Nursing Praxis in New Zealand

UNCOVERING THE ETHIC OF CARE

Belinda Hodge, RCompN, Dip.Grad(Bioethics)
Lecturer, Nursing & Midwifery Department
Otago Polytechnic, Dunedin

INTRODUCTION

This paper will explore some of the issues which have arisen while listening to and talking to nurses about their caring practices, and the ethical dilemmas they face. It is generally held that 'care' is the primary focus for nursing. If this is to be accepted, nurses need to begin to question the role of traditional bioethical principles in helping them articulate and resolve such dilemmas. The exemplars presented in this paper come from student nurses and clinicians and are typical of the concerns and frustrations that nurses everywhere face in their day-to-day nursing practice. The following discussion may well generate more questions than it does answers - questions I believe, nurses need to be asking themselves at this time.

Historical Perspective

Watson (1985) in Nursing: the Philosophy and Science of Human Caring provides a picture of nurses and the expectations of nurses historically. According to Watson, nurses were predominantly 'other' directed rather than 'inner' directed. The professional lives of nurses were controlled and influenced largely by physicians, and nurses became a submissive group particularly to doctors. Because of the lack of control nurses had over nursing, they had difficulty accepting authority as a part of their own practice, and also with challenging it. As a result nurses learnt not to question or complain, but to accept. Nurses were seen but not heard, were dedicated, and self sacrificing. Many of these attitudes can still be seen in practice today.

For example,

> *The volutrol on an intravenous (IV) giving set ran empty of IV fluids the other day. A doctor must have seen it as an account of this appeared in the patient's notes inferring this was quite unsatisfactory practice. (Staff Nurse, 1992)*

In this instance the issue is that the doctor has taken for granted his right to comment in the patient's notes, about areas of patient care for which nurses are accountable, without discussing it with the nurses concerned.

Even in areas where there is a need for collegial decision making and planning of care, submissive behaviour is still apparent. For example,

> *A consultant ordered a wound management strategy we knew to be contraindicated. Due to the nature of the relationship between the consultant and the nurses on our ward, and his manner and reputation, this plan was not challenged (Staff Nurse, 1992).*

Why was this not challenged? The nurses knew it was contraindicated and had research to back up this claim. The status quo was maintained, the patriarchal system of decision making was condoned.

Nurses frequently accept authority, become passive recipients to doctors orders,

and develop an ethic of 'doing'. Because of this there is no need for nurses to know or understand the principles behind decisions or even why they do what they do. Nursing knowledge is applied and practical. As long as nurses can 'do' as requested, that was all that was required of them. Nursing work, therefore can be reduced to tasks, carrying out orders, procedures, charting, physical care, and the efficient management of the ward. Nurses can be invisible - that is show no expression, or personal feelings and there may be little distinction among nurses as people. Nurses are often expected to be, self controlled, self regulated, self composed, and conformists. Given this prescribed role in the health system, it is little wonder then that nurses have had difficulty accepting responsibility and using their own authority.

If nurses are not encouraged to think and critically reflect on their practice, be accountable and independent, it is considered inconceivable that they should concern themselves with ethics. One of the earliest advocates of a code of ethics for nurses in America was advised by a physician "Be good women but don't have a code of ethics..." (Dock, cited in Johnstone, 1989:1).

Fortunately nurses have ignored this advice and as a profession have developed an international code of ethics which makes explicit nurses' independent responsibility and accountability for nursing care (Johnstone, 1989). New Zealand nurses have a Code of Ethics formulated by the Professional Services Committee of the (then) New Zealand Nurses Association (1988).

