like Bowden, is concerned about the requirement of selflessness that has traditionally put women in a bad position. Frye insists that the self must be held separate from the beheld. Does this, however, put us into the same position in which we began this project – that distanced perception is the only way to ensure the continuance of proper, sustainable nurse-patient relationships? Does this position not fly in the face of what I have been advocating for an ethic of care – an ethic based on the capacity to understand, indeed to see illness, from a patient’s eyes?

Maria Lugones has similar concerns with Frye’s work. Lugones acknowledges the complex, interdependent perceptions created within personal relationships that support our concepts of selfhood. Lugones suggests that the ability to see from another’s perspective can promote mutually beneficial concepts of selfhood. To acknowledge another is to also assert one’s self and one’s position in society. “The more independent I am” emphasizes Lugones, “the more independent I am left to be” (7). This leaves us with a concept of our self as ‘not quite whole’. When we meld our self, our hopes, dreams and fantasies, with others, we actively invest our self in the world of others. This changes us. Coming to understand the other in a loving way is not only beneficial to the beheld but also to the self. To be acknowledged as a self, in Lugones, is central to the formation of a mutually beneficial concept of self. Perception, in this way, becomes mutually beneficial.

Nursing care, I have argued, should not be concerned with the kind of loving perception that Lugones is talking about. Clinical care should be distinct from loving. Nursing care and loving are different primarily because, as Bowden argues, within nurse-patient relationships, there are “crucial differences in commitment, compared with the personal caring of a mother or a friend” (Bowden, 110). Nursing is clinical, and the boundaries of the nurse-patient relationship are clear – the nurse is the caregiver, and the patient is the recipient of care. This accentuates the fact that “nursing does not depend on receiving reciprocal attention from the patient” (Bowden, 111). The perception required in nursing is directed and focused. I have argued that part of the focus is in the discovery of new meanings for the patient. In this way, nurses and patients can work together in the discovery of value and meaning in a patient’s experience. I have also argued in this section, however, that this uni-directional focus may serve the patient well, but may do damage to a nurse’s personal concept of selfhood. It seems we have come full circle.

In the following section, I will consider Lugones’ possible solution to the problem as I have articulated it. Many nurses have indicated that the close personal relationships they have had with patients have contributed to their own values and experiences. Perhaps, the requirement of nursing is closer to loving perception than I have originally articulated it. Nurse Parker, we remember, described her relationship with Mike, her patient, as being “a close traveling companion on an uncertain journey” (38). To deny that nurses gain from the close personal relationships they have with their patients might not do justice to just how close and important these relationships are. Acknowledging Lugones’ insights into the interdependence of selfhood might contribute to the valuation

of the close personal relationships that seem central to capturing the richness and complexity of nursing care.

3.2 Emotional Responses in Nursing

Caring is a certain kind of perception. A caring perception is distinct from an indifferent one. One of the ways in which perception can be altered is by engaging with others in an effort to 'see from *their* perspective'. This is a particularly important capacity nurses learn in their effort to care for their patients. Benner concedes this point when she cites studies that "demonstrate that a certain level of involvement is essential if people are to move from a competent level of performance to a proficient or expert level" (Gordon and Benner, 51). By and large, virtue theorists acknowledge that the distant and detached understanding of other people fundamentally limits what one can know about others and thus closes off the perception of moral salience.

A person's engagement in personal relationships involves caring about other people's hopes, dreams, fears, needs and wants. This engagement entails emotional involvement. Emotions are not excluded from the compassionate nurse-patient relationship. Benner argues that emotions must enter the picture if we want to capture the wholeness of human experience. "Detached unemotional reasoning alone", she says, "cannot provide the ground for the development of human expertise" (Gordon and Benner, 51). Emotions, then, are necessary for the complete grasping of the human experience. Sherman contrasts Aristotle's position on the subject with the Kantian notion that emotions require a "romantic spirit, free of calm and deliberate intention" (Sherman, 47). Instead, emotions are necessary as they contribute our valuations about not only that something is ethically relevant, but also the degree to which we are motivated to do

something about it. Sherman identifies the role of emotions as capturing the ethically relevant features of a situation. She writes,

