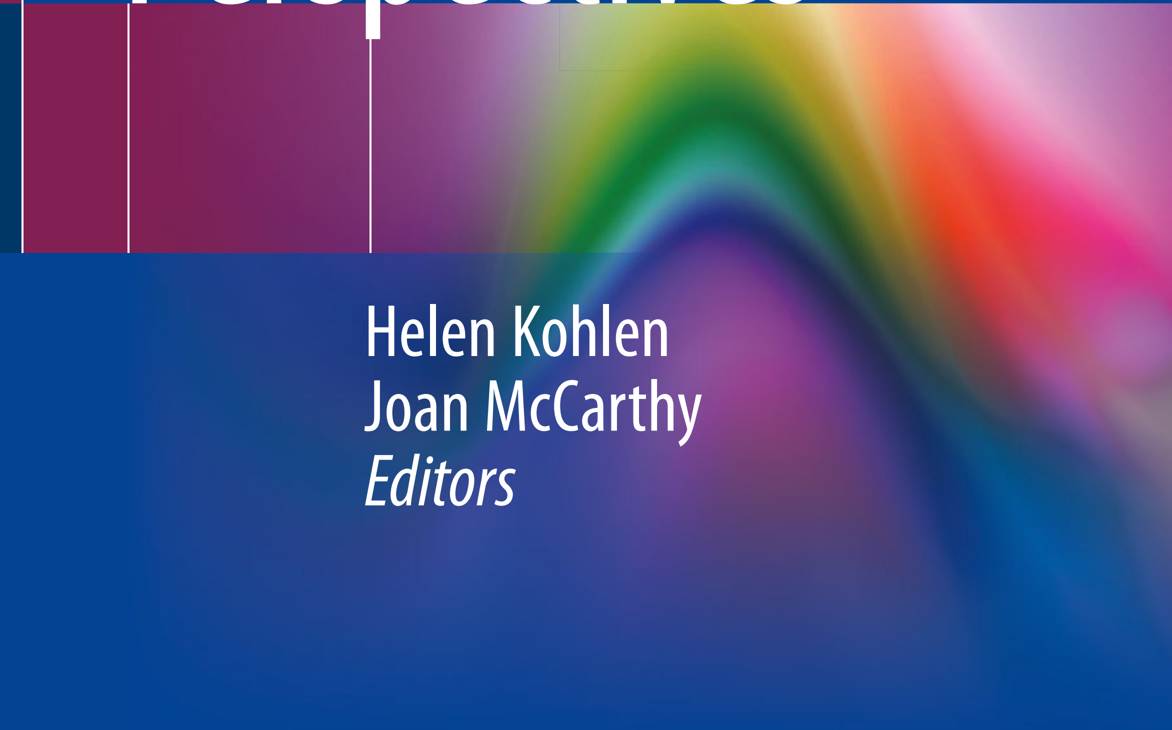
# Nursing Ethics: Feminist Perspectives



Helen Kohlen
Joan McCarthy
*Editors*

Springer

# Nursing Ethics: Feminist Perspectives

Helen Kohlen • Joan McCarthy
Editors

# Nursing Ethics: Feminist Perspectives

Springer

*Editors*
Helen Kohlen
Department of Nursing Science
Philosophical-Theological University
of Vallendar
Vallendar
Rheinland-Pfalz
Germany

Joan McCarthy
School of Nursing and Midwifery
University College Cork
Cork
Ireland

ISBN 978-3-030-49103-1 ISBN 978-3-030-49104-8 (eBook)
https://doi.org/10.1007/978-3-030-49104-8

© Springer Nature Switzerland AG 2020
This work is subject to copyright. All rights are reserved by the Publisher, whether the whole or part of the material is concerned, specifically the rights of translation, reprinting, reuse of illustrations, recitation, broadcasting, reproduction on microfilms or in any other physical way, and transmission or information storage and retrieval, electronic adaptation, computer software, or by similar or dissimilar methodology now known or hereafter developed.
The use of general descriptive names, registered names, trademarks, service marks, etc. in this publication does not imply, even in the absence of a specific statement, that such names are exempt from the relevant protective laws and regulations and therefore free for general use.
The publisher, the authors, and the editors are safe to assume that the advice and information in this book are believed to be true and accurate at the date of publication. Neither the publisher nor the authors or the editors give a warranty, expressed or implied, with respect to the material contained herein or for any errors or omissions that may have been made. The publisher remains neutral with regard to jurisdictional claims in published maps and institutional affiliations.

This Springer imprint is published by the registered company Springer Nature Switzerland AG
The registered company address is: Gewerbestrasse 11, 6330 Cham, Switzerland

*Living a feminist life does not mean adopting a set of ideals or norms of conduct although it might mean asking ethical questions about how to live better in an unjust and unequal world … how to create relationships with others that are more equal; how to find ways to support those who are not supported or are less supported by social systems; how to keep coming up against histories that have become concrete, histories that have become as solid as walls (Sarah Ahmed, Living a Feminist Life, 2017, p. 1).*

# Foreword

I have had the pleasure of knowing Joan McCarthy and Helen Kohlen for many years. Both Joan and Helen serve as Editorial Board members of the journal *Nursing Ethics*. At our Board meetings, we take stock of journal trends and note the progress of the journal year on year. A regular topic of discussion is the dominance of empirical research submissions to the journal and the paucity of groundbreaking philosophical scholarship in nursing ethics.

I was then excited to learn of plans for a book on the theme of feminist perspectives, edited by Joan and Helen.

It is a privilege to write the foreword to this book and to have had the pleasure of reading the manuscript before it moved to production. It became clear that this is a book which is timely, important, and innovative. It is a book that fills a gap for innovative and radical scholarship in nursing ethics.

The book is timely as it is published during the COVID-19 pandemic when usually invisible care practices have been made visible and, temporarily at least, recognised as being of value. It is timely also in that it is published during the 200th anniversary year of the birth of Florence Nightingale, an anniversary which is stimulating a renewed interest in nursing history and values. The World Health Organization (WHO) nominated 2020 as ‘International Year of the Nurse and Midwife’ and responded to some of the international challenges for nursing in a seminal report by WHO, in partnership with the International Council of Nurses and the global Nursing Now campaign. The *State of the World’s Nursing Report 2020* points out that the global nursing workforce is 27.9 million with 19.3 million identified as ‘professional nurses’.

The WHO report confirms that ‘nursing remains a highly gendered profession with associated biases in the workplace’. Whilst some 90% of nurses are female, few are in leadership positions and there is evidence of gender-based discrimination in pay and in the work environment. The report also points out that there is a global shortage of some 6 million nurses and that one in every eight nurses works in a country other than their home country. The ten key actions identified in the *State of the World’s Nursing Report 2020* include deliberate planning ‘for gender-sensitive nursing workforce policies’ which ensures ‘equitable and gender-neutral’ remuneration, ‘enabling work environments for women’ and ‘gender transformative leadership development for women in the nursing workforce’. Another key action, pertinent to this book, relates to the effective monitoring and responsible and ethical management of nurse mobility and migration. For too long, more affluent countries have recruited nurses from areas which need their expertise and experience (see file://homes.surrey.ac.uk/home/downloads/9789240003279-eng%20(3).pdf).

This book is important in speaking to these critical issues and, it is hoped impactful, in bringing to readers' attention insights from 14 expert feminist and ethics scholars from 6 countries (Ireland, Germany, USA, Canada, New Zealand, and England). Their contributions inform of the breadth and depth of feminist theory and illuminate its potential to challenge conventional approaches to ethical practice, thus promoting improvements in the way we think, value, and practice. The book is also important in highlighting the complexity of care practices and necessary engagement with history, culture, politics, economics, gender relations, and ethics. The book is, overall, a treasure trove of scholarship from some of our finest feminist and ethics theorists and researchers.

The book is innovative in that it brings together—and makes accessible—an engaging range of feminist perspectives. Many of the perspectives being brought to bear are new and are persuasive in urging a critical rethinking of conventional approaches to nursing ethics. A rethinking that goes beyond gender to consider also race, class, religion, and culture. A rethinking that embraces intersectional, intercultural, interrelational, and interconnected lenses on nursing and midwifery care practices. The book chapters stimulate reflection on the relationships amongst past, present, and future scholarship; between philosophical and practical approaches to nursing ethics; between 'real ethical problems' and those considered 'petit ethical problems'; and amongst personal, professional, policy, and political dimensions of care practices.

What is also innovative is the inclusion of many diverse ethical concepts, drawn from feminist perspectives, which illuminate the complexity and contextual and cultural richness of care practices. These concepts include, for example, moral habitability, care respect, bearing witness, presence, we-identity, moral space, and conscientious commitment. The book also urges action, for example, in relation to the tragic Canadian example of Brian Sinclair who was 'ignored to death' (Chap. 4); the author asks if there might have been a different outcome 'if even one nurse had advocated on his behalf'.

The book delivers on its promises to, first, explore historical and philosophical perspectives, drawing on feminist thought. Introductory chapters on the history, evolution, and interaction between feminist perspectives and nursing ethics set the scene. These chapters challenge readers to critically consider different ways of engaging with the role and nature of nursing ethics and to expand their horizons from the local to the global and from the personal and professional to the philosophical and political. The inclusion of feminist and ethical perspectives applied to experiences of indigenous and marginalised peoples enables readers to go beyond usual parochial concerns. Secondly, the book delivers on its promise to apply a feminist lens to some of the most pressing ethical issues encountered by nurses and midwives: issues such as technology in home care, organisational culture and leadership, clinical ethics support, research, and providing care during a pandemic.

This book is a call to action, a book to stimulate much-needed reflection and to challenge complacency. It is a book which enables us to consider anew our global care obligations and to enact what Shelagh Rogers refers to as 'a collective responsibility to make things better. To act. Because if we do nothing, nothing will change.'

Ann Gallagher
International Care Ethics Observatory
University of Surrey
Guildford, UK

# Acknowledgements

First of all, we thank the authors who have generously contributed to this book with enthusiasm, integrity, and patience—it has been our honour and delight to work with you.

Joan thanks her colleagues in the School of Nursing and Midwifery, University College Cork (UCC), who have always been ready to humorously and patiently put up with the fact that, even though she is not a nurse herself, she is never short of some pronouncement or other on what nurses should or should not, could or could not, do! Truth to tell, what motivates and inspires Joan is the work ethos, valour, and patient-centred commitment of her university colleagues, clinical colleagues, and students. She is also indebted to other UCC colleagues and friends who have stretched her feminist bow beyond the healthcare realm: Dolores Dooley, Department of Philosophy (now retired but always philosophising); Órla O'Donovan, Department of Applied Social Studies; Róisín O'Gorman, Department of Theatre; Mary Donnelly, Faculty of Law; and Claire Murray, Faculty of Law. Her medical ethics colleague, Louise Campbell, in the School of Medicine, National University of Ireland Galway, is also deserving of sincere thanks for her ever-vigilant and astute philosophical and feminist oversight, as is her colleague, Katherine O'Donnell, Department of Philosophy, University College Dublin, who keeps Joan's feminist ruminations current and modest. In the summer of 2015, Helen was invited to the University for Humanistic Studies in Utrecht (UvH) as a visiting professor to teach feminist ethics and its application in the clinical setting. The discussions with students and colleagues were very motivating to broaden and deepen her knowledge in feminist care ethics. Helen particularly thanks her colleagues from the UvH, Inge van Nistelrooy, Merel Visse, Carlo Leget, Alistair Niemeijer, Frans Vosman, and Vivianne Baur, who continuously support her in developing her expertise. Helen also thanks her doctoral students at the University of Vallendar for their interest in raising feminist questions and reading feminist work beyond the curriculum.

In April 2019, thanks to Brocher Foundation in Switzerland, we were able to spend a full month writing and editing on the shores of Lake Geneva. We thank our international 'April Hermits' group (Zoe Dubus [France], Michal Lavidor [Israel], Sara Mattheisen [USA], Bernike Pasveer [Netherlands], Diane B. Paul [USA], Oddgeir Synnes [Norway], Gerrit Jan van der Wilt [Netherlands]), who shared the time with us in Brocher and with whom we had inspirational talks about the book. In November 2019 we went to New York to interview Joan Tronto and there we benefitted from her wise and witty insights about nursing ethics, care ethics, and our plans for the book.

Finally, we would like to extend our thanks to Springer Nature for taking a chance on our idea. When we both got an invitation from Springer Nature to work on a book on nursing, the publisher had some initial doubts about the necessity of a book on feminist ethics. An extended book proposal and evaluations by respected international scholars were convincing and we were eventually given the go-ahead to undertake this feminist project.

We would especially like to thank Barbara Zöhrer who was convinced about our idea from the beginning and supported us in every way possible. We would also like to thank Nathalie Lhorset-Poulain who took over the editorship when Barbara went on maternity leave and has guided us to this point. Finally, we thank Smitha Diveshan and Vinodhini Subramaniam who patiently accompanied us on every step of the development of the book.

Of course, no woman is an island. Alice and June, Helen's daughters, supported the work of the book as they are convinced about any endeavour necessary to move on with the goals of feminism. We also deeply appreciate all the Sundays, holidays, and other days, when our partners (Helen's Tom and Joan's Elixxchel) talked through our editorial conundrums with us, kept the home fires burning and the dinner in the oven while we Skyped or typed or crafted this book into being.