Despite this philosophical shift little real progress has been made. Johnstone believes that morally condescending attitudes towards nurses still prevail. Nurses are still expected to be merely 'good women' and more than ever, it seems, not to have a code of ethics - or if they do, not to take it too seriously. She says that nurses are certainly not expected to have a substantive moral position on anything significant, and are most certainly not expected to express a view publicly. For example, the Report of the Cervical Cancer Inquiry (cited Johnstone, 1989) stated grave reservations about nurses' ability to defend patients' rights. The commissioner commented that:

Nurses who most appropriately should be the advocates for the patient, feel sufficiently intimidated by the medical staff (who do not hire and fire them) that even today they fail or refuse to confront openly the issues arising from the 1966 trial (Cartwright, 1988:172).

There are many issues that arise for nurses from this inquiry, too many to be dealt with here. However, one which bears direct relevance to the historical position of nurses, is the fact that the report did not apportion blame to those nurses who knew what was happening but did nothing. The commissioner effectively reinforced the notion that nurses should "be good women, but not have a code of ethics" and thus not be independently morally accountable to those who are in their care (Johnstone, 1989). Until nurses themselves, or the institutions that employ them, confront the issues that disempower nurses and cause them to be morally unaccountable, in this instance by being seen and not heard, these situations will continue, and nurses will not practice ethically.

Caring as a Focus for Nursing

Caring has emerged as the focus of contemporary nursing (Rawnsley, 1990). Writers have described caring as the 'core' (Watson, 1988) or the 'essence' (Leininger, cited in Morse et. al., 1990) of nursing. This is not new to nursing. Historically however, nursing was organised under the expectation

that its practitioners would accept a duty to care rather than demand a right to determine how they would satisfy that duty. Nurses were expected to act out of an obligation to care, taking on caring more as an identity than as work, and expressing altruism without thought of autonomy either at the bedside or in their profession (Reverby, 1987). Nurses are still struggling to dispel this belief as they argue for their status as health professionals to be respected, and as they attempt to articulate what is caring.

Human caring in nursing is not only an emotion, concern, attitude, or benevolent desire, caring is the moral ideal of nursing whereby the end is protection, enhancement, and preservation of human dignity. Human caring involves values, a will and a commitment to care, knowledge, caring actions, and consequences (Watson, 1988). There is no doubt that caring as a concept has had a profound effect on nursing philosophy, education, practice, and research. Nurses understand caring as an intrinsic part of nursing practice, even if they have difficulty articulating this. Fry (1988), suggests the ethic of caring serves as a universal value that guides nursing practice.

Watson (1988) asserts that caring for nursing is a moral ideal, that nurses have a moral imperative to care. However as Benner & Wrubel (1989) have reminded us we live in a highly technical society that values individualism, scientific advancement, and demonstrates the devaluation of care. Reverby (1987) supports this idea by suggesting that the central dilemma facing nursing today is the 'order to care in a society that refuses to value caring'. Nurses are expected to do more, with fewer resources, and often lack the autonomy and authority to determine how they will provide the care demanded by society.

The Privileged Place of Nursing

Nurses are in a unique position in the health care setting, and as a result are faced with unique ethical dilemmas. When Shrock (cited Sheehan, 1985) examined the matter of moral issues in nursing she made the assertion that few nurses have to face with any frequency, actual conflicts and decisions concerning abortion, human experimentation, organ transplantation, euthanasia, psychosurgery, or even resuscitation. However she goes on to deal with issues such as honesty, keeping promises, respecting physical and emotional privacy, doing justice to people, examining the limits of obedience, using and not abusing professional power, and preventing incompetent practices which, she claims, are important to nursing practices, but are largely ignored.

Walker (1992) and Dillon (1992) also write about the reconceptualization of the moral situation itself. Rather than the moral situation being a dilemma or crisis which one must deliberate or choose, emphasis is moving to morality as a way of being in a relationship with others.