Even if without [emotions], we could somehow see ethical salience, the way we see would still be defective and imperfect. That is, we might have the right (ethical) viewpoints, but lack the right modes of seeing and appreciating. We would see with an inferior kind of awareness. The point is that without emotions, we do not fully register the facts or record them with the sort of resonance and importance that only emotional involvement can sustain (47)

In the nursing context, personal involvement helps nurses understand a patient's experience of illness. The loss of self, feelings of vulnerability, the loss of control over one's own body, are emotionally significant in a patient's experience. For a nurse to understand a patient's experience, she must also attend to a patient's emotional responses (and their sources). The critical situations that are often part of the nursing environment are saturated with emotion. Nurses understand and attend to a patient's experience by first seeing emotions from that patient's perspective. Once she is able to appreciate how a patient is feeling, she is in the better position of engagement in that patient's world – joining that patient in her 'journey'.

I argued in the above section that personal involvement can take on at least three forms. The first involves self-effacement. The second involves an 'appropriate' kind of involvement. Benner discusses 'appropriate levels of personal involvement in nursing. Nursing expertise, she suggests, "does not develop when the person is flooded or overwhelmed by emotion" (Gordon and Benner, 51). The third form of involvement is one that is explained by Lugones – that personal investment (of the fully 'self' aware) means entering the world of another as a separate 'self'. In this effort to understand the world of another, one must first be aware of one's own presence in the world. However,

when we do enter into the world of another (in a loving way) we are in a position to appreciate the empowering structure of loving relationships. People in loving relationships, in this way, acknowledge the interdependence of identity. A nurse, in this way, is also not alone in the maintenance of her 'self'. Expert nurses acknowledge their roles as 'caregivers' in the patient's experience. The nurse and patient are mutually dependent on each other – they not only co-exist, but instead, form a bond that can be mutually beneficial.

The second formulation (Benner's) of the nurse-patient relationship is commonly held to be the most desirable. Virtue takes shape in the ability to maintain appropriate perceptions and responses to the world. The relationship between expert nurse and patient is balanced by the deliverances of a nurse's fine-tuned perception and awareness about her capabilities. However, the practical reality of nursing does not support nurse's personal engagements with their patients.

Many good nurses become overwhelmed with their work. The burden of caring has often been left to individual nurses. "The burden of responsibility for the realization of the ethical possibilities of nursing care" says Bowden "seems to fall squarely on the [shoulders] of individual nurses themselves" (127). Furthermore, the context of institutionalized healthcare has often neglected the possibilities for ethical work – making it difficult for nurses to care in the way I have described it. Bowden writes,

chronic short staffing, lack of recognition, lack of possibilities for professional growth, strained relationships among hospital personnel, and insufficient time to establish the intimacy that is the hallmark of good nursing, are the creation of powerful socio-historical interests that command nurses to care while refusing to value caring (128)

Nurses, in short, are not given the tools they need to function as the virtuous caregivers we would want them to be. But, nurses still do enter into close personal relationships with patients. They continue to care about their patients despite the limitations placed on them by the systematic devaluation of care. One of the ways in which nurses combat these limitations is by appreciating the co-dependence of fellow nurses. Nursing is often characterized by a 'communal solidarity' where nurses face the world of limitations together. Others, like Parker, care despite the frustrations and limits placed on them. This kind of caring requires the special kind of devotion. It challenges the nurse and the patient to enter into a relationship *despite* the limitations that are initially placed on them. This kind of relationship requires the emotional investment in another's experience that is best captured by loving. For this kind of relationship to be sought after – because it is so difficult to attain given the external, systematic limitations placed on care – nurses require the emotional motivation, and perhaps the mutual dependence that Lugones is talking about.