Cork, Ireland Joan McCarthy
Bremen, Germany Helen Kohlen

# Introduction

Over the course of our personal and professional lives, we have been deeply engaged with feminist thinking and its emancipatory implications for human life, health, and well-being. We first met in 2007 at the 10th Nursing and Philosophy Conference in Dublin when Joan presented her co-authored book, Nursing Ethics: Irish Cases and Concerns (with Dolores Dooley, Gill and Macmillan, Dublin, 2005/2012). Over the years, shared participation in nursing ethics conferences and collaboration on an international research project confirmed that our interests and politics were closely aligned and that our work together was as much fun as it was productive.

Helen began thinking about feminism and feminist ethics during her studies in literature when she read Toni Morrison, Charlotte Perkins Gilman, and Susan Sontag. She had enthusiastically read La Deuxième Sexe by Simone de Beauvoir when she was 14, but did not know anything about feminism at that time. Similarly, Joan was astonished and relieved to read Simone de Beauvoir, Iris Marion Young, and Sarah Hoagland in her undergraduate and graduate studies. Tools that were not the master's tools (thanks Audre Lorde) became available to them to make sense of their lives and their place in the world.

Helen's time training as a nurse was marked by everyday ethical concerns and questions of gender inequality. She kept a diary with narrative accounts of ethical issues that stimulated her later to investigate the political-ethical dimensions in clinical ethics. During her time as a visiting researcher at the Center for Bioethics, University of Minneapolis, in the USA, Helen was introduced to feminist philosophy and its relevance for nursing by Joan Liaschenko. Meanwhile, Joan's PhD supervisor, Dr. Dolores Dooley, University College Cork (UCC), introduced her to nursing ethics and to the nursing ethics curriculum that she was developing for public health nurses who were undertaking the first programme of nursing studies to be rolled out by the university. She also introduced Joan to the seminal feminist text on medical ethics, Feminist Perspectives in Medical Ethics, edited by Helen B. Holmes and Laura Martha Purdy (Bloomington and Indianapolis; Indiana Press. 1992). In the intervening years, Joan Liaschenko and, later, her co-author and friend, Elisabeth Peter, from the University of Toronto, have consistently brought a feminist voice to nursing ethics scholarship—their contribution to advancing the political breadth and depth of the field continues to inspire us both. We are very thankful that they supported our book from the very first step and immediately agreed to contribute their work.

## Nursing Ethics and Feminist Perspectives

Nursing ethics is a field of scholarship that pays attention to the ethical dimensions of the professional work and practices of nurses and midwives (Midwifery is a profession that has its own distinct history, practices, and goals. Nevertheless, there are some significant overlaps between the practices of nurses and midwives – especially as they pertain to the gendered nature of these practices. As such, we suggest that much of the content of this book is also relevant to midwifery professionals and chapters 2 and 10 explicitly address midwifery concerns). To do this, nursing ethics draws on traditional ethical theories such as deontology and utilitarianism, and, in the last four decades, principlism, which have provided diverse conceptual and methodological resources for policy makers, healthcare organisations, regulatory bodies, and health professionals, including nurses, who are faced with ethical challenges in the provision of healthcare. Historically, these theories have dominated the ethical landscape navigated by health professionals in general. However, while nursing ethics scholarship applies many of the tools of these traditional ethical approaches, it is also deeply engaged with the unique history, goals, and practices of nursing which have evolved around a distinctive way of engaging with patients and with health. Many scholars working in nursing ethics pay attention to the specific quality of the everyday relationship the nurse has with patients. Human relationships, and the ethical bonds and responsibilities to which they give rise, have been seen to be at the heart of the moral realm of nursing practice. In the 1990s, US-based Anne Bishop and John R. Scudder stated, ‘if the moral sense is inherent in nursing, then moral problems appear in everyday practice and are resolvable from within practice’ (Bishop and Scudder 1990, p. 113). Patricia Benner’s seminal work also pays close attention to the quality and range of caring practices required of the nurse in order to expertly engage in a more holistic way with patients (Benner 1984). From Canada, Janet Storch describes nursing ethics as being centrally about ‘being in relationship to persons in care’ (Storch 2004, p. 7). She highlights the everyday ethical dimension of nursing practices: ‘Almost every nursing action and situation involves ethics. To raise questions about ethics is to ask about the good in our practice’ (Storch 2004, p. 7).

In addition, the scholarship of nursing ethics has also viewed the practice of nursing as an act of service to the wider community and has involved deliberation on the responsibilities of nurses in relation to the welfare of society as a whole. Attention was given to this theme in the very first documented textbook on nursing ethics by Isabel Robb, *Nursing Ethics: For Hospital and Private Use,* published in 1900, and the first journal of nursing, *The Trained Nurse,* that included articles on nursing ethics starting in 1888 (Fowler 1984). Ongoing international scholarship on issues of equality, equity, and justice, as well as the inclusion of a commitment to social justice in many contemporary nursing codes, also suggests that the idea of service, human rights, and social inclusion continues to be a key concern of nursing ethics (The ICN 2012; Canadian Nursing Code of Ethics 2017). For example, the Faculty of Nursing at the University of Alberta has established a Health Equity Research Group that aims to build and support research capacity and scholarship related to global health, social justice, and social policies, which specifically considers the ways in which these broad topics intersect with issues of equity, diversity, and inclusion.

The history of the nursing profession and of nursing ethics as a discipline is also, inescapably, a history of women. That nursing has been, and continues to be, a predominantly female profession—over 90% of the global nursing workforce is female (World Health Organisation 2020)—is not a matter of chance or 'nature'; it is because the work of caring has long been designated the work of women. It would seem necessary then that any enquiry about the ethical nature and scope of nursing practices should address the ways in which gender might impact our understanding of these—hence the need for a feminist perspective on nursing ethics.

The diversity of theoretical starting points when tackling the subject of ethics makes it difficult to identify a single 'feminist perspective' in ethics. Some of these starting points include traditional ethical theories as well as more contemporary approaches. What feminist perspectives on ethics share is that they critique these ethical frameworks from a feminist perspective. Feminist approaches to ethics, in general, consider the impact of gender roles and gendered understandings on the moral lives of individual human beings. In addition, they draw attention to the power and power differentials inherent in moral relationships at individual, societal, and organisational levels. These emphases are applicable to women and men wherever power differentials and gender bias are evident. As Margaret Little points out, feminist perspectives concern the way in which gender impacts the ways women and men live in the world, but also the ways in which they think about the world, what they value, and what they attend to:

> At its most general, feminist theory can be thought of as an attempt to uncover the ways in which conceptions of gender distort people's view of the world and to articulate the ways in which these distortions, which are hurtful to all, are particularly constraining to women. These efforts involve theory—and not merely benign protestations of women's value or equality—According to feminist theory, that is, distorted and harmful conceptions of gender have come to affect the very ways in which we frame our vision of the world, affecting what we notice, what we value, and how we conceptualize what does come to attention (Little 1996, pp. 1–2).

Feminist perspectives are also not just concerned with the marginalisation and disempowerment of women in sexist societies; they are often sensitive to the way in which oppressive structures and power imbalances are experienced among different social groupings based on age, race, class, sexual orientation, and identity. Applied to healthcare, these feminist approaches to ethics have widened the scope of healthcare ethics to include consideration of the social, economic, cultural, and political dimensions of moral decision-making in healthcare settings. Susan Sherwin makes this point in the following way:

> [M]edical and other health care practices should be reviewed not just with regard to their effects on the patients who are directly involved but also with respect to the patterns of discrimination, exploitation, and dominance that surround them (Sherwin 1992, p. 4–5).

While, historically, feminism and nursing, more generally, have had a somewhat tense and troubled relationship (Chinn and Wheeler 1985; Susan 1987a, b; Baer 1991; Gelfand Malka 2007), some pioneering work by a number of nurse ethicists forged a common ground between nursing ethics and feminist ethics scholarship (Fry 1989; Liaschenko 1993; Bowden 2000; Rodney et al. 2004; Storch 2004; Peter and Liaschenko 2003). We hope that bringing a range of feminist perspectives to nursing ethics in this volume will add to this important trajectory. We believe that the issues raised by feminists in the humanities more than three decades ago are more relevant than ever in the twenty-first century. This makes exploring the horizon and meaning of feminist lines of thinking for the nursing profession worthwhile.

Moreover, it is important to recognise that nursing ethics, as with all areas of inquiry, has not occurred in a vacuum. History, culture, gender relations, political and economic forces, healthcare policies, and organisational hierarchies all contribute to the often vastly different roles and responsibilities that nurses assume locally and globally. This means that we need to be sensitive to the possibility that nursing practices themselves may reflect disempowering structural relations that could render aspects of the good inherent in these practices ethically problematic.

## The Organisation of This Book

This book is divided into two parts. Part I examines historical and philosophical perspectives on the impact of feminist thought on the field of nursing ethics scholarship. A short interlude—an interview with political theorist, Joan Tronto—provides a theoretical/practical hinge between Parts I and II. Part II applies a feminist lens to some of the ethical issues that arise in nursing and midwifery managerial and administrative roles, clinical practice, and research.

In Part I, Marsha Fowler focuses on the history of nursing ethics scholarship and the impact of feminist ethical and political perspectives on its evolution in 'The Influence of the Social Location of Nurses-as-Women on the Early Development of Nursing Ethics'. She traces the birth of nursing ethics to the work of early nursing leaders largely based in the USA at the end of the nineteenth century. Her analysis and appraisal of their work suggest that they were acutely aware of women's social location and disenfranchisement and that their cognisance of this shaped their perspective on the professional roles, responsibilities, and ethical norms of nurses as women working under medical hegemony. Highlighting the creation, in 2019, of the Nursing Ethics Collection at the University of Surrey, which makes the early works of nursing leaders accessible to contemporary scholars of nursing ethics, Fowler draws attention to the feminist concerns of the early pioneers of nursing ethics scholarship. These included issues of authority over their personal lives as well as practice and education; suffrage and civic participation; and rigid gender roles and expectations.

'An Evolution of Feminist Thought in Nursing Ethics,' by Elizabeth Peter and Joan Liaschenko, reminds us that the feminist concerns articulated by nurse ethicists in the nineteenth century continue on into the twenty-first century. They begin their chapter by outlining the engagement of nurse ethicists in the 1980s and 1990s, firstly, with the ethic of care and its focus on human caring and relationship and, secondly, with feminist scholars who paid attention to the operations of power and structures of oppression. They draw attention to the transformative potential of feminist perspectives to situate nursing care practices in relation to race, class, gender, and so on and to understand the oppressive and the emancipatory potential of power. Central too, for Peter and Liaschenko, is the feminist location of the experience of illness within a network of relationships and in particular socio-political contexts. They pay particular attention to the influence of feminist thought on midwifery and nursing ethics which has made central the importance of women's autonomy and relationships during birth. They go on to explain and discuss the significance for nursing ethics of a range of feminist concepts such as care, respect, moral responsibility, cultural safety, and moral habitability.

'Piecing Together a Puzzle: Feminist Materialist Philosophy and Nursing Ethics,' by Janice L. Thompson, challenges nursing ethics scholars to think critically about the political-economic structures—specifically transnational corporate capitalism—that impact our understanding of gender, care, nursing practice, and nursing ethics. First, Thompson takes time to outline and explain some of the key themes of Nancy Fraser's pragmatic materialist feminist philosophy highlighting, in particular, her nuanced account of social justice and she demonstrates its relevance to understanding the challenges experienced among personal care workers during the COVID-19 pandemic. In the second section, Thompson provocatively proposes that ignoring, obscuring, or not addressing the context of capitalism is unhelpful for nursing and nursing ethics and that a pragmatic materialist feminist approach provides a means of transforming the root causes of oppression in capitalism, including its exploitation of care activities. The chapter concludes with an in-depth critical analysis of the development of an ethics of care, a feminist ethics of care, and an ethics of social justice in nursing and outlines the emancipatory potential of Fraser's feminist materialist philosophy as a theoretical tool that will strengthen the reach and relevance of nursing ethics.

In 'Bearing Witness and Testimony in Nursing: An Ethical-Political Practice,' Christine Ceci, Mikelle Djkowich, and Olga Petrovskaya explore the concept of bearing witness and testimony in nursing practice. They contrast the description of bearing witness in the nursing literature with the understanding of testimony in the feminist literature. With regard to nursing they first focus on the work of William Cody who suggests that bearing witness results in the limited moral obligation of 'true presence'. Then they turn to the feminist philosopher, Lorraine Code, who suggests that an ability to receive testimony, or bear witness, requires analysis of the ways that social structures and identities influence understanding. Ceci *et al.* share Code's view and understand bearing witness and testimony as a politicised practice in the sense that knowing is always a political activity. The authors discuss these ideas in relation to a Canadian exemplar of witnessing: The work of the Truth and Reconciliation Commission of Canada to understand and address the historical injustices done to indigenous peoples in Canada. Beyond nursing's predominantly individualistic and psychologised conception of bearing witness and the obligation of ‘true presence’, they argue that bearing witness as a nurse entails both moral and political responsibility which includes the work of addressing injustice.

‘Intercultural Perspectives,’ further develops the discussion of the cultural dimension of ethical nursing practice and the way in which feminist perspectives and strategies interface with this dimension. Dianne Wepa explores gender roles and the ‘we-dentity’ of Māori culture and she suggests that the use of ‘we’ and ‘us’ is indicative of a collective cultural orientation. Wepa points out that although feminism is considered a Western construct and social movement, First Nation peoples traditionally supported clearly defined and complementary roles for men and women. Wepa favours the revival of an understanding of we-dentity and proposes that when nurses engage with Māori patients, clients, and families, they need to recognise and acknowledge their we-dentity. Wepa argues that nurses must carefully consider the impact of their own cultural history and how this might impact the patient’s cultural practices. Attention to culture from the nurse and patient perspective provides the framework for ethical decisions to take place that are regardful of difference and not regardless of difference.