Many of the conflicts are direct effects of the nurse's complex role within the health care delivery system. The nurse is in the incongruous position of undertaking considerable responsibility for managing patient care which requires her to have a high level of knowledge and skill while customarily holding little authority to make or execute decisions (French, 1984). The nurse could be said to be at the 'work face' where accountability and responsibility are demanded, but where the locus of control is removed. For example,

> *A situation arose in our ward the other day whereby a patient was under two different consultants. As a result of this we were faced with conflicting medical orders. Effec-*

tively this is not our problem. As nurses, we need only to refer it back to the medical teams concerned for them to sort it out. However it just isn't that simple. We are in a complicated position in that we are working with this patient and their family 24 hours a day and because of this they see nurses as the people who should be able to explain the situation and deal with the confusion. If that can't be done it is often us who take the blame even though we have no control over the confusion and conflict, only the ability to facilitate its resolution, and even then in a limited capacity (Staff Nurse, 1992).

I was so frustrated the other day. A patient's stitches were ready to be removed. It was so obvious - they were red and the patient was complaining that they were itchy, and the wound had healed beautifully. I wanted to take them out then and there, but I knew I had to phone the registrar first. So I did and you wouldn't believe it, I was told they hadn't been in for 10 days yet so they were not to be removed. Nothing could persuade her otherwise. This type of thing happens all the time and it is so frustrating (Staff Nurse, 1992).

As a nurses in an acute surgical area we cared for patients having major bowel surgery and they were often in incredible pain postoperatively. The nurses on our ward realised that those patients who returned from operating theatre with morphine infusions in progress had a much shorter post operative recovery. They mobilised sooner and so minimised the risk of chest infections, deep vein thrombosis, constipation and the like. However we were unable to persuade certain anaesthetists to initiate these continuous infusions in operating theatre. This was incredibly frustrating for us (Staff Nurse, 1992).

The medical profession has long maintained a paternalistic attitude towards nursing (Payton, & Yarling, cited French, 1984). In this relationship the question of the nurses accountability, to physician or to patient, creates even further conflict. A nurse strongly committed to serving the interests of the patient may find themselves an uncomfortable adversary to the physician on moral issues. Various authors (see French, 1984:44) have expressed concern for the moral problem of the nurse who, out of conscience, wishes to act as the patient's advocate. In bureaucratic institutions other people make many of the key decisions which nurses must ultimately implement.

The nurses were visibly stressed the other afternoon when there were more patients in the ward than there were beds available. One of the medical teams had transferred a patient up to the ward from Accident and Emergency, and they were resting on another patient's bed while that patient was resting in the lounge. There was nothing we could do (Charge Nurse, 1992).

During a ward meeting, one of the staff nurses questioned the medical staff as to whether one of her patients was for resuscitation or not. The nurse felt this needed to be discussed with the woman sooner rather than later. The medical team replied they would not make a decision until the pathology was confirmed, and that aside, it would not be wise to discuss it with her at this time because 'it would not improve her mood'. The staff nurse was visibly unhappy with this decision however it appeared

there was little she could do (Personal Observation, 1992).

Caring requires that the nurse has daily intimate contact with the patient, be it in a hospital or community setting. Nurses provide care for people in the midst of health, pain, loss, fear, disfigurement, death, grieving, challenge, growth, birth, and transition on an intimate front line basis. This is the 'Privileged Place of Nursing' (Benner & Wrubel, 1989:xi). I believe it is this 'privileged place' that Benner & Wrubel write about, that creates for nurses ethical dilemmas unlike others in health care.

Traditional Approaches to Ethics

Let us take a moment to review the traditional approaches (Beauchamp & Childress, 1989) to bioethics before we explore further the emerging ethic of care. The two most commonly referred to ethical theories include *consequentialist theory* and *deontological theory*. Simply, consequentialism is the moral theory that determines that actions are either good or bad according to their consequences rather than any intrinsic features they may have. We may well ask 'so what is good?' and 'whose good should be promoted?' The most prominent consequentialist theory is *utilitarianism*. Utilitarians believe that 'good' is promoting the greatest good for the greatest number, that we must always maximize good over bad.

Deontological theories on the other hand, deny much that consequentialist theories affirm. Actions are considered right or wrong for reasons other than their consequences. Some actions in this view are obligatory regardless of their consequences. The classical origins of this theory are diverse and include religious traditions that act according to divine command, such as the ten commandments.