I have been using Nurse Parker's story about 'Mike' as a paradigmatic case for nursing care. If Benner had read Parker's article, we wonder if she would approve. Is this really a case of caring practice, or has Parker gone 'too far'? Certainly, for 'Mike', the answer would be "No". But, it is crucial to examine the possibility that caring practice, without the institutional structures to support it, demands too much emotional investment of nurses. Emotional burnout, explains Bowden, "typically result[s] from the sort of involvement in which the nurse identifies with the patient's emotion, and consequently succumbs to the same sort of involuntary and unconscious immediacy that the patient experiences" (111). Bowden, however, argues that nursing does not rely on emotional

involvement, but rather, on an 'emotional participation' that is different because it is a "professional's directed focus, conscious emotional intensity and 'external' perspective [that] understands and supports [a patient's] emotional complexity, without falling prey to the isolation and partiality generated in the immediacy of their distress" (Bowden, 111). Having said this, emotional burnout continues to be the leading cause of nurses' leaving the profession. An international study found that over one third of Canadian nurses attribute a change in career to emotional burnout (<http://www.cna-nurses.ca/frames/search/searchframe.htm>).

What is the proper response to human suffering? I have defined excellence in nursing practice, in part, as being: 1 – focused on the values of caring practice, 2 – integral in the development of a patient's personhood, 3 – particularly skilled in the perception of salience, and 4 – emotionally appropriate in maintaining a distance inherent in the structure of the nurse-patient relationship, while, at the same time, acknowledging emotions as essential parts of the experience of illness.

Perhaps the most difficult day of my life was the day I found out that my daughter's cancer had spread. It was *not* the day that I found out that she had cancer. This is because the diagnosis was supplemented with the hope that the cancer had not spread, in which case her complete recovery would almost have been guaranteed. If, on the other hand, the cancer had spread her future, and mine, seemed rather bleak. What I most remember from that day, and what was also most comforting, was that the nurse who had known us very little sat beside me and sobbed alongside of me and my husband when we got the news. Any other reaction – the cries of our family members or the detached concern of the doctors – seemed neither comforting, nor helpful to us. Because she

understood the immensity of the news, and had already been tending to my daughter with expert care, it seemed that the nurse was the only person in the position to respond appropriately to *our* suffering. The salient response was to be open to our suffering and suffer with us. And, to be clear, it is not that she overstepped some boundaries in her role as nurse. It was, rather, that her caring practice did not give her the choice but to suffer with us. Sometimes, it seems, the correct response to human suffering is to suffer too.

In the final section of this chapter, I examine the possibility that, sometimes, even in caring practice, suffering requires an emotional participation that looks and feels more like co-suffering. This leads to emotional burnout, but, as this section will explore, it leads to even more far-reaching problems.

3.3 The Public/Private Nature of Human Suffering

Hannah Arendt is concerned with the distinction between the public and private realm. The public realm – where political activity is based – is where a plurality of perspectives come together in the sharing of their perspectives through language. The private realm, on the other hand, is not shared with other perspectives. Suffering, especially physical suffering, she claims, is essentially private and can be “transformed for public appearance” only with great difficulty (Spelman, 60). Elizabeth Spelman distinguishes two, seemingly contradictory claims that Arendt makes about suffering. On the first hand, Arendt seems to be suggesting that suffering is essentially private. On the other, she claims that suffering is public because we “can know that others are in pain, miserable, in constant want, or in a state of humiliation” (Spelman, 62). Spelman explains these two seemingly contradictory claims.