‘An Interview with Joan Tronto on Care Ethics and Nursing Ethics’ bridges the theoretical-philosophical and practice-oriented parts of the book with an interview with internationally renowned political theorist, Joan Tronto. Tronto’s book, *Moral Boundaries* (1993), established care ethics as a scholarly discipline and led to new initiatives and new ways of thinking especially in political theory, professional ethics, and studying care as practice. Nearly 30 years on, she remains committed to an expansive understanding of care and, in this interview, she addresses the synergy between scholarship in care ethics and nursing ethics. First, she recognises the situation of nurses within healthcare organisations which affords them the opportunity to defend and promote caring as a central form of human practice. She points to some of the key challenges for nurses and nursing ethics from a care ethics perspective: how the larger issues of healthcare and cost containment affect the ethical possibilities of what nurses can accomplish; the tension between increasingly technical and technologically distant practices and the basic human needs of patients, such as the need to be touched and to be heard; and the organisational and political tension between professionalism for nurses and the place of nurses as advocates for everyone else in care settings—especially their role in respecting difference and addressing disparities. Finally, she touches on some of the challenges which the COVID-19 pandemic presents and suggests that, even though it is a huge crisis in healthcare, it also presents nurses with the opportunity to reorient social values towards all forms of care.

Part II begins with Louise Campbell’s chapter, ‘Organisation Ethics, Relational Leadership and Nursing.’ Organisation ethics is a relatively new discipline which analyses the ethical behaviour of healthcare organisations. Campbell draws attention to the ways in which organisational structures condition the behaviour and attitudes of employees and determine the values at play in the working environment. It becomes clear that the existence of accepted ‘ways of doing things’ can significantly influence the quality of care received by patients. Campbell examines the relevance of the concept of leadership for healthcare organisations and argues that traditional definitions of leadership are no longer adequate in the face of the momentous changes confronting healthcare leaders and health and social care professionals. She invites leading actors in healthcare organisations to focus on the quality of the relational practices and interactions which define the organisation's culture, including its values. Developing relational competencies, Campbell argues, may transform nurses' understanding of their own agency and increase their satisfaction with the work they do. She concludes that a relational approach to practice, not only with patients, but also with colleagues across organisations (from frontline workers to managers in leadership), might reduce burnout and moral distress.

'Hospital Ethics Committees and the Dismissal of Nursing Ethical Concerns: A Feminist Perspective,' by Helen Kohlen, explores the discursive space of Hospital Ethics Committees (HECs). She shows why and how nursing ethical concerns are dismissed in these spaces. First, in HECs, as in hospitals, profession, rank, and academic degree often determine the extent to which permission is given to speak freely and authoritatively. Since nurses' position of power is usually comparatively low, their voices and ethical concerns are often marginalised. Second, the application of principle-based ethics reduces the significance of care practices and devalues nurses' ethical issues. When Kohlen considers the development of care ethical approaches and the feminist turn, a solution to the dismissal of nurses' voices evolves. She suggests that the language that care ethics offers can grasp issues of nursing care while a feminist approach provides a lens to thematise the relevance of power, including rank and position. Her analysis of two case consultations illustrates how the feminist care ethical approach of Joan Tronto puts questions of attentiveness, competence, responsibility, responsiveness, as well as power relationships and conflicts of care, on to the agenda.

'Feminist Reflections on Home, Digital Health Technologies, and Ethics,' by Elizabeth Peter, addresses a range of ethical concerns that arise in relation to the use of digital health technologies in the home. Drawing on the thinking of both feminist ethics and feminist relational geography, Peter argues that 'home' is much more than the site in which we live. Her feminist perspective draws attention to the power relations that are omnipresent in the home and the gendered practices of caring and domestic work that are associated with home-making. Peter's central thesis is that the increasing use of digital health technologies will disrupt traditional forms of caregiving and care-receiving in both positive and negative ways. She concludes the chapter by highlighting, in particular, the ways in which these technologies will transform our understanding of standard norms such as individual privacy and autonomy and challenge our assumptions about nursing and family caregiving relationships.

'Conscience, Conscientious Objection and Commitment: Midwives, Nurses, and Abortion Care' addresses the complex issue of conscience and the role it plays in the work of midwives, nurses, and other health professionals in the provision of abortion care. First, the authors, Joan McCarthy and Sheelagh McGuinness, give an account of the notions of 'conscience', 'freedom of conscience', and 'right of freedom of conscience' as they are articulated in the standard bioethical literature. They also consider the notion of 'conscientious objection' with particular reference to the scope and limits of any appeal to conscientious objection made in order to justify the refusal to provide abortion care. The rest of the chapter outlines and explains a feminist account of conscience which views it as informed, enabled, and constrained by social and institutional relations of power. It also discusses the notion of 'conscientious commitment' which signals that conscience is not simply the purview of those who refuse to provide termination of pregnancy services—it also applies to those who do provide the services. The authors conclude with the suggestion that ethical stances are taken in specific real-world contexts and that the shared range of tasks and psychosocial supports involved in the delivery of any kind of clinical treatment may work to reduce what seem like intractable conflicts in the case of abortion care. Ireland provides the context for these considerations: a country which until January 2019 had one of the most restrictive pieces of abortion legislation in the world.

The final chapter of the book, 'Feminist Ethics in Nursing Research,' by Heike Felzmann, discusses the limitations of traditional practices and core concepts in research ethics and presents feminist ethics as an important resource for achieving ethically sensitive nursing research methodologies and practices. First, she explains the power dynamics inherent in institutionalised research ethics review and then points out the different ways in which the vulnerability of research participants can be exacerbated by the context, content, and methodology of research. Felzmann also acknowledges that autonomous decision-making is perceived to be a core expression of human agency in research but she takes issue with the assumption that the requirement of informed consent and the principle of confidentiality can sufficiently express, document, and protect the autonomous agency of research participants. Instead, Felzmann offers the feminist notion of relational autonomy as a means of capturing the socially embedded and contextual nature of decision-making and the idea of participatory research as a more comprehensive way of promoting genuine inclusion. The chapter also includes a more nuanced understanding of the duty of care in research by appealing to care ethics as a means of extending understanding of the researcher's caring responsibilities. Drawing on insights from feminist ethics and from nursing research ethics literature on trust, as well as standards of trustworthiness, Felzmann concludes by highlighting the unique and particular perspective of each participant, and the need for empathic, reciprocal, respectful, equal, and trusting relationships between researcher and participant.

To conclude, this project was born out of an idea to draw on our networks to further the discussion of the relevance of feminist theory for the field of nursing ethics. An essential part of this discussion involved drawing attention to the ways in which the 'traditional' feminist critique of the impact of gendered social relations is mirrored in all other critiques of power which aim to uncover the structural biases and unconsciously adopted norms which undermine social justice. We would have liked to have done more but we hope that our book will help to spark further engagement on these issues and encourage those of us working in these fields to be more self-conscious about our privilege and more attentive to opportunities to be more inclusive. With this in mind, we invite future collaboration from colleagues in other disciplines and coming from different perspectives who are similarly engaged in thinking, writing, advocacy, and activism with the overarching aim of dismantling the structures which thwart equality and promote injustice in the field of health and social care.

Cork, Ireland Joan McCarthy
Bremen, Germany Helen Kohlen

## References

Baer, Ellen. 1991. *The Feminist Disdain for Nursing*. New York Times, 25

Benner, Patricia. 1984. *From Novice to Expert: Excellence and Power in Clinical Nursing Practice*. Menlo Park: Addison-Wesley Publishing Company.

Bishop, Anne H., and John R. Scudder 1990. *The Practical, Moral, and Personal Sense of Nursing. A Phenomenological Philosophy of Practice*. New York: New York University Press.

Bowden, Peta. 2000. An “ethic of care” in clinical settings: Encompassing “feminine” and “feminist” perspectives. *Nursing Philosophy* 1: 36–49.

Canadian Nursing Code of Ethics. 2017. https://www.cna-aiic.ca/~/media/cna/page-content/pdf-en/code-of-ethics-2017-edition-secure-interactive. Accessed 27 Feb 2020.

Chinn, Peggy L, Charlene Eldridge Wheeler. 1985. Feminism and nursing. Can nursing afford to remain aloof from the women’s movement? *Nursing Outlook* 33: 74–77.

Fowler, Marsha 1984. *Ethics in Nursing, 1893-1984: The Ideal of Service, the Reality of History*. Los Angeles: University of Southern California.

Fry, Sara T. 1989. The role of caring in a theory of nursing ethics. *Hypatia* 4 (2): 89–103.

Gelfand Malka, Susan. 2007. *Daring to Care: American Nursing and Second Wave Feminism*. Champaign-Urbana: University of Illinois Press.

Liaschenko, Joan. 1993. Feminist ethics and cultural ethos: Revisiting a nursing debate. *Advances in Nursing Science* 15 (4): 71–81.

Little, Margaret Olivia. 1996. Why a feminist approach to bioethics? *Kennedy Institute of Ethics Journal* 6 (1): 1–18.

Peter, Elizabeth, Joan Liaschenko. 2003. Whose morality is it anyway? Thoughts on the work of Margaret Urban Walker. *Nursing Philosophy* 4: 259–262.

Rodney, Patricia, Bernadette Pauly, Michael Burgess. 2004. Our theoretical landscape: Complementary approaches to health care ethics. In *Toward a Moral Horizon*, eds. Janet L. Storch, Rodney Patricia, Starzomski Rosalie. 77–97. Toronto: Pearson Education.

Sherwin, Susan. 1992. *No Longer Patient: Feminist Ethics and Health Care*. Philadelphia: Temple University Press.

Storch, Judith 2004. Nursing ethics: A developing moral terrain. In *Toward a Moral Horizon*, eds. Janet L. Storch, Rodney Patricia, Starzomski Rosalie. Toronto: Pearson Education.

Susan, Reverby. 1987a. A caring dilemma: Womanhood and nursing in historical perspective. *Nursing Research* 36 (1): 5–11.

Susan, Reverby. 1987b. *Ordered to Care: The Dilemma of American Nursing*. New York: Cambridge University Press.

The ICN Code of Ethics for Nurses. 2012. https://www.icn.ch/sites/default/files/inline-files/2012_ICN_Codeofethicsfornurses_%20eng.pdf. Accessed 27 Feb 2020.

World Health Organisation. 2020. *State of the World’s Nursing 2020: Investing in Education, Jobs and Leadership*. Geneva: World Health Organization. https://www.who.int/publications-detail/nursing-report-2020.

# Contents

## Part I Nursing Ethics and Feminist Theoretical Challenges

**Part II Nursing Ethics in Organisation, Clinical Practice, and Research through a Feminist Lens**

# About the Authors

**Louise Campbell** is a clinical ethicist and a lecturer in medical ethics in the School of Medicine at the National University of Ireland, Galway, Ireland. Her research interests include issues in clinical and organisation ethics and ethical issues in end-of-life care.

**Christine Ceci, PhD, RN** is an associate professor in the Faculty of Nursing, University of Alberta. Her programme of research includes empirical and theoretical work concerned with the organisation of care practices for frail older people, currently focused on the situations of families in which one member has dementia. She is a co-editor of *Perspectives on Care at Home for Older People and Philosophy of Nursing: 5 Questions*.

**Mikelle Djkowich** is a Registered Nurse at the Stollery Children's Hospital in Edmonton, Canada. She completed her Master of Nursing at the University of Alberta in December of 2019. Her thesis research focused on the use of non-invasive ventilation in the paediatric population. Throughout her programme, she was able to collaborate on and publish work related to feminist ethics and nursing.

**Heike Felzmann** is a lecturer in Philosophy/Ethics at the National University of Ireland, Galway, Ireland. Her main areas of research are healthcare ethics, ethics of information technologies, and research ethics. Her work in research ethics includes extensive experience with ethical review of research, training provision for RECs, membership of Irish working groups on research ethical issues, and research on research ethics governance. She has also been involved in various European research projects at the intersection of healthcare and information technology, especially on ethical issues in healthcare robotics.

**Marsha D. Fowler** is a Professor of Ethics at Azusa Pacific University; a Visiting Professor in the Faculty of Health and Medical Sciences, University of Surrey; and an Adjunct Professor, Trinity Western University, Langley, British Columbia. She holds a PhD in Social Ethics. Her research and publications focus on ethics, social ethics, feminist ethics, and intersections of religion, ethics, and nursing practice. Her longitudinal research focus is on the history and development of nursing ethics in the USA, the UK, and Canada.

**Ann Gallagher** is a Professor of Ethics and Care, International Care Ethics Observatory, University of Surrey. She is Editor-in-Chief of Nursing Ethics and a Fulbright Scholar. Ann has published widely on ethics and care and is the author of *Slow Ethics and the Art of Care* (2020).

**Helen Kohlen** is a Professor of Care Policy and Ethics at the Philosophical-Theological University of Vallendar, Germany, and an Adjunct Professor at the University of Alberta, Canada. Her empirical research focuses on the transformation of care practices. Intensive care and palliative care are her main fields of interest, and she has collaborated on several international studies. She has a background in social science, and questions of inequality, mostly with regard to gender and ethnicity, are always part of her research and teaching.