In contrast, Immanuel Kant, who believes these actions should be based on reason not religion, describes this as the 'categorical imperative' that is absolutely binding and prescribes how to act. Kant also emphasises the dignity and worth of the individual and believes we must not treat people as means to our own ends. We must do unto others as we would have done to ourselves.

In addition to these ethical theories, moral principles also play and important part in guiding moral behaviour. These principles include autonomy, non-maleficence, beneficence, and justice. They are complex and have enjoyed considerable discussion in the literature. Autonomy relates to a persons ability to make a self determining choice and to be self governing. Non-maleficence would condemn any act which unjustly injures a person or causes them to suffer an otherwise avoidable harm. According to this principle one ought not to inflict harm. Beneficence requires a positive step, one must provide benefits, and balance benefits and harms. By this principle an act that does not bestow benefits on people or which fails to address an imbalance of harms over benefits, should rightly be condemned. Finally, justice is often describes as fairness. It is concerned with the equal distribution of benefits and harms.

These theories and principles have been at the centre of bioethical debate for some considerable time. They have formed the basis for many decisions that have been made in health care. However, a review of the literature, and discussion with nurses reveals that nurses have had little to say in this arena. This seems to be at odds with the fact that nurses make up the largest number of professionals in the health care system and they are the ones often working with the patient, and their family, on a 24 hour a day basis. As Parker (1990:34)

writes nurses are having trouble because the 'conventional scripts of bioethics' don't fit for nurses. "When the story line of traditional moral theories fails to inform our experiences as nurses, we question our moral competence. This uncertainty further reinforces our passive subservient role." This causes nurses to take their stories underground. As a result "nurses are struggling to learn a new vocabulary, a different moral language that is reflected in our stories of moral conflict...and with each story a nurse tells, the language becomes clearer" (p39).

Uncovering the Ethic of Care

Nurses are on a journey attempting to describe the 'essence' or 'core' of their practice. In this process is also the challenge of redefining the morality which is associated with this ethic of care. In an attempt to uncover this ethic of care, nurses are telling their stories and embedded in these stories are the clues to this ethic.

The following story adds to the threads which will eventually make up this tapestry of the ethic of care.

Nurses are called upon to care for individuals and their families in many unique situations. In this case an elderly woman, who we shall name Grace, is being cared for in an institutional setting. She has a severe muscular condition which causes her tremendous pain and weakness. The most effective way to relieve this pain is to soak in a hot bath. She is a proud and modest woman and while she is happy to accept help into and out of the bath, she is unwilling to allow anybody to be present while she is in the bath. This was accepted by the nurses, until on a couple of occasions she was discovered almost submerged in the bath, and due to the weakness of her muscles she was unable to do anything to prevent herself slipping under the water. When this was discussed with her she acknowledged the potential danger in this situation. She said she was prepared to sign a statement with her lawyer and the patient advocate as witnesses, in order to absolve the nursing and medical staff of any responsibility. The nursing staff do not feel comfortable with this and have sought advice on how to act in this situation (Personal Communication, 1992).

The Principle of Autonomy

Beauchamp and Walters (cited Johnstone, 1989:77) write "Insofar as an autonomous agent's actions do not infringe on the autonomous actions of others, that person should be free to perform whatever action he or she wishes (presumably even if it involves considerable risk to himself or herself and even if others consider the action to be foolish)." This means that as long as peoples' actions do not threaten the rights or moral interests of others then they should be free to choose and act accordingly.

If we relate this principle then to the case study above, it would appear that Grace was well able to act autonomously in choosing to bath alone with the potential threat of drowning. On the surface it would appear that she would also satisfy Beauchamp and Walters's criteria by not infringing on the autonomous actions of others in choosing to accept this risk. Even if we regard what Grace is choosing to do as foolish, we must still respect her as a dignified and rational human being capable of making her own decisions about what is in her best interests. In appealing to the principle of autonomy therefore it would appear that Grace is in a position to bath alone fully aware of the consequences.