For Arendt, the experience of human suffering elicits one of two responses. The first response is something like the reaction of the nurse that I described in the previous section – that of co-suffering. This is where “one is so much a co-sufferer that the ordinary distance between oneself and that sufferer is abolished” (Spelman, 63). Arendt warns that, because suffering is essentially private, co-suffering is marked by a “kind of mutedness” (Spelman, 63). Beyond being a cause of emotional burn-out, then, co-suffering seems to cut the project of caring practice off at its roots since caring practice is founded on actions and exchanges that are publically available⁹. Professions of caring for the suffering are, then, “completely at odds with what political life requires” (Spelman, 65). For Arendt,

the perception of suffering that informs real compassion [co-suffering] is too sure, too impervious to alteration, to be open to the possible change of opinion, open to the challenge to its claim to truth, which for Arendt is constitutive of public and political life (Spelman, 66)

In virtue of the closeness of co-suffering, the kind of open communication necessary for caring practice, and the opportunities to define excellence in nursing are cut off.

On the other hand, the other response to suffering, Arendt claims, is where the experience of another person’s suffering leads to pity. Pity creates an urge to “put forth an authoritative interpretation of the experiences of those suffering” (Spelman, 64). Because pity elicits ‘speaking for, or representing another’, such a response, contrary to co-suffering, widens the gap between the pitier and the sufferer. Since the act of pity is not imbued with suffering, the choice of the pitier to be connected to suffering indicates

⁹ As I argued previously, the nurse-patient relationship is publically defined as caregiver and receiver of care. The project of the establishment of personhood in the patient begins with the ability a nurse has to help a patient acknowledge feelings, fears, and losses, by talking about them and setting out to provide solutions.

“a selfish and cruel wallowing in the misfortunes of others” (Spelman, 65). If caring practice were viewed in this way, it would be no more than a project of self-affirmation through a patient’s suffering. Certainly, this is not the positive possibility of caring practice for which I have been arguing.

There are good reasons why Arendt’s concerns should not be ignored. I am claiming that virtue may sometimes (notably, contrary to Benner) demand co-suffering. I want to hold to these claims because of my personal experience with a nurses’s co-suffering, and because the fact remains that so many nurses do indeed claim that it is a relevant and important part of their work. I will thus conclude my examination of nursing care with the direction that I think should be undertaken if caring practice is to become the definitive aim of the profession of nursing. Narrative – the ability to both view and create experience through stories – calls on the very virtues that are important in caring practice. Narrative, I will argue, can solve the kind of problems I have examined in this chapter.

4 Narrative as Curative

The cultivation of the virtue of care is a process whereby nurses become increasingly proficient at perceiving the salient moral features in a situation that would otherwise be missed by someone lacking that virtue. Sometimes, caring breaks the idealized emotional distance between nurse and patient. This rupture in the original structure of caring practice, I have argued, is sometimes necessary and it is guided entirely by a fine attunement to the suffering of a particular and unique individual. I will argue that narrative helps ease this rupture and provides caring practice with a tool that helps both patients and nurses overcome the suffering inherent in the nursing profession.

Not all authors are convinced of the power of narrative. Alex Vernon, in his examination of Tim O'Brien's The Things They Carried, is skeptical about the power of narrative. Vernon asks the question, "can we revisit our wars in writing stories – can we make imaginative pilgrimages back in time and space – and find some solace, some meaning, some salvation?" (173). The answer, for Vernon, is "No". Sometimes, our experience of terror is simply too personal, too close, for us to be able to express it or gain any relevant meaning from it. "Beyond the simple act of sharing [his experiences of war] with others", argues Vernon, "O'Brien has realized the futility of transcending war's meaningless[ness] through writing" (Vernon, 187).

There are two reasons why Vernon's concerns about the power of narrative are not detrimental to caring practice. Firstly, the act of 'simple sharing' may not transcend the meaninglessness of war but can, nonetheless be very powerful. The following personal experience illustrates how sharing stories has been an important and valuable tool for me.