**Joan Liaschenko** is Professor Emerita in the Center for Bioethics and the School of Nursing at the University of Minnesota, USA. Her research has focused primarily on exploring the morality embedded in nursing practice through the lens of feminist ethics. She has also published on clinical ethics.

**Joan McCarthy** is a Senior Lecturer in Healthcare Ethics in the School of Nursing and Midwifery, University College Cork, Ireland, and a Visiting Professor in the Faculty of Health and Medical Sciences, University of Surrey, UK. With a background in philosophy, she has collaborated on several international research projects and her publications focus on ethics at the beginning and end of life, nursing and midwifery ethics, and feminist perspectives on bioethics.

**Sheelagh McGuinness** is a Reader in Law at the University of Bristol Law School, where she is Co-director of the Centre for Health, Law, and Society. She has wide-ranging research and teaching interests in health law and policy, particularly regarding the regulation of reproduction. Sheelagh has published across these areas, including in law, ethics, and healthcare journals, and was recently a co-investigator on an ESRC-funded project entitled ‘Death before Birth: Understanding, informing and supporting the choices made by people who have experienced miscarriage, termination, and stillbirth’. Sheelagh’s educational roles include being coordinator on the ‘Health Law and the Body’ unit of the University of Bristol’s LLM in Health, Law, and Society. She is currently a member of the BPAS Board of Trustees and the Irish National Screening Advisory Committee.

**Elizabeth Peter** is a Professor at the Bloomberg Faculty of Nursing and a member of the Joint Centre for Bioethics at the University of Toronto, Canada. She is also the Chair of Public Health Ontario’s Ethics Review Board. Her scholarship reflects her interdisciplinary background in nursing, philosophy, and bioethics. Theoretically, she locates her work in feminist healthcare ethics which aligns her scholarly pursuits both substantively and methodologically.

**Olga Petrovskaya** is an Assistant Professor in the Faculty of Nursing, University of Alberta, Canada. Her research, funded by the Women and Children's Health Research Institute in Alberta and the Social Sciences and Humanities Research Council of Canada (SSHRC), focuses on politics and ethics of novel digital health technologies, known as eHealth, and the impact of these technologies on healthcare practices and patient care.

**Janice L. Thompson** is a retired Professor of Nursing and a Fellow of the American Academy of Nursing. Her previous academic affiliations were with the University of Southern Maine in Portland, Maine, USA, and also with the University of New Brunswick, Fredericton, NB, Canada. Still mentoring graduate students at the University of New Brunswick, she maintains registration as a R.N. (retired) in the USA and in Canada. Her background in transcultural nursing, women's studies, and critical theory has contributed to research and publications both in the USA and in Canada.

**Joan C. Tronto** is a professor emerita of political science at the University of Minnesota and the City University of New York. She has published widely on care ethics, including *Moral Boundaries: A Political Argument for an Ethic of Care* (1993) and *Caring Democracy: Markets, Equality and Justice* (2013).

**Dianne Wepa** originates from Hastings, New Zealand. Her iwi (tribe) is Ngati Kahungunu. Dianne's PhD focused on how Maori (indigenous people) from New Zealand engaged with healthcare services. She has published textbooks on cultural safety and clinical supervision. Dianne is a registered social worker in New Zealand and an Accredited Mental Health Social Worker in Australia with interests in mental health, youth health, and Maori health. Dianne currently coordinates a range of courses focused on First Peoples' Health at the University of South Australia and is currently supervising research students on topics such as the impact of digital technology on suicide prevention, the social impact on dementia, and fathers' use of Kangaroo Care with newborn babies.

# Part I

# Nursing Ethics and Feminist Theoretical Challenges

# The Influence of the Social Location of Nurses-as-Women on the Early Development of Nursing Ethics

Marsha D. Fowler

## 1 Introduction

The development of nursing's ethics is intimately tied to the social location of women in the founding years of modern nursing with effects that continue to this day. This claim necessitates attention to the early history of nursing to examine how the influence of the social location of nurses-as-women shaped and informed the development of nursing ethics. The received explanation for the genesis of the Nursing Code of Ethics and its supporting literature is that the primary impetus for the first American nursing code of ethics was to reinforce nursing's claim to being a profession and to mimic medicine. Yet this explanation is not entirely adequate to explain the extensive and extraordinary body of ethical literature found in the first 100 years of American nursing, from the mid-1800s to 1965. The leaders of early modern nursing were, indeed, concerned to establish nursing as a profession, but the content and development of nursing ethics were not tied to an attempt to parallel medicine or law as recognized professions.

## 2 A Cautious Overview of Nursing in the United States, 1860s–1960s

Early modern, secular American nursing first becomes visible during the Civil War of 1861–1865. Here we differentiate modern secular nursing from pre-Civil War religious nursing orders and nursing education for women who would practice "sick nursing" as wives and mothers but never as paid nurses (D'Antonio 2010a, p. 13). Nursing begins as a sponsored profession, sponsored by wealthy, philanthropic

---

M. D. Fowler (✉)
School of Health Sciences, Faculty of Health and Medical Sciences,
University of Surrey, Guildford, UK
e-mail: mfowler@apu.edu

H. Kohlen, J. McCarthy (eds.), *Nursing Ethics: Feminist Perspectives*,
https://doi.org/10.1007/978-3-030-49104-8_1

gentlewomen, keen to reduce battle casualties. In order to place women-as-nurses in battlefield hospitals and later in public hospitals, nursing's sponsors ceded all authority for patient care to military physicians. Nurse historian Dorothy Sheahan writes

> [H]aving no identity with nursing as an occupation, nor any vested interests in its presumed or projected "professional prerogatives," the women made no bid for "rights of practice."[...] In choosing to abdicate in the name of nursing, any claim to participate in patient-care decisions, the American founders inflicted a degradation of status, both socially and professionally, on succeeding generations of nurses.[...]the lady founders were there for the sponsorship of nursing, not its practice. Their aim was institutional reform (Sheahan 1979, pp. 181–182).

These non-nurse founders established and cemented a nursing workforce that would practice with neither authority over, nor control of, their practice. The emerging nursing leadership continued a class stratification with a group of elite, educated, White, largely single, women as its leaders, school superintendents, and educators who steered nursing; and lesser-educated, working-class, White, women as its rank-and-file. Approximately 76% of the leadership did not marry (Bullough et al. 1992, p. xiv). There is also a general presumption throughout the early literature (including Nightingale's writings) that nursing and nursing education was Christian and the nursing literature contained Biblical allusions as well as direct quotes of Christian scriptures. From the start, issues of gender and class, as well as race and religion, affect nursing's development in ways that are beyond the scope and ends of this paper. Nursing would be well served to bring together the complexity of all four intersections in future research.

The early nurse leaders' goal was to create a respectable, educated, female profession. The literature reflects that impetus as well as a backdrop of interlocking social-structural oppressions and advantages faced by women and nurses-as-women (D'Antonio 2010b, p. 212). Within nursing itself there have been divisions between its leadership that pressed for higher and higher standards of education to professionalize and raise the social status of nursing, and nurses in direct patient care who lived the structural vicissitudes of nursing work. However, there were exceptions, as a number of leaders (e.g., Lavinia Dock, 1858–1956) were acutely sensitive to working nurses, and some working nurses supported the efforts of the leaders to advance nursing even though many felt they were out of touch with their reality (Garofalo and Fee 2015). While nurses did not have the means to improve their lot, that would come through the work of the leaders who set in place the mechanisms that would enable the rank and file to make workplace gains.

A caveat is necessary: summarizing the first century of modern secular nursing history, from the 1870s forward, is challenging as circumstances were very different in the subperiods of that history. In the pioneer period of 1873–1890, nursing school graduates were relatively few in number and the main emphasis of leaders was on remaking "nurse's training" as higher education. Graduates could generally find work, mostly in private duty. The issues that developed later around the balance of student learning versus service to the hospital were not so obvious in this early period. Between 1900 and 1920, the number of schools, students, and graduates escalated, and the problems of "service-versus-learning" with an oversupply of graduates became acute, leaving graduates desperate to find work while hospitals continued to recruit students to provide patient care. Hospitals were slow to make the workforce changes that had taken place outside the hospital (Flood 1981).

Outside of nursing, universities became dominant as postsecondary institutions, replacing many specialized postsecondary institutions (or welcoming them in as professional schools). During The Great Depression of the 1930s, hospitals began a move toward a richer mix of graduate nurses, in addition to students, to staff hospitals. This helped to mitigate the overproduction of graduates in the last years of the decade (Flood 1981).

The national nursing organizations gained strength and influence during World War II so that both the professional association (the American Nurses Association—ANA) and the successor to the Society of Superintendents of Training Schools (the National League for Nursing-NLN) were poised to move forward. In the late 1940s and through the 1950s, ANA, the national umbrella for all the state nursing associations moved an agenda of economic and general welfare for nurses. NLN launched an ambitious program of professional accreditation of the many diploma training schools, strongly influencing curricula, and encouraging the development of baccalaureate programs in colleges and universities (Flood 1981). In 1965, the ANA issued a policy statement calling for the movement of nursing education into institutions of higher education. This was followed by the rapid closure of a majority of the nation's hospital-based, diploma programs. By the 1970s, there is a rapid closure of diploma programs as nursing education moves into colleges and universities, thereby setting nursing on a new educational course.

## 3 The Social Location of Women and Nursing's Professional Beginnings

At the time of the founding of the first nursing schools in the United States (1873) and into the 1900s, women who married were shackled by a number of legal and social disabilities. Social vestiges of an earlier legal doctrine of *coverture,* inherited from English Common Law, remained. Coverture is

> the merger of the wife's legal personality into that of her husband, with the result that the wife is disabled from freely and independently engaging in most legal acts—signing a contract, suing in court under her own name, the owning and disposing of property[...]. The vocabulary of coverture was intended to express and enforce a total and complete subordination of married women to men at common law (Reid Jr. 2013).

Coverture begins to erode in the mid-1800s though legal remnants persist until women achieve suffrage in 1920; sociocultural strictures persist after coverture ends. While marriage need not have forced a woman out of nursing, social convention required women to retire from nursing upon marriage. Many nursing leaders did not marry—some from a genuine love of nursing—but also because marriage could be a crippling legal and social shackle. Had nursing's early nurse leaders married, the profession would have been gutted of its leadership. Still, single professional women of this period were in an ambiguous social position. Denied suffrage, women of this period were, thus, proscribed from direct participation in political processes necessary for changing the legal status of women—or nursing. And yet, even without enfranchisement, some early nurse leaders were vehement activists for social change on behalf of women, disadvantaged persons, and nurses.

The early years of nursing traverse The Progressive Era (1890s–1920) in the United States. In this period, there is a shift from a laissez-faire marketplace capitalism that eschewed government intervention in business affairs, toward the development of governmental and legislative remedies to address the ills brought about by industrialization, and the urbanization that resulted, immigration, and corrupt political machines. This period would usher in worker protections and various aspects of a social safety net.

Early nursing leaders became involved in an astonishing range of Progressive Era social causes under a broad interpretation of health and health promotion and as a means of advancing nursing (Fowler 2016). Nurses were involved in advocating for child labor laws, for the welfare of industrial factory workers, for garment workers and unionization, for housing reform, for women's access to reproductive education and birth control, for the rectification of a megacosm of terrible social injustices and, of course, for the control of the nursing profession, including education and practice. These social ethical and nursing concerns were not seen as stand-alone issues; they were seen collectively as interrelated, social-structural issues that would be pivotal for nurses and nursing, and the health of the nation. The social activism of early nursing leaders would bring to the nursing literature, and nursing education through curricular requirements, a recognition of issues of social justice and the progress of nursing. For nursing's first 100 years, of necessity, nursing leaders were intrinsically, practically, politically, and sometimes militantly feminist and humanist, to both greater and lesser effect.

## 4 The Professionalization of Nursing: Enfranchisement, Education, Regulation

Nursing leaders actively sought the advance of nursing education and practice along "scientific lines." They aspired to the social status, recognition, freedom, and livable compensation of a profession, and so sought to professionalize nursing. Yet, it became clear to them that if nurses-as-women could not vote, they could not effectively bring about the changes necessary to advance nursing. Suffrage thus became not just a women's issue but a nursing issue as well, though it was not supported by all nurses. Professionalizing nursing would require legal structures, state government cooperation for individual licensure, and educational regulation. Social power and authority would also be essential to move nursing from hospitals to institutions of higher learning when universities replaced special-purpose schools as the dominant site of postsecondary education. While women's suffrage was viewed as important in its own right, it was also seen as one key to the professionalization of nursing, to securing authority over nursing, and to influencing the legislative processes that these would require. Some of the nurses and nursing leaders who supported women's suffrage marched, in nursing uniform, in the women's suffrage parade in Washington DC in March 1913. They were joined by women and nurses from Canada, England, Australia, Norway, and other countries (New York Times 1913; Harvey 2001). Some states had granted suffrage; eventually, the 19th Amendment granting women's suffrage nationally (but not equal rights), was passed in 1920.

The professionalization of nursing would require several conjoined developments in addition to women's suffrage. These included full political and social citizenship, in keeping with an emphasis on "civic professionalism" (Sullivan and Shulman 2004), nursing unity through a national professional association; movement into postsecondary collegiate education; nursing control of nursing education and practice; state licensure, social welfare legislation, labor legislation, and more.