One could also argue that this situation should not be allowed to eventuate by appealing to the principle of non-maleficence - above all do no harm. Beauchamp and Childress (1989) argue that it is impor-

tant to distinguish between non-maleficence and beneficence - above all do good. They contend that the duty not to injure others is both distinct from and more stringent than the duty required by the principle of beneficence to take positive steps to benefit someone. This considered it would appear from a nursing perspective an issue for debate as to whether this situation would constitute harm. Obviously on the surface when a patient drowns in the bath this would definitely constitute harm. However when the patient has autonomously consented to this is it still considered to be harm? I would suggest not. In this instance the principle of autonomy would override that of non-maleficence.

My intuition makes me feel this is a cold hard way of viewing this situation and this decision being made by this vulnerable woman. To reduce this immense decision to one of mere principles is reductionist and doesn't fit with nursing's philosophy of humanism. Benner and Wrubel (1989) suggest that there is an emerging belief that autonomy is not the pinnacle of achievement in adult development as has been assumed for so long. As in this case, when it is viewed as the individual being insular and unrelated to others it is a damaging cultural myth to see autonomy as the hallmark of maturity and health. Rather, caring and interdependence are our ultimate goals.

It was suggested to me when discussing this scenario with a colleague that this dilemma could be compared to the act of administering long term narcotic pain relief, as in palliative care, knowing that eventually the narcotic would cause respiratory arrest and the patient would die. From a consequentialist perspective these scenarios are alike. Both result in the death of a patient, deaths that were knowingly consented to. However from a nursing perspective I believe they are quite dissimilar. When a patient drowns in a bath, even if they have autonomously consented to this potential outcome, it is the nurse who must return to the bathroom to find the patient dead/drowned in the bath, and then retrieve that person from the bath, knowing that nurses consented to place the patient in this situation in the first place.

When a nurse administers narcotic pain relief and the patient quietly slips away, and dies, often nurses or family members are present and it is a peaceful and dignified death. No less sad for staff or family but nonetheless different.

The consequentialist perspective ignores the importance of process. For nurses and nursing, although the outcome is of vital importance the process bears as much importance. Ramos (1992) believes that questions arise when process and outcome variables seem to be artificially separated. If death is to be the result then how the person dies matters to nurses. If a terminally ill patient requires such large doses of narcotics to maintain adequate pain relief, and this causes them to respiratory arrest and they die, this from a nursing perspective could be accepted. It is peaceful, dignified, and respectful for those left behind. Whereas a nurse who must return to the bathroom to discover her patient drowned in the bath would need considerable support in this situation. The process has much to bear on the nurse's ability to accept a person' s death, not merely the outcome. There is little to be found in the literature to support this idea. Drawing on my own practice and experience I believe it has to do with it being a deeper professional relationship, that develops between a nurse and a patient and their family, than is commonly acknowledged. Nurses share their lives with patients and their families and in turn they share theirs with the nurse. As a result the dynamics of the

relationship become quite unique in the health care setting. This is supported by Ramos who writes that some authors assert that the bond between nurse and patient is unique among professional liaisons, yet there is little empirical evidence to support that assumption. This is obviously an area in nursing that needs exploring, and I will discuss this in more depth shortly.

Traditional theories and principles emphasize detachment, impersonality objectivity and individual autonomy at the expense of attachment, particularity, emotion, and intersubjectivity. The later can be described as part of the context. Benner and Wrubel (1989) say the context describes all the ways the person is connected in the world. The person brings with them to each present moment all the relevant understandings of their past. In other words each situation is informed by meaning. Background meaning is also part of the context. This includes being raised in a particular culture, subculture, and family at a particular time. This shapes how the person understands the world. Concern is another way one is connected to the context. Concern is the involvement people have when things matter to them. It is not just an understanding that allows the person to define the situation in a certain way, the situation itself defines the person because of the way concern involves the person in it. Because of these meanings people inhabit their worlds in an involved rather than in a subject/object way. Benner and Wrubel write that people are constituted by their worlds and solicited by them. This point is often missed. To be the nurse who places a patient in a bath knowing they may return to discover them drowned is an horrific thought. When nurses are spending 24 hours of their day caring for patients on such an intimate front line basis, it becomes impossible for them to divorce themselves from the concern they have for the person, and the context of the situation. The nurse is an inextricable part of this situation.