A fellow mother of a cancer patient felt the power of sharing her story with others. Her story took the form of a scrapbook. It began with a picture of her 17-year-old daughter a few days after her diagnosis of metastatic bone cancer. Underneath the picture was her name and age. She appeared healthy and surprisingly happy. Every visit to the hospital meant another picture in her scrapbook. Beneath the picture was generally a few simple descriptive words – 'Sophie had a good day today', 'Sophie threw up 3 times today, but felt better after she took some Ondansetron', 'Sophie turned 18 today – Happy Birthday!'. Aside from the obvious advantage of taking up some time and focusing her attention elsewhere, Sophie's mother felt that the activity of narrating this particular

experience in their lives was helpful both to them and to others. I was introduced to the book when I mentioned that I was curious about a particular procedure that my daughter was scheduled to undergo later that day. Sophie's mother quickly turned to the page in the book with the picture of Sophie before and after the procedure. She looked noticeably relieved in the 'after' picture – the caption wrote 'it didn't hurt half as much as she thought'. For me, Sophie's picture spoke a thousand words. Not only did it reassure me of the ability of my daughter to undergo the procedure, but it also gave both me and Sophie's mother the occasion to talk about our experiences and those of our daughters in a concrete and real way. The ability to represent the ongoing trials and tribulations of illness – to put them into words – gives patients (and their families) a vocabulary and, more importantly, a forum to discuss. These forums are important in the development of positive meanings – to look back and remember that some days weren't so bad. This particular conversation with Sophie's mother reminded me that our family, like Sophie's, could still manage to be happy in the face of misery.

The second way in which Vernon's insights are not damaging to the power of narrative in our context, is that caring practice is not primarily about finding meaning in illness (which, like war, is essentially, meaningless), but about finding meaning in life. The project of caring practice *is* ethical because it concerns itself, in part, with the development of identity through, and even, despite illness. It reminds patients that illness does not cut them off from life – instead, complete personhood in illness requires a reorientation of goals, dreams, and possibilities. Narrative works in this context because the subject of caring practice is inherently *meaningful*.

Illness places patients in new and alien contexts. When patients are in new and alien contexts, old priorities, goals, and values do not make sense to them anymore. Caring practice makes sense of these contexts and renders them familiar. This is an important feature of caring since, as I have shown, without new barometers that include illness, a patient's sense of self is fractured. Caring practice allows for the emergence of a patient's new and complete sense of self. In Disrupted Lives, Gay Becker explains the value of narrative to re-establishing personhood following illness. Becker describes a particular patient's experience in coping with kidney cancer: "talking about what has been happening to him is clearly an effort to heal the breach in his life story and begin to create a new sense of continuity, one that encompasses this disruption" (45).

Caring practice is not about creating meaning. Virtue ethics, like narrative ethics, rests on a foundation of realism where commitments, goals and values make sense only against a corresponding backdrop of setting and context. Practical reason, as I explained in chapter 1 in my discussion of the major and minor premise, crystallizes particular understandings through experience. "Aristotle makes it very clear" explains Nussbaum, "that his own writing provides at most a 'sketch' or 'outline' of the good life, whose content must be given by experience, and whose central claims can be clarified only by appeal to life and to works of literature" (Nussbaum, 141).

The way in which narrative and practical reason are related is explained by Sheila Mason, in her article, *Citizenship, Practical Reason and Narrative*. She explains that both narrative and practical reason require "linking together two dimensions of experience, our sense of what is important, of value, and the particular events which, seen through the lens of value, are appreciated for the value they have" (Mason, 12). Narrative brings

together chronological and the non-chronological. The chronological consists of the “episodes or events of the story” (Mason, 12). The non-chronological consists of “a bringing together, or a *making present* in one moment salient features of a particular [story]” (Mason, 12). In a similar way, practical reason crystallizes the salient ethical features of a situation. Both narration and virtue require the “connecting experiences of value or meaning” (Mason, 13). In this way, when a nurse explains a highly technological procedure like a CT-Scan as “a 3-D picture of your soft-tissue organs”, or complex test results as “it’s saying you need to take some iron pills”, or discusses with a diabetic patient the meaning of ‘quality of life’ a nurse’s ability to both recognize the need for patients to understand what is happening to their bodies, and to notice the important features of these experiences, allows meaning to emerge.