The battle over nursing education was waged on more than one front. Into the early 1900s, society generally and many physicians argued against women's higher education as out-of-keeping with women's proper role in society and as a danger to women's fertility. While there were some notable physician defenders of nursing progress (e.g., William Osler), in general, cultural inertia supported efforts to maintain the gender status quo and impeded the progress of nursing education.

Susan Reverby notes that "before the early 1900s[...]a hospital opening a nursing school had no minimal standards to meet[...]. In 1895, even a hospital with a dozen beds, and a patient census of one, could purport to have a 'school' with two pupil nurses" (Reverby 1987, p. 61). These alleged training schools "could provide a hospital both with cheap labor source and additional income from fees collected when students were sent out to patients' homes on private cases" (Reverby 1987, p. 61). The ANA passed a resolution that a hospital of 25 or fewer beds could not have a nursing school. Nursing students staffed the hospitals and the nursing supervisors were often more senior students. The innovation of recruiting young, mostly White women to come to live at a hospital, to exchange their work for a set period of time for training that led to a recognized diploma, seemed a solution to the lack of systematically trained attendants for the hospitals that were being established or reformed in the United States. This bargain worked well for a couple of decades for both hospitals/training schools and trainees/graduates. But as the number of hospitals and their censuses grew, this original quid pro quo began to break down. From the hospital side, as various forces combined to require more, and more regularized, instruction, rotation of each student to gain experience with the full range of patients, and competition for desirable potential trainees that required, for example, more attractive housing, the cost of student staffing rose. From the potential student side, the discipline and hard work of nursing student life became less attractive as other work fields opened up after World War I. To the extent that potential students learned of competition for postgraduation work, this too tipped the scale toward other fields. Starting in the early 1900s, nurse leaders recognized the bind inherent in the tie between patient care demands and rising educational demands. In an effort to gain broad support for raising educational standards, much was written about student exploitation. This undoubtedly reflected the perspective of leaders from their longer and broader experience. But from the standpoint of the young potential women students, nursing offered preparation for family care or paid employment postgraduation with little out-of-pocket cost, along with safe housing and adequate board.

Nurses in the early 1900s were unlike other working women in a number of ways: they worked outside the home, had a specialized education, were paid, and (unlike elementary school teachers) touched adult males to whom they were not related—all of which ran counter to social norms for women at that time. In terms of social structures, nursing itself formed a distinctive category, as it faced the dominance of medicine and hospital administration. Hospitals and eleemosynary institutions were exempt from labor laws so that nurses (i.e., nursing students and graduates who staffed hospitals), as well as medical interns and orderlies, were also unlike workers in other occupations as they were not included under labor law. Even when nursing students were not actually exploited, they still labored under difficult work practices (excessive hours, doubling back to work additional shifts, low or no pay, etc.) and were under the complete control of physicians and hospital administrators. Accommodations and meals, with or without a small payment, were considered adequate compensation for their service (Flood 1981).

Though students began slowly to be replaced by paid graduate staff nurses in the 1930s, the majority of graduates still practiced in private homes. Most graduate nursing labor was solitary, hidden in homes, undervalued by society and hospitals, often seen as a form of domestic labor, and economically unstable. At the other end of the spectrum, were private duty nurses whose availability was a prerequisite to the scheduling of major surgery. Nursing did not move fully into hospitals with a paid nursing staff for direct patient care until after World War II (Flood 1981). The means to progress would have been to bring nursing under labor laws (state-by-state) that would set the hours and some conditions of work. However, doing so would wrest control of nursing from hospitals and physicians, and require nurses to shift allegiance from their schools, administrators, and physicians to nurses themselves, through professional associations, that would represent them in legislative affairs and in advancing the economic and general welfare of nurses. To side with the physicians and administrators, who had social and political power, would situate nursing on the side of middle-class professional work; to side with those seeking to bring nursing under labor laws would benefit nurses doing direct patient care in terms of control of work conditions and pay, but ran the risk of turning nursing toward “the trades,” that is, nonprofessional occupations. Moreover, bringing nursing under labor laws would implicitly favor an apprenticeship model of nurse training over education. Both licensure and the creation of educational standards would have the same effect—they would move nursing from physician and hospital control to individual state’s control. These issues perpetuated stratification and division within nursing with nurse leaders and educators generally on one side and direct care nurses generally on the other. Meanwhile, in the trenches, direct patient care nurses suffered from exhaustion, illness, and economic insecurity and saw the nursing leaders as distant from their own experience (Dock 1913).

## 5 Introduction to the Nursing Ethics Heritage Literature

This cursory nursing history is intended only to take note of various themes and issues regarding the social location of women and nurses in modern nursing's founding years. It allows the enduring presence of these themes in contemporary nursing's ethics to be highlighted. There was a flurry of early second-wave feminist analyses of nursing's history and development in the 1970s and 1980s; the reader is referred to these works for a more adequate picture of the Sisyphean challenge of nursing's development. Of particular note is the excellent and rigorous work of Susan Reverby, professor emerita of history of ideas; women; and gender studies, in *Ordered to Care*. Her balanced and careful scholarship provides analyses of women's and labor history, and the social structures that have been formative in the development of nursing, as a profession "ordered to care" in a society that devalues the "female" work of caring (Reverby 1987; Melosh 1982; Sheahan 1980).

Before moving to the social influences on nursing's ethics it is important to give an overview of nursing's ethical heritage literature. Between the 1880s and 1965, there were approximately 100 nursing ethics textbooks and editions available for ethics education in nursing schools, most of which were written by nursing leaders and leading nurse educators. A few of these textbooks were written by Roman Catholic priests. At any given time, there were at least two, and as many as 11, such textbooks in addition to several hundred ethics articles in nursing journals, ethics columns in the *American Journal of Nursing*, innumerable papers on ethics given at ANA and NLN conventions, graduation addresses, and more. All of this exists prior to the rise of the discipline of bioethics. With the exception of Isabel Hampton Robb's *Nursing Ethics*, discussed below, much of this literature is unknown, even to nurses in ethics (Robb 1900). It is often wrongly dismissed as "primarily feminine etiquette" (Fry 1989, p. 88); etiquette forms the necessary interstices of relationships that create diplomatic spaces for interaction and negotiation. This body of ethics textbooks was initially lost when nursing moved from hospital-based to collegiate education in the 1960s and the hospital libraries were dispersed. A number of digital library catalogs (e.g., WorldCat) contain Robb's book, and some list the works of Aikens and Parsons, but most, including that of the archived books at the National Library of Congress, do not include the majority of these works. In addition, nursing ethics education was shifted from nurse educators to departments of philosophy and theology and, simultaneously, the discipline of bioethics began its rise. However, all of these early works, including most successive editions, have been retrieved and are now available to scholars and researchers at the Nursing Ethics Heritage Collection, through the International Care Ethics Observatory at the University of Surrey. The collection also includes nursing ethics textbooks from 1965 forward.

In addition to textbooks and journal articles, the successive iterations of the American Nurse's Association's *Code of Ethics for Nurses with Interpretive Statements* are an important expression of nursing's ethical concerns and values and comprises the profession's ethical standard for all registered nurses in the United States. The codes of ethics, with a focus on concrete guidance for graduate practice, differ somewhat from the general body of ethics textbooks that focused on ethics education and formation.

The ANA1896 articles of incorporation set forth its aim:

> The object of the Association shall be to establish and maintain a code of ethics, to the end that the standard of nursing education be elevated; the usefulness, honor, and interests of the nursing profession be promoted; public opinion in regard to duties, responsibilities, and requirements of nurses be enlightened; emulation and concert of action in the profession be stimulated; professional loyalty fostered, and friendly intercourse between nurses be facilitated (American Society of Superintendents of Training Schools for Nurses 1896).

There was initial resistance within ANA to writing a code of ethics. As "[t]he Ethics of Nursing is taught in all our training schools" (Committee on Ethical Standards, ANA 1924) it was thought unnecessary to write a code of ethics. When it became clear that nurses wanted such a code, and that states were beginning to take it upon themselves to write their own codes, the decision was made to proceed with writing a national code. The ANA published a Suggested Code (1926) (ANA Suggested Code 1926) and a Tentative Code (1940) (ANA Tentative Code 1940), both written in narrative style and published for critique; neither was adopted. Initially, the Committee on Ethical Standards of the ANA examined the codes of ethics of other professions with considerable focus on the American Medical Association's (AMA) code, and how it was disseminated. In the review, a motivation toward professionalizing nursing was present, and the AMA code of ethics served as an initial guide and template in terms of topics to be covered, but it was subsequently decided that "we should go much farther than the medical profession has gone in the matter and publish a code which is far more comprehensive than theirs" (Committee on Ethical Standards, ANA 1934). In some minor ways, the committee did ape medicine's code, for example, by including a provision against advertising, but otherwise the code that was created was distinctive.

The 1950 code of ethics was formally adopted and consisted of an enumerated list of provisions. Since then there have been successive revisions, approximately every 10 years. The *Current Code of Ethics for Nurses with Interpretive Statements* was adopted in 2015 (ANA Code 2015).

## 6 First Wave Nursing Ethics: Elements

Work has not been done on the periodization of nursing ethics. I would preliminarily propose that the period from 1800s to 1965 be regarded as its first wave. The second wave commences with both the issuance of the 1965 ANA policy paper mandating the movement of nursing education into colleges and universities and the simultaneous rise of medical ethics (subsequently termed bioethics) in the United States. In the mid-1960s nursing shifts from its heritage nursing ethics to medical ethics. The ANA Code of Ethics with Interpretive Statements is the sole holdout as it remains the vestige of nursing ethics and does not transition to bioethics. The emerging third wave of nursing ethics, not yet settled, subjects bioethics to feminist, philosophical, and other forms of critique in an attempt to forge an ethics better suited to nursing values, ends, concerns, art, and practice. The first wave would include persons such as Harriet Camp, Isabel Robb, Charlotte Aiken, Charlotte Talley, Annie Goodrich, and Sr Rose Hélène Vaughn. The second, transitional, wave would include Anne Davis, Mila Aroskar, Sara Fry, Sally Gadow, Marsha Fowler, and Patricia Benner. The emergent third wave includes Pamela Grace, Connie Ulrich, Amy Haddad, Joan Liaschenko, and some of those from the second wave who continue their scholarship, such as Benner and Fowler. A fourth wave is on the distant horizon as the third wave reformulates on the basis of its critique of the second wave. From this preliminary schema of periodization, we move to identify a few of the distinctive elements of early nursing ethics, and then to show how the social location of nurses-as-women shaped nursing ethics at the start of the coalescence of the profession, with effects that are enduring to present-day nursing ethics.

## 7 Distinctives of Nursing's Heritage Ethics

*Ethics education as moral formation:* Early nursing viewed ethics education as essential and held that the role of nursing education was both moral formation and nursing preparation and that these are tied to a primary, virtue-based ethics that also relied upon the specification of concrete moral responsibilities. As indicated in the previous sections, much of early nursing was practiced independently in the home and not under direct supervision. Nursing leaders understood that the educational environment must work to shape the moral character of the nurse both generally and for independent practice. The emphasis on moral character formation in addition to nursing topics also embodied cultural and period norms for class, education, and gendered roles— for "womanhood." The incoming probationer was seen as a morally and educationally unformed girl who must be shaped into a morally good woman, nurse, and citizen. Isabel Hampton Robb, Superintendent of Nurses for the Johns Hopkins School and instigator in the formation of the American Society of Superintendents of Training Schools for Nurses, (1900) writes:

> [T]he training school of a hospital may, therefore be regarded as a place not only for fitting women to properly undertake the care of the sick, but as an educational institution, where properly selected women are given such educational advantages that they can go forth equipped and ready to aid in the practical solution of social problems, which are to be mastered only by the help of intelligent womanly work (Robb 1900, p. 47).

The educational advantages that Robb anticipated specifically included "systematic" ethics education, from the outset. She writes:

> Instruction in the science of ethics and the rules of etiquette should be commenced from the moment the pupil-nurse enters a hospital, and from the very beginning of her term of probation. It should go hand in hand with the training in the theory and practice of nursing, [...] Such instruction should be practical and systematic, beginning with the moral laws and rules she will need first to put into practice, and progressively leading up to an appreciation

> of her greater and higher obligations to herself, to her profession and to humanity (Robb 1900, p. 47).

Sara Parsons (1864–1949), a mental-health nurse and superintendent of Massachusetts General Hospital, acknowledges the importance of character matched by the "unwomanly" attribute of a developed intelligence. She writes:

> Only the character that is built on a foundation of generosity and sweetness (if linked to intelligence, common sense, and humor) is safe in any exigency that may arise. This character foundation is seldom inherited, but must be built up by training and practice (Parsons 1916, p. 8).

There is one final point to be made regarding ethics education. Just as the early ethics textbooks were written by leaders of the profession, so too were ethics lectures delivered by school superintendents and head nurses, not lower level instructors. Robb writes:

> This systematic instruction should come largely from the superintendent herself, and should never or seldom be relegated primarily to any of the various members of her staff or head-nurses or assistants, although these by example and precept should never fail to emphasise this part of the training (Robb 1900, p. 16).

Early nursing education was a matter of formation or habituation of virtues, largely (supposed) womanly virtues for independent practice. But which virtues specifically?