Reciprocity

Further mention must be made of the relationship that exists between the nurse and the patient. It has been suggested that for nurses the covenantal model is the most appropriate on which to base their relationship with their patients (Cooper, 1988). Inherent in the relationship based on the covenant model, which is ideally characterized by mutuality, reciprocity, and caring, is the concept of fidelity. Covenantal relationships are to be mutually beneficial. Patients' needs, which include physical as well as spiritual and emotional needs, are determined as they arise rather than being prescribed when the relationship is established, as in the contractual model. Less obvious and more limited than patients needs, nurses needs are acknowledged as basic human needs that are grounded in the indebtedness to the patient and a recognition of the shared human condition. This acknowledgement of the reciprocity of need dictates mutual obligation. May (cited Cooper, 1988:52) writes, "A reciprocity of giving and receiving nourishes the professional relationship. The professional does not function as benefactor alone but also as beneficiary."

This idea of reciprocity to nourish the relationship must inherently imply mutual responsibility. A responsibility to respect the effect that one's actions may have on another. In this case, Grace would be required to respect the impact her drowning in the bath would have on her nurse and take that into consideration when making her decision. There is an expectation in the covenantal model that the feelings of both patient and nurse will be respected. By accepting autonomy as the overriding principle that would allow drowning to occur, no account is being taken of the nature of

the nurse patient relationship as described in this covenant model.

Gadow (1988) describes a covenant of care that helps us reconcile this problem. She believes that for nurses, the covenant of care is the commitment to alleviating another's vulnerability. She writes that only in the context of care can the overpowering of one person by another that cure entails be redeemed, and thus relieve the persons vulnerability. In Gadow's framework, care is the ethical principle or standard by which interventions are measured. Interventions as extreme as cure that succeed through power alone are the most difficult to justify by the moral standard of care. She identifies that for health professionals there is a dilemma created by the idea of 'holding on' and 'letting go,' but that these concepts only make sense within an ethic devoted to cure. "In that model we face often agonizing ethical choices predicated on the difference between continuing the struggle for recovery and giving in to death" (p14).

In the ethical model Gadow (1988) describes, based upon the covenant of care, the crucial distinction is not that between health and death, but that of alleviating and intensifying vulnerability. The central moral choice that emerges is not whether to hold on to or let go of life, but whether to hold onto or let go of the special covenantal relationship of caring. Giving up on cure and giving in to death need not mean letting go of that relationship. This casts a new light on the dilemma of Grace being allowed to bath alone.

Gadow contends that both the nurse and the patient must acknowledge their vulnerability. It is this vulnerability that creates a chasm between the nurse and the patient. Crossing this chasm is the only means of relieving this vulnerability. The nurses caring for Grace have expressed their discomfort about her being allowed to drown in the bath. We may well ask if this is because of the nurses' inability to acknowledge their own vulnerability in this situation, and thus, are unable to reach out and hold Grace in her vulnerability? "The greatest ethical task of the nurse is reconciling those two extremes, maintaining a relationship in which the chasm is never uncrossable, where no assault is permitted unless it can be redeemed, not by its future effect but by the immediate, present caring of the nurse who, because she has not let go of her own vulnerability, is able to reach across and hold on to patients in their vulnerability" (Gadow, 1988:14). Using this framework therefore, the nurses caring for Grace need to acknowledge theirs and Grace's vulnerability, and reach across the chasm and accept Graces decision as part of respecting her autonomy and holding on to the covenantal relationship of caring. "Without question, such a synthesis is the highest moral accomplishment and the most arduous task we face in nursing" (Gadow, 1988:14). Bridging the chasm removes none of the moral ambiguity of Grace's death, but Gadow would suggest it relieves the urgency for erecting moral frameworks in which to justify death.