Martha Nussbaum explains why novels are needed to supplement traditional books of moral philosophy. Novels, she explains “involve valuable aspects of human moral experience that are not tapped by traditional books of moral philosophy” (Nussbaum, 143). One of these significant aspects is the “develop[ment of] our ability to confront mystery with the cognitive engagement of both thought and feeling” (Nussbaum, 143). It is the idea that human life is a quest, punctuated by critical moments like illness, that leave us bewildered and in suspense. My daughter’s frightening diagnosis of cancer left me suddenly unsure and terrified of what might happen. What narrative helps us, in part, accomplish is to appreciate the richness and complexity of tragic human situations, and at the same time, imagine positive ends and perceive new possibilities. “If our moral lives are ‘stories’ in which mystery and risk play a central and a valuable role, then it may well seem that the ‘intelligent report’ of those lives requires

the abilities and techniques of the teller of stories” (Nussbaum, 142). The eagerness of nurses and patients to tell stories reflects the understanding that the richness and complexity of human experience is not captured by statistics, charts, or protocols alone.

There are three other ways in which narrative is important to caring practice. Firstly, the sharing of stories is particularly important to the structures of personal support that are necessary for the flourishing of excellence in practice. Nurse Parker argues that nurses need storytelling in order to develop and improve their practice. She writes,

my experience with Mike suggests that the values essential to the moral foundation of nursing cannot be extracted from any abstract or decontextualized moral theory. These values derive from generations of nurses’ relational stories of caregiving. If these stories are woven together with care, nurses collectively can fashion a tapestry of rich and diverse experiences from which to pattern a nursing ethic (34)

The ability to share experiences and contribute to a Nursing Ethic is an opportunity for nurses to undermine the oppressive gender-based structures that I discussed in the previous chapter. Narrative gives nurses the power to determine what is, for them, a meaningful and Just practice. As nurses develop their own practice through story telling, so too do they develop opportunities for self-reflection and education.

Thus the second way in which narrative is important to nursing care is in the structure of learning and training in virtue. “The telling of stories”, explains MacIntyre, “has a key part in educating us into the virtues” (MacIntyre, 201). Understanding our roles in our environment depends, in large part, on our understanding of context. Because caring practice depends on unique and particular relationships, the education of nurses depends on stories defining and contextualizing the limits of the nurse-patient relationships and the institutional structures in which these relationships flourish. This

happens in two ways. Firstly, nurses' stories are used as a way to contextualize a certain situation as a springboard for discussion. Like with Sophie's stories – the scrapbook provided an invitation to discussion. Secondly, nurses learn from expert nurses' stories. As I showed in Parker's story, the power of a story to teach us about essential elements of lived experience is central to the development of virtues. The idea here is that narrative – because it, in part, is focused on expressing something both essential and unique about a situation – is most congruent with the concepts of particularity implicit in virtue ethics. Stories allow us to practice attention and focus on particular characters in particular situations. In nursing, narrative can bring light to the experience of strangers – putting itself there for nurses to care about.

Finally, the third way in which narrative is useful for caring practice is in its cultivation of imagination. Stories have the capacity to move and to educate. What makes narrative particularly poignant is moral imagination. The ability to imagine ourselves in other situations allows us to look beyond our personal goals and projects and incorporate other people's needs and wants. What we gain when we imagine is the possibility of different, and engaged, perspectives. Nussbaum argues narrative is essential to moral life in its capacity to "extend it, making us reflect and feel about what might otherwise be too distant for feeling" (47). One of the reasons that this is particularly important to nursing care is that nurses are required to have an ability to act quickly in acute situations, to discern the salient features of a situation in, sometimes, very little time. Stories provide nurses with an opportunity to engage themselves in a life with a focus they might not otherwise have the opportunity to develop in a lived situation. Imagination both allows

nurses to cultivate a caring perception by learning from stories, and is essential in dealing with new and unanticipated situations.