*Virtues—Necessary nursing characteristics:* There is a wide range of virtues and excellences that were listed as required to make a *good* nurse, *good* in a moral sense. In one of the earliest lists, Miss (Wilhelmina) Mollett, Matron of Chelsea (UK) Infirmary from 1886 to 1889, identifies six necessary nursing characteristics: honor, purity, courage, discipline, culture, and love. (At some point, *sympathy* is substituted for *love*.) She agreed to write a series of articles for the 1888 *The Nursing Record*, one on each characteristic.

*Honor:* She begins with honor, a characteristic that combines truthfulness, rectitude, and integrity. Honor was an interiorized characteristic that was to be operative when not under supervision and in effect—irrespective of the work conditions (Mollett 1888a).

*Purity:* Purity entails performing duties decently and in order, without any impropriety, being an influence for good, and shunning all coarseness, including coarse levity. It also includes a perspective that surfaces throughout the early nursing literature (Mollett 1888b).

Mollett's purity includes issues of female authority over men as well as a refining female moral influence upon men, which would prevent what would now be called sexual harassment or professional boundary violations (Mollett 1888b).

*Courage:* Courage is "the backbone of honor and purity," and enables the nurse to "carry into practice unflinchingly those principles she knows to be right." Its absence renders honor and purity of no effect. Courage is essential for nurses

> to live the higher, purer life as well as dream it, to do the good they feel to be right, and to abstain from the evil they know to be wrong; not to be afraid of telling a lie, but with higher courage and without fear to choose to be truthful, to dare to take their stand on what they know and feel to be the right ground, and having chosen, to stand firm (Mollett 1888c).

It should be noted that she specifically identifies *moral courage*, a concept that is also deployed in contemporary nursing ethics though without reference to (Mollett 1888c, p. 77). Charlotte Aikens, a hospital superintendent and associate editor of the *National Hospital Record*, in *Studies in Ethics for Nurses* (1923), also identifies *moral courage* as *backbone*. She writes that executive ability in the nurse requires "these two striking and important traits of character—moral courage and self-reliance. These two might be combined in the well-understood quality known as backbone" (Aikens 1916, p. 197). Mollett identifies three additional necessary characteristics: *discipline*, *culture*, and *love* (Mollett 1888c, p. 77).

*Discipline:* She defines true discipline as "the obedience loyally given to rules and laws that have been voluntarily accepted" (Mollett 1888d, p. 100). There is an element, then, of free will in accepting the organizational discipline, that is, its rules and structures.

*Culture:* By culture, Mollett means "performing one's work as a skilled artist who loves his creations" (Mollett 1888e, p. 125). It is an interesting combination of devotion to one's nursing work, of a broadly educated mind, and egalitarian treatment of patients. She writes that the nurse "should have the breadth of understanding, freedom from prejudice, and refinement of manner that spring from a cultured mind—a mind that has had a liberal and not a narrower education" (Mollett 1888e, p. 125).

*Sympathy:* Without explanation, Mollett's final "necessary characteristic" is changed from *love* to *sympathy*. Her understanding of sympathy more closely describes what today would be called *empathy*, a word not yet in use in her day (nor does it appear in English until 1903) (Empathy, Oxford English Dictionary Second Edition on CD-ROM (v. 4.0.0.3) 2014). She states that "sympathy should be *with*, not *for* its object," by putting yourself in the other person's place, viewing her or his situation from their viewpoint rather than your own (Mollett 1888f, p. 193). However, in the absence of genuine sympathy there should be a demonstration of kindness, courtesy, and consideration—and never condemnation or denigration (Mollett 1888f, p. 193).

In her 1925 work, *Ethics: A Text-Book for Nurses and Lesson Plans for Schools of Nursing Applying Ethical Principles to Nursing Problems*, Charlotte Talley, a training school and hospital superintendent, has a section for students on acquiring and practicing specific virtues in order to develop them. She advises several exercises including reflection on specific virtues, observing and examining instances of a particular virtue, keeping a notebook of these instances, and weekly self-examination (Tally 1925, pp. 122–126).

This list is both reflective of class and gender expectations for women of the 1880s, and at the same time they do bend toward expectations that are in part inconsistent with the social norms for women of their day. The literature noted above is an admixture of received cultural norms for women; countercultural norms for a scientific, intelligent, highly trained and courageous practitioner; and aspirations that the nurse would meet “greater and higher obligations to herself, to her profession, and to humanity” (Robb 1900, p. 16).

*Nursing ethics’ relational nexus:* Early nursing ethics is relationally based. As I have noted elsewhere (Fowler 2017) the earliest American journal articles on nursing ethics (1889) begin by identifying classes of relationship. Camp, in an article in *The Trained Nurse* in 1889, identifies seven:

> For convenience sake, I will divide the duties of a nurse into seven classes: (1) Those she owes to the family. (2) Those she owes to the doctor. (3) Those owing the family, friends, and servants of the patient. (4) To herself. (5) To her own friends. (6) To her own hospital or school. (7) To other nurses (HCC 1889, p. 179).

The subsequent series of articles gives equal weight to all of the relationships. The nursing ethics literature subsequently follows a relational motif in articulating the duties that accrue to the nurse within each class of relationship, though through the years the number of classes will be reduced and reconfigured. It is a “ground-up” articulation that has much in common with contemporary feminist ethical critiques that begin with lived experience. All the issues and concerns that arise in nursing ethics fall within one of the seven relationships. This, then, gives nursing, from the start, a typology within which nursing’s ethical responsibilities, concerns, issues, and decisions are categorized. Many of the nursing ethics heritage books organize their chapters by this typology of relations though some address only one relationship: nurse and patient. This relational motif has suffused nursing’s early ethics but is implicitly retained in every iteration of the ANA Code of Ethics for Nurses to the present.

## 8 The Nurse to Society Relationship: Two Examples of Enduring Issues

The social location of women across the first century of nursing, and to the present, has shaped nursing’s ethics. Of the numerous issues that could be taken up, space allows for a brief examination of two sample issues within the context of the five nursing relationships to which ethical duties accrue: citizenship and civic engagement and; profession and just compensation.

### 8.1 Citizenship and Civic Engagement

The nursing literature gives the sense that *we have struggled, and suffered, under disenfranchisement, and have marched, picketed, been arrested, bled, and died for suffrage, in order to receive the vote—now we must use it. We now have full citizenship—we must do something with it.* In the words of Lavinia Dock, “we should all remember that we owe all the freedom we have to just such ‘unladylike commotion’ carried on in the past by all those women who first broke bonds” (Dock 1910, pp. 593–594).

Nurses were henceforth expected to continue their unladylike commotion by engaging with society to effect changes in social structures that harmed health or impeded the development or practice of nursing. Discussions of nurses' relationship to society pervade the early literature and are usually discussed under the topics of *citizenship*, *democratic ideals* or *democracy,* and *love for humanity*. The nursing ethical literature is clear that, at the least, nurses must be informed voters, with knowledge of their state Nurse Practice Act, and should be engaged with the health needs of the community. Beyond that, they should stand for office and influence the shape of health and nursing legislation. The Suggested Code of 1926 states

> The nurse is primarily a citizen. The fundamental basis of ethics is the same for every profession. The obligation of each individual is to serve society as well as possible by contributing that for which he is best fitted (American Nurses Association (ANA) 1926).

The 1940 Tentative Code states that nurses are to

> Participate actively[...]in securing and maintaining nursing legislation for the protection of both the patient and the nurse. She should know the provisions of the nurse practice act in the state in which she's practicing, and she should cooperate in making it effective.[...] Because the nurse is a good citizen and because of professional preparation especially qualifies her, she will[...]offer suggestions and help for the health protection of the individual, the family, and the community. She will participate, according to her ability, in national activities that are carried on for social improvement (ANA 1940).

By 1950, the code becomes an enumerated list of 17 provisions, the last three of which are devoted to concerns of citizenship:

> 15. The nurse as a citizen understands and upholds the laws and as a professional worker is especially concerned with those laws which affect the practice of medicine and nursing.
>
> 16. Nurse should participate and share responsibility with other citizens and health professions in promoting efforts to meet the health needs of the public—local, state, national, and international.
>
> 17. The nurse recognizes and performs the duties of citizenship, such as voting and holding office when eligible; these duties include an appreciation of the social, economic, and political factors which develop a desirable pattern of living together in a community (ANA 1950).

By 1960, the code has expanded the role and expectation of the nurse in civic engagement:

> As a professional person, the nurse's special background enables her to have a greater understanding of the nature of health problems. This understanding poses a particular responsibility to interpret and speak out in regard to legislation affecting health. The resources of the professional association enable the nurse to work with colleagues in assessing current or pending health legislation and its effect upon the community and to determine the stand that should be taken in the interest of the greatest possible good. Sometimes this stand may lead to concerted action with other health groups. At other times, nurses may find it necessary to work alone to support principles that the profession believes will result in the greatest benefits to patient care (ANA 1960).

Subsequent iterations of the code (1968, 1976, 1984, 2001, 2015) increasingly amplify and refine the ethical expectations of nurses and nursing associations. There is an increasing emphasis on addressing social structures that disadvantage individuals or populations; on the impediments to the progress of nursing education, practice and research, and on civic as well as global engagement.

The ethical literature mirrors the code of ethics in its ethical expectations of nurses to work for the common good. By the 1940s and 1950s, the literature begins to include discussions of *human rights*. From early days, there is a concern for those who live in poverty who require nursing care and who might not have access to it. Aikens writes:

> The established order of things sometimes has to be upset before much progress can be made. There are conditions that are not right in regard to nursing which should be worked at till better conditions are assured (Aikens 1916, p. 223).

In an extremely popular textbook on nursing history, Jamieson and Sewell make an astonishingly direct and political statement. In 1944 they write

> As we scan the great mural depicting the story of mankind, there may be discerned the long and devious course of the evolution of nursing, throughout which the woman's skill in caring for the unfortunate has served always as an instrument of social progress.[...] Today's professional nurses are recognized as the utilization of woman's special gifts in raising the level of the social order through the medium of nursing. At times her work has been smothered by great forces of hatred and intolerance, the fruits of her labors apparently lost. Yet we see, always, a surging forward in spite of temporary retardation and decline (Jamieson and Sewell 1944, pp. 622–624).
>
> [...] [I]n an age in which society is assuming new responsibility in relation to the underprivileged, the aged, the sick, and even the delinquent, emphasis is changing from mere alleviation of suffering to a scientific viewpoint which demands the searching out of causes of poverty, disease, and crime.[...] At the same time governments are proposing to secure food, shelter, and health for their peoples, according to need and regardless of ability to pay. More and more it is being recognized that only by creating a sense of relationship and understanding among all the various groups of society may there be brought about any permanent amelioration of the condition of the unfortunate (Jamieson and Sewell 1944, pp. 622–624).

These passages reflect both a typical and a persistent theme across the 125 years of nursing ethics literature. Early (1916) mandated curricular content in ethics in nursing schools included lectures on "ethical and social principles," "social virtues," "ethical principles as applied to community life," "modern social problems," "democracy and social ethics," "modern industry," "housing reform," and "the spirit of youth and the city streets" (Board of Nurse Registration, California 1916). Nursing and nurses are interested in the plight of those who are socially disadvantaged and so are active in social programs and social activism. These obligations go beyond a concern for health disparities focused on specific diseases or access to/cost of health care.

## 8.2 Profession and Just Compensation

The early nursing ethical literature assumes that nursing is a profession and it defensively proclaims it so for over 100 years. The 1940 Tentative Code begins with a declaration of nursing as a profession, sets out the attributes of a profession, and notes how nursing has met each of these attributes (ANA 1940). As such, it is a defensive, nonethical, statement that is wholly out of place in a code of ethics.

Nursing was also considered a religious or quasi-religious calling. Part of the concern about conceptualizing nursing as a calling is that while it might ennoble, it was also used by medicine to propound a notion of the "born-nurse" as a strategy to block the advance of nursing education (Fagin and Diers 2000). It might also communicate nursing-as-religious-vocation or nursing-as-natural-womanly-vocation. While early nursing leaders argued against these, the early ethics literature embraced nursing as both a profession and a personal calling. In addition, however, two interrelated strands of discussion are advanced in the literature here: (a), the nature of nursing education as a scientific, professional education; and (b), of just remuneration, the problem of exploitation of nursing student labor, inadequate compensation, and abusive work conditions of graduate nurses. As an example, Isabel Hampton Robb (1900), defends nursing as a developing profession that should be adequately paid:

> In speaking of nursing as a profession for women, I have used the term advisedly. Some prefer the term vocation, or[...] calling. The last, if made to bear the significance of a direct call from God to a consecrated service, would rather suggest, on first thought, a sisterhood with its religious restrictions: and surely profession means all that vocation does and more. The work of the clergy, the lawyer and the physician is spoken of as a profession; the term implies more responsibility, more serious duty, a higher skill and an employment needing education more thorough than that required in some vocations of life. Every day these qualities are more and more being demanded of the trained nurse by modern physicians and exacting laity[...](Robb 1900, pp. 32–33).

She proceeds to state that

> The trained nurse, then, is no longer to be regarded as a better trained, more useful, higher class of servant, but as one who has knowledge that is worthy of respect, consideration and due recompense—in a certain degree a member of a profession (Robb 1900, p. 37).

Most of the pre-1965 ethics literature touches upon remuneration and work conditions, particularly for students staffing hospitals, as well as for graduate nurses. Pay was asserted to be inadequate and neither commensurate with education, particularly as education advanced into colleges, nor commensurate with that of a profession. Work conditions were also of concern for their long hours, patient load, split shifts, and more. In addition, it was noted that nursing students were overworked leading to illness and overworked in ways that prevented learning. Hospitals, nurses, and nursing students had heretofore been exempt from labor law; adequate remuneration would require being brought under labor laws, Workers' Compensation (for work-related disability), and Social Security (a form of retirement funding).