Where to from here?

Much has been written about the appropriateness of traditional bioethical principles for nursing. This is not an attempt to dismiss the traditional view, but to add to the process of discovering an alternative approach which feels more comfortable for nurses and which in turn compliments existing models. As part of this process nurses must believe in themselves, as moral beings, the value of their practice, their stories, and their perspective on moral issues and their ability to articulate this. Increasingly narrative and metaphor are being identified as ways for nurses to capture the essence of their practice, and I believe their differing perspective on moral

issues. This is something that warrants further exploration. Caring is a moral ideal. Its end is protection, enhancement, and preservation of human dignity (Watson, 1988), and involves a commitment to alleviate another's vulnerability (Gadow, 1988). This begins to capture the emerging ethic of care. Nurses must be able to articulate their position on moral issues, and it seems that nurses will be most able to do this if situations are considered in a context of care.

REFERENCES

Beauchamp, T. L. & Childress, J. F. (1989). Principles of biomedical ethics (3rd Ed.). New York: Oxford University Press.

Benner, P. & Wrubel, J. (1989). The primacy of caring. California: Addison-Wesley.

Cartwright, S.R. (1988). The Report of the cervical inquiry. Government Printing Office: Auckland.

Cooper, M. C. (1988). Covenantal relationships: Grounding for the nursing ethic. Advances in Nursing Science, 10(4), 48-59.

Dillon, R.S. (1992). Care and respect. In E.B. Cole, & S. Coultrap-McQuin, (Eds.). Explorations in feminist ethics- Theory and practice. Indianapolis: Indiana University Press

French, D. G. (1984). Ethics: Nurse, am I going to live? Nursing Management, 15(11), 43-46.

Fry, S.T. (1988). The ethic of caring: can it survive in nursing? Nursing Outlook, 36(1), 48.

Gadow, S. (1988). Covenant without cure: Letting go and holding on in chronic illness. In J. Watson, & M.A. Ray, (Eds.). The ethics of care and the ethics of cure: Synthesis in chronicity. New York: National League for Nursing.

Johnstone, M.J. (1989). Bioethics: A nursing perspective. Sydney: Harcourt Brace Jovanovich.

Morse, J.M., Solberg, S.M., Neander, W.L., Bottorff, J.L. & Johnson, J.L. (1990). Concepts of caring and caring as a concept. Advances in Nursing Science, 13(1), 1-14.

Parker, R. S. (1990). Nurses' stories: The search for a relational ethic of care. Advances in Nursing Science, 13(1), 31-40.

Professional Services Committee, New Zealand Nurses Association. (1988). Code of ethics. Universal Print: Wellington.

Ramos, M. C. (1992). The nurse patient relationship: Theme and variations. Journal of Advanced Nursing, 17, 496-506.

Rawnsley, M. (1990). Of human bonding: The context of nursing as caring. Advances in Nursing Science, 13(1), 41-48.

Reverby, S. (1987). A caring dilemma: Womanhood and nursing in historical perspective. Nursing Research, 36(1), 5-11.

Sheehan, J. (1985). Ethical considerations in nursing practice. Journal of Advanced Nursing, 10, 331-336.

Walker, M.U. (1992). Moral understandings: Alternative "epistemology" for a feminist ethics. In E.B. Cole, & S. Coultrap-McQuin, (Eds.). Explorations in feminist ethics - theory and practice. Indianapolis: Indiana University Press.

Watson, J. (1985). Nursing: The philosophy and science of caring. Colorado: Colorado Associated Press.

Watson, J. (1988). Nursing: Human science and human care. A theory of nursing. New York: National League for Nursing.