The fact that we are able to care about fictional characters in a novel indicates that we are able to genuinely exercise our imagination to develop morally. Nussbaum writes,

by identifying with [characters] and allowing ourselves to be surprised (an attitude of mind that storytelling fosters and develops), we become more responsive to our own life's adventure, more willing to see and to be touched by life (162)

Learning (about becoming virtuous) from a story does not have the social and personal implications that real life situations might have. More importantly, the exposure to narrative allows nurses to be morally engaged and to work at practicing appropriate personal involvement without risking damaging the patient or herself.

But, moral imagination has the power to go beyond simply substituting 'unreal' experiences for real ones. I have yet to address Arendt's issues with co-suffering. Arendt claims that the only appropriate reaction to suffering is co-suffering. I have suggested that my experience has indicated this to be true in some circumstances. A person can co-suffer only with the active use of moral imagination. This heightened sense of imagination, however, is also the same faculty that can imagine other possibilities.

Howard Broody writes about the healing power of narrative. In explaining imagination and narrative he writes, "narrative allows us to try on the future as much as we can try on different suits of clothes before buying one of them" (202). It is this imagination of other possibilities that allows nurses to remove themselves from co-suffering and resume their previous role. Because suffering, like all human experiences, is temporary so too is the silence that accompanies co-suffering. Imagination can help nurses cope with the

emotional burden of co-suffering by infusing the suffering with a vocabulary geared towards the future – a horizon of possibilities for herself and the sufferer. This forward-looking glance is attuned to the exercise of caring practice in its effort to re-inject *telos* into a patient's fractured self.

Conclusion

The goal of this thesis has been to articulate my experience of nursing care as a mother of a cancer patient. The best nurses – the ones who were the most skilled, understanding, innovative in their approaches, and insightful about their role and the impact of illness on my family – were the nurses who developed a personal, caring relationship with my family. This is the kind of care that the recommendations of the CCC are aiming at.

In Chapter 1, I began my thesis by defining virtue. I showed that virtue is a reliable sensitivity to a moral landscape. That virtue is an enduring part of one's character, learned through a process of habituation, whereby a person develops a perception and can see opportunities for virtuous action and acts accordingly. Virtues are necessary for practices to flourish. Unlike Kantian ethics and utilitarianism, Virtue Ethics approaches ethical life from the 'inside', and is based on the deliverances of a virtuous perspective and requires no extra-explanatory powers beyond that perspective.

In Chapter 2, I showed how the vocabulary of Virtue Theory can be used to understand CCC. I used the concept of virtue to describe and further explain the recommendations of the CCC. Because these recommendations value close personal relationships, a dynamic evaluation and re-evaluation of goals, and the nurse as providing

a refined perception of the salient features of situations, Kantian ethics or utilitarianism would fail to capture some essential key points of CCC.

In Chapter 3, I extended the discussion of the nurse-patient relationship beyond the recommendations of CCC, and discussed some difficulties that may arise from a nurses' efforts to enact CCC in an institution that fails to provide adequate support for these initiatives. This led to an exploration of Hannah Arendt's articulation of the issue of silence in co-suffering.

In Chapter 4, I provided an answer to Hannah Arendt's problem of the silence of co-suffering by appealing to moral imagination and Narrative Ethics. I argued that the sharing of stories helps nurses navigate the uncertain terrain of a moral landscape, while moral imagination helps nurses overcome the emotional pain that comes with being open to suffering.

I am forever grateful for the virtuous nurses whom I encountered at Montreal Children's Hospital. Without their expert perception, I doubt that Anastasia would be the well-adjusted, happy, trusting little girl that she is today. Our trips to the hospital are increasingly less frequent. Anastasia continues to enjoy re-visiting her favorite nurses who have formed a special bond with her. I continue to marvel at the devotion that these nurses have to caring for my daughter and the countless others who benefit from their virtue.

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