Nurses were divided over the conceptualization of the nurse as a professional versus a laborer. They were also split over the means by which nursing salaries might be made to reflect the knowledge, skill, and education of nurses and the means by which work conditions might be changed for the welfare of both the patient and the nurse. This, like all of nursing history, is a complicated issue as it relates to broader social changes, the increasing scientization of medicine, the movement toward hospital care, the advent of hospitalization insurance, the enlarging middle-class and their utilization of hospitals, the advance of nursing education and practice, as well as changes in the sociocultural views of women and women's work.

The ethical literature, throughout, discusses issues of compensation and work conditions and views both individual nurses and professional associations as having a role in securing the economic and general welfare of the nurse. Furthermore, under the rubric of ethical duties to one's self, the literature discusses savings, retirement, and securing one's economic well-being. The code of ethics also enjoins nurses to work for just compensation and humane and adequate work conditions conducive to high-quality nursing care. The second provision of the 1950 code states: "The nurse has an obligation to give conscientious service and in return is entitled to just remuneration" (ANA 1950). By 1960 two provisions are devoted to remuneration and working conditions:

> 7. The nurse participates responsibly in defining and upholding standards of professional practice and education.
>
> 10. The nurse, acting through the professional organisation, participates responsibly in establishing terms and conditions of employment (ANA 1968).

This is modified in 1968 to read:

> 7. The nurse participates in the efforts of the profession to define and upgrade standards of nursing practice and education.
>
> 8. The nurse, acting through the professional organisation, participates in establishing and maintaining conditions of employment conducive to high-quality nursing care (ANA, 1968).

By 2015, the provision, which has an extended interpretive statement, reads:

> Provision 6: The nurse, through individual and collective effort, establishes, maintains, and improves the moral environment of the work setting and conditions of employment that are conducive to safe, quality health care (ANA 2015).

The modifications increasingly expand from a basic concern for the concrete, economic welfare of the nurse and nursing work conditions, to a wider concern for the broader moral and structural environment in which nursing care takes place.

The code of ethics in its successive iterations gives evidence of the persistent and unresolved nature of the concerns of nursing across 100 years of women's/nursing's history. Nursing today continues to face many of the same issues that it encountered in the late 1800s and early 1900s. Issues of just remuneration, authority over practice, the "invisibility" of nursing work, and the structural power and authority of nurses, are some of the enduring issues and they underline the need for radical reform informed by feminist perspectives (see chapters in this book by Campbell, Kohlen, Ceci, Peter and Liaschenko).

## 9 Conclusion

The battles and disabilities of the social location of women have informed and affected the shape of nursing ethics and are in evidence throughout the nursing ethics heritage literature and the Code of Ethics in the past as well as today. As outlined in the previous sections, nursing's heritage ethical literature, from the 1800s to 1965, is comprehensive and wide-ranging. Thematically, it is a virtue-based ethics that regards nursing education as both scientific and moral, and is explicated around nursing relationships to which various ethical duties inhere. Like the code of ethics, it is formulated by the nursing-leadership elite. These nursing leaders sought to create a modern, scientific, educated, women's profession of nursing.

Barbara Melosh sees nursing as offering an "illuminating example of the ways in which gender informs work, and conversely, how work both reproduces and transforms existing relationships of power and inequality" (Melosh 1982). She writes that

> On the one hand, professional aspirations empowered nurses, pushing them beyond the confines of domestic ideology into new possibilities of the labor market. Leaders brought a certain realism and vitality to the problems of nursing[...]they refused limiting conventions of gender in their own lives and in their goals for nursing as an occupation. Although most nursing leaders did not identify themselves as feminists, their commitment to work and their efforts to claim professional privileges did implicitly challenge and unsettle traditional constraints on women in the workforce (Melosh 1982).

Both the aims of the nursing leadership and the needs of the nurse in direct patient care come together and find their way into the early nursing ethical literature and the code of ethics. These aims and needs have a continued presence in today's ethical literature and code of ethics. For all of nursing's gains and the increasing percentage of men in nursing, the social location of women and nurses-as-women continues to affect the ethics of the profession. However, despite the profession's inability to fully control its destiny, D'Antonio writes:

> When we look at the history of practice, we see much evidence of strength, purpose, and successful political action. [...]We do not deny some historical circumstances of marginalization, invisibility, and gender biases. They existed and still do. [...][yet] [a] small group of individuals transformed the most traditional of gender expectations—that of caring for the sick—into respected and respectable work. [...] [N]urses' power comes not only from their work at the bedside, but also as actors in larger social and political arenas. (D'Antonio 2010a, pp. 207–208, 212).

Structural impediments to the advance of nursing practice, education, and research have existed from the earliest days of modern nursing. They are rooted in the gender inequality that attaches to the social location of nurses-as-women. They have included, to name but a few, cultural and physician opposition to women's education, social devaluing of caring work of women, the hiddenness of women's work, obstructions to women's participation in the public and political spheres, failure to codify gender and pay equity in law, formal exclusion and denial of recognition of women's contributions to science, and more. These enduring issues make their way into the profession's ethical discourse and codes of ethics. For nursing, the hallmark of success will be that these issues and concerns are so firmly resolved, as to no longer appear in the code of ethics.

**Note**: The gender-specific language of the quotes is left as originally written. In addition, it is customary to obscure female authorship through the use of initials in place of a given name. That practice is not followed herein.

## References

Aikens, Charlotte A. 1916. *Studies in Ethics for Nurses*. 1st ed. Philadelphia: WB Saunders.

American Nurses Association. 1926. A suggested code. *The American Journal of Nursing* 26 (8): 599–601.

———. 1940. Tentative code. *American Journal of Nursing* 40 (9): 977–980.

———. 1950. *Code for Nurses*. New York: ANA.

———. 1960. *Code for Professional Nurses*. New York: ANA.

———. 1968. *Code for Professional Nurses*. New York: ANA.

———. 2015. *Code of Ethics for Nurses with Interpretive Statements*. New York: ANA.

American Society of Superintendents of Training Schools for Nurses. 1896. *Convention of Training School Alumnae Delegates and Representatives from the American Society of Superintendents of Training Schools for Nurses, proceedings of the Convention, 2–4 Nov*, 1896. Harrisburg, PA: Harrisburg Publishing Company.

Bullough, Vern, Lilli Sentz, and Alice Stein. 1992. *American Nursing: A Biographical Dictionary, Volume 2*. New York: Garland Publishing.

Committee on Ethical Standards, American Nurses Association. 1924. *Minutes of the Meeting of June 28, 1924*. New York: ANA.

———. 1934. *Minutes of the Meeting of December 31, 1934*, 2. New York: ANA.

D'Antonio, Patricia. 2010a. Nurses and physicians in nineteenth century Philadelphia. In *American Nursing: A History of Knowledge, Authority, and the Meaning of Work*, ed. P. D'Antonio, 13–27. Baltimore: Johns Hopkins University Press.

———. 2010b. Nurses and physicians in nineteenth century Philadelphia. In *American Nursing: A History of Knowledge, Authority, and the Meaning of Work*, ed. P. D'Antonio, 13–27. Baltimore: Johns Hopkins University Press.

Dock, Lavinia L. 1910. Forced feeding of political prisoners. *The American Journal of Nursing* 10 (8): 593–594.

———. 1913. The Status of the Nurse in the Working World. In "Proceedings of the sixteenth annual convention of the American Nurses' Association". *American Journal of Nursing 13 (9)*: *971*.

Fagin, Claire, and Donna Diers. 2000. Nursing as metaphor. In *Essays on Nursing Leadership*, ed. C. Fagin, 31–34. New York: Springer.

Flood, Marilyn E. (1981). *The Troubling Expedient: General Staff Nursing in United States' Hospitals in the 1930s*. PhD diss., University of California at Berkeley.

Fowler, Marsha D.M. 2016. Heritage ethics: Toward a thicker account of nursing ethics. *Nursing Ethics* 23 (1): 7–21.

Fowler, Marsha D. 2017. Why the history of nursing ethics matters. *Nursing Ethics* 24 (3): 292–304.

Fry, Sara. 1989. The role of caring in a theory of nursing ethics. *Hypatia.* 4 (2): 87–103.

Garofalo, Mary E., and Elizabeth Fee. 2015. Lavinia Dock (1858–1956): Picketing, parading, and protesting. *American Journal of Public Health* 105 (2): 276–277.

Harvey, Sheridan. (2001). Marching for the vote: Remembering the woman suffrage parade of 1913. Library of Congress, American Memory, American Women. Retrieved from https://memory.loc.gov/ammem/ awhhtml/aw01e/aw01e.html .

HCC. 1889. The ethics of nursing: Talks of a Superintendent with her graduating class. *The Trained Nurse* 2 (5): 179–183. The author's name (Harriet C. Camp) is not given.

Jamieson, Elizabeth, and Mary Sewell. 1944. *Trends in Nursing History*. 2nd ed. New York: WB Saunders.

Melosh, Barbara. 1982. *The Physician's Hand: Work Culture and Conflict in American Nursing*. Philadelphia: Temple University.

Mollett, Wilhelmina Jane. 1888a. Honour. *The Nursing Record* 1 (4): 40–41.

———. 1888b. Purity. *The Nursing Record* 1 (5): 54–55.

———. 1888c. Courage. *The Nursing Record* 1 (7): 76–78.

———. 1888d. Discipline. *The Nursing Record* 1 (9): 99–101.

———. 1888e. Culture. *The Nursing Record* 1 (11): 125–127.

———. 1888f. Sympathy. *The Nursing Record* 1 (16): 192–193.

Parsons, Sara E. 1916. *Nursing Problems and Obligations*. Boston: Whitcomb and Barrows.

Reid, Charles J., Jr. 2013. The journey to Seneca Falls: Mary Wollstonecraft, Elizabeth Cady Stanton and the legal emancipation of women. *University of St. Thomas Law Journal 19* (4): 1123–1183. Retrieved from http://ir.st-thomas.edu/cgi/viewcontent.cgi?article=1337&context=ustlj.

Reverby, Susan. 1987. *Ordered to Care: The Dilemma of American Nursing, 1950–1945*. New York: Cambridge University Press.

Robb, Isabel Adams Hampton. 1900. *Nursing Ethics: For Hospital and Private Use*. New York: E.C. Koeckert.

Sheahan, Dorothy. (1979). *The Social Origins of American Nursing and its Movement into the University: A Microscopic Approach*. PhD Diss. New York: New York University.

———. 1980. *The Social Origins of American Nursing and its Movement into the University*. New York: New York University.

Sullivan, William M., and Lee S. Shulman. 2004. *Work and Integrity: The Crisis and Promise of Professionalism in America: The Carnegie Foundation for the Advancement of Teaching*. 2nd ed. San Francisco: Jossey-Bass Inc.

Tally, Charlotte. 1925. *Ethics: A Text-Book for Nurses*. New York: GP Putnam.

# An Evolution of Feminist Thought in Nursing Ethics

Elizabeth Peter and Joan Liaschenko

## 1 Introduction

The use of feminist ethics in nursing has at least a 30-year history. The use of this school of ethical thought has influenced the development of nursing and midwifery ethics, particularly through the development of ethical concepts. These have helped not only to make visible the types of ethical concerns nurses and midwives face, but have provided insights as to how nurses and midwives can improve practice to enhance the well-being of patients, the public, and also nursing/midwifery itself. In this chapter, we examine the contributions of nurses and midwives who have used feminist ethics in their scholarship, recognizing that we are presenting an incomplete account. Given space limitations, we do not describe the contributions of philosophers who have made use of feminist ethics or others, including nurses, who have brought insights from feminist epistemology to nursing scholarship.

Specifically, we begin by highlighting the early scholarship in nursing ethics that began to explore the possible strengths and limitations of using the ethic of care, as articulated by Gilligan (1982) and Noddings (1984), and then turn to the transition to feminist ethics, which attracted nursing scholars because of its sensitivity to the relevance of power to ethics. We next explore developments in nursing ethics that build on the importance feminists place on relationships in ethics which have added richness to our knowledge of nursing work, especially the nurse-patient relationship and the significance of family relationships on the experience of illness. In particular, we analyze the use of feminist approaches in the ethics of midwifery and

---

E. Peter (✉)
Lawrence S. Bloomberg Faculty of Nursing and Joint Centre for Bioethics, University of Toronto, Toronto, ON, Canada
e-mail: elizabeth.peter@utoronto.ca

J. Liaschenko
Center for Bioethics and School of Nursing, University of Minnesota, Minneapolis, MN, USA
e-mail: jliasch@umn.edu

H. Kohlen, J. McCarthy (eds.), *Nursing Ethics: Feminist Perspectives*,
https://doi.org/10.1007/978-3-030-49104-8_2

perinatal nursing which have influenced the development of women-centred practices that highlight the significance of relationships. Lastly, we outline the impact of exploring context in nursing ethics and the contribution of the concept of moral habitability (Walker 1998). Overall, feminist ethics has had an impact on nursing and midwifery ethics, albeit modest, providing a lens to a broad range of ethical phenomena and issues.

## 2 Early Work

Feminist ethics, while not a unified perspective, tends to share two major common features and assumptions. First, it builds on an ontological understanding of persons as connected, interdependent, uniquely situated, and both rational and emotional, as opposed to one that characterizes persons as autonomous, independent, rational, and unencumbered. This sense of personhood has its roots in the work of Gilligan (1982) and Noddings (1984) who articulated an ethic of care in the 1980s as an alternative perspective to mainstream principle-based ethics. They focused on the fundamental nature of ethical responsibilities we have to each other through our deep connections of care and responsibility. One of the first to comment on the relevance of Gilligan and Nodding's work as an appropriate approach for nursing ethics was Fry (1989) who stated, "the value foundations of nursing ethics are located within the existential phenomenon of human caring within the nurse/patient relationship instead of in models of patient good or rights-based notions of autonomy as articulated in prominent theories of medical ethics" (p. 88). Later, the potential of Gilligan and Noddings' work to inform nursing ethics was explored by authors such as Gallagher (1995), Lützen (1997), and Peter and Gallop (1994) who also considered the strengths and limitations of principles, the importance of context, and the influence of gender in their early explorations of the relevance of an ethic of care for nursing.

The second characteristic of feminist ethics grew out of concerns expressed regarding the ethic of care, leading to a significant turn in feminist ethics scholarship. Moral philosophers, such as Tronto ( 1993) and Card (1990), recognized that while an ethic of care may describe the moral orientation of many, particularly women, it has limitations. Without attention to justice and politics, relationships of care can be exploitative and overly partial because they can be too focused on immediate 'others' to the exclusion of broader concerns of care. These relationships can also exploit caregiving through the devaluation and lack of sufficient recognition of care. As a consequence of these concerns, Sherwin (1992) has called ethical approaches that only describe the moral orientation of women, such as an ethic of care, "feminine ethics," as opposed to "feminist ethics." To be considered feminist, an ethic must be political and attend to power and oppression. In doing so, many feminists focus on the moral-social context and particulars of ethically relevant phenomena.

We became drawn to feminist ethics ourselves as a means to situate nursing's ethical concerns within a political framework that takes into account how persons are situated as a result of race, class, profession, gender, and so on. As practitioners, educators, and scholars in nursing, we had frequently experienced a disjuncture between mainstream principle-based bioethics and our sense of what mattered most ethically and what had the potential to facilitate change. Since our doctoral work, we have used feminist ethics not only in our shared scholarship, but also with our students and other projects.

During her doctoral studies, Liaschenko (1993) wrote "Feminist Ethics and Cultural Ethos: Revisiting a Nursing Debate" which was published in *Advances in Nursing Science* in 1993 arguing that a feminist ethic is necessary to attend to the social and institutional form of life in which the work of nursing exists. This explicit introduction of feminist ethics to nursing built on the well-known work of Davis and Aroskar (1978) and Yarling and McElmurray (1986) who argued that nurses are not free to practise nursing in a way that is consistent with their professional and moral standards because they have conflicting responsibilities to patients and those who are more powerful, such as physicians, administrators, and employers.

Similarly, during Peter's doctoral studies, she became acquainted with Baier's (1986) publications exploring the phenomenon of trust that built on Gilligan's (1982) ethic of care, but did so in a fashion that revealed the potential for oppression in trust relationships. This led to the publication (Peter and Morgan 2001) of "Explorations of a Trust Approach for Nursing Ethics" in *Nursing Inquiry* in 2001 which also argued for nursing ethics to adopt a feminist approach to better conceptualize nurse-patient relationships in a way that recognizes the role of power. Other authors at that time, such as Crigger (1997), Rafael (1996), and Cloyes (2002), also drew attention to the limitations of care approaches for nursing and the need to politicize care to avoid the exploitation of caregivers, including nurses. Crigger (1997) aptly concluded that the "advancement of a caring paradigm and an ethic of care is possible if nurse scholars are willing to suspend their own partiality toward a caring paradigm and to objectively examine the criticisms" (p. 221).

These early theorists in this area demonstrated that nursing ethics could draw on ethical theory in a way that both reflected and helped articulate the moral lives of nurses while offering a perspective that could attend to power. As theorizing continued, more emphasis also began to be placed on the potential for nurses to be powerful themselves, thereby recognizing that power is not always oppressive. In part, this was accomplished by bringing the work of Foucault together with feminist ethics. While nurses have often been characterized as powerless, Lunardi et al. (2002) argued that nurses can and do exercise power through their actions and inactions, having implications for their patients and themselves. They also maintained that feminist ethics, because of its underlying assumptions regarding the potential for transformation, could be of assistance in deconstructing stereotypes of nurses to reconceptualize nursing and to promote new health and healthcare agendas.

Likewise, Peter et al. (2004a), using feminist ethics and Foucauldian concepts, identified the constructive nature of power and the importance of nurses' acts of resistance that function as ethical action. Through a review of the literature, they concluded that when nurses, as a result of their moral stance, refused to participate, acted as patient advocates, or engaged in verbal disputes, they exercised their power.

These actions were at times successful in leading to the resolution of conflict, but at other times led to different forms of punishment, such as the loss of employment. There were also many instances, however, of nurses being submissive. The significance of this publication stems from the recognition that feminist ethics can inform how nurses can effectively resist, which might lessen the likelihood of submissiveness. While the acquisition of negotiation and political action skills can be essential, it is necessary that nurses also receive institutional support to ensure that their ethical actions are not thwarted.

## 3 Centrality of Relationships

Traditionally the nurse-patient relationship has been viewed as the moral cornerstone of nursing (Yarling and McElmurry 1986). Given the relational ontology that is a core characteristic of feminist ethics, it is not surprising that nurses have found feminist ethics to be highly relevant when explicating the moral responsibilities and concerns that they have in their relationships with patients and families across various nursing specialty areas. For instance, Liaschenko (1997) argued for considering the nurse-patient relationship as a kind of geography. In so doing, she demonstrated the moral harm that can accrue to both patients and nurses by virtue of the social space they occupy. Relationships are "constituted by the relative positions that entities hold in a given set of circumstances" (p. 46) and these range from the local and intimate to the impersonal and structural. For Liaschenko (1997), relationship is "a place from which one acts and is acted upon, a place seen as socially, complexly determined by structural factors" (p. 48), what feminist geographer, Massey (1991) calls "power geometry" (p. 25). In her study, nurses identified poverty, exploitation of patients to meet institutional needs, homogenization of identity, and fragmentation of care as the moral problems that occur because of the social space patients occupy. The space that nurses occupy is gendered, and this led to participants identifying three issues as moral problems for them: the invisibility of nursing work, the instrumentality of nursing work, that is, the moral problems that occur because nursing stands in an instrumental relation to the ends of medicine, and finally, relations with other nurses. The latter is largely the result of the fact that conflict at the top of a social group is deflected downwards within power structures so that groups who are oppressed tend to oppress their own group members.

In the area of mental health nursing, Rose (2005), Rose et al. (2011), and Lago et al. (2017) have further developed the concepts of respect and trust in the relationship between mental health nurses and their patients. Because these patients can often lack liberty and rationality as they are usually understood, Kantian notions of autonomy can imply that these patients should be given the status of nonpersons (Rose 2005). A feminist conception of relational autonomy avoids this problem and can foster respect for patient autonomy because of its attention to the context of autonomy and the role of related others who have the capacity to strengthen and diminish autonomy.

Later, Rose et al. (2011) empirically examined how respect is understood and enacted by forensic psychiatric nurses by using Dillon's (1992) concept of care respect. Care respect demands a cherishing attitude in which attention and appreciation are expressed for the particularities of persons and requires that persons are understood in their own terms and that responsibility for the promotion of persons' well-being is demonstrated. The results of this study indicated that nurses have difficulty demonstrating care respect and instead often express a detached form of respect that is Kantian in nature, unless patients demonstrate remorse or motivation. With the insights that Dillon's (1992) perspective made possible, the challenges that nurses experience in forensic psychiatry were made visible in a fashion that had not been possible previously, revealing nurses' attitude that respect is linked to persons' capacity to take responsibility for their actions. Similarly, Bjorklund's (2006) critical review of the social organization of responsibility emphasizes that a feminist understanding of moral responsibility recognizes that a person must experience worthiness and inclusion in a moral community. Too often people with mental illnesses experience invisibility, which fosters irresponsibility. Taken together, these authors reveal that respect in nursing relationships is a product of relationships and communities which are often lacking for people with severe mental illnesses.

Others have focused on nursing relationships in practice settings where technology, long-term illnesses, and end-of-life care are commonplace. O'Keefe-McCarthy (2009) has argued that technology has inserted itself into nurse-patient relationships, resulting in a distance that situates nurses as powerful epistemic authorities and limits their moral agency when they are uncritical of the omnipresent technology surrounding them. Ferrell (2005), Ramvi and Ueland (2019), Dreyer and Strom (2019), Jacobs (2018), Mohammed and Peter (2009), Peter et al. (2014, 2015), and Killackey et al. (2020), building on feminist interpretations of moral responsibility, compassion, autonomy, and hope, locate the experience of illness squarely within the network of relationships that surround people who are in need of care. They underscore the influence of family and the healthcare team in shaping the illness experience, including the use of "futile" life-sustaining interventions. The analysis of ethical dimensions of these social influences has greatly benefited from feminist ethics as a result of greater attention being given to those who surround patients and the unique particularities of each of their experiences.

Ramvi and Ueland (2019) broadened their analysis by also examining the relationships among nurses and the next of kin of dying patients. While nurses mainly described these relationships as positive, with next of kin acting as an important resource to patients and themselves, they also reported a number of challenges that restricted them from being able to follow their professional ideals. For example, at times nurses were unable to influence care decisions because of the pressure to often prolong the life of their loved ones even when they would have preferred to die in peace. They concluded that "nurses' moral identity may be threatened by the feeling that their care expertise is not valued by next of kin and also by not being recognized as doing good" (p. 208).

A number of nursing authors have also found the work of Tronto (1993) to be especially helpful in broadening the lens of nursing ethics to consider the social and political forces that enable and restrict caregiving relationships. Gallagher (2014) highlighted Tronto's (1993) six key concepts: power, politics, particularism, pluralism, purpose, and practice. She spoke of how nursing ethics can benefit by considering these in order to address inequalities, the impact of politics on care, the individuality of patients, the diversity of cultural perspectives, and the meaning and purpose of caregiving (Gallagher 2014). Similarly, in her study on the participation of nurses in hospital ethics committees, Kohlen (2009) revealed how caring issues are sidelined and dismissed when using a principle-based model that is decontextualized from the everyday practices. She offered a feminist care perspective based on Tronto's (1993) key concepts which would give space to thematize nurses' issues of care.

Woods (2014), Rankin and Campbell (2014), and Peter and Liaschenko (2014) have also drawn on Tronto's (1993) work to examine the impact of current sociopolitical contexts of health care, characterized by neoliberalism and fiscal restraints, in a fashion that moves their analyses away from a focus on individuals to deeper system-level problems. Woods (2014) stresses the need for social justice and cultural safety to bring about socially inclusive nursing practice to shift nurses' power to patients, arguing for a socio-ethical approach that "offers a close connection between a relational ethic of care and social justice" (p. 108). Rankin and Campbell (2014) discuss how the technologies of nurses' work are organized in hospitals that limit nurse's capacity to engage in caring work, and Peter and Liaschenko (2014) identify social policies that are eroding care and caregiving in society. Collectively, these publications, inspired by Tronto (1993), enable a vision for nursing ethics that may begin with an understanding of the importance of proximal relationships with patients in hospitals or community, but recognizes that caring work and caring relationships are only possible in sociopolitical contexts that foster them.

## 4 The Ethics of Midwifery and Perinatal Nursing

Not surprisingly, given the force of women's health movements internationally to demedicalize childbirth, feminist ethics has been used successfully to guide both midwifery and perinatal nursing work. For example, Thompson (2002) has argued that professional codes, which are generally based on abstract principles, are not adequate for a woman-centred approach because they do not focus enough on ethical engagement. Instead, they focus on what is right and wrong. Because codes capture neither the particularity of situations nor the moral agency of those involved, she advocates for the use of feminist ethics, stating, "the aim and, in some instances, the lived reality, of midwifery at the micro level is that of partnership not patient, friendship not unknown expert within the hospital system, and individual persons 'within' relationships not the powerful professional body with elite knowledge practicing on the respectful powerless" (Thompson 2002, p. 531). Similarly, MacLellan (2014) endorses an "Ethic of Care" for midwifery in order to retain its unique identity given midwives' identification with the social model of birth as opposed to the medical model. MacLellan (2014) also describes the core element of practice as the relationship among midwives, women, and birthing partners so that the experience of birth does not become dehumanized and women's expectations can be met. Feminist ethics has been especially valuable for midwifery as it is possible to articulate a relational approach to midwifery that is more consistent with its core values and practices, unlike principle-based bioethics and traditional codes of ethics.

A number of other leaders in ethics in perinatal nursing care have also emphasized the centrality of relationships and the benefits of feminist ethics in this regard. For example, Simmonds' (Simmonds et al. 2013; Simmonds and Peter 2007; Simmonds 2008) research, which has used the work of Walker (1998), has offered a more nuanced portrayal of the relationship of nurses with childbearing women. While advocating for women and fostering their autonomy are clearly the moral responsibilities of nurses, these are enacted within a political context that can influence nurses' capacity to enact them. Personal and professional beliefs of nurses can have an impact, especially if their beliefs and fears about the safety of birth override women's goals and ultimately result in the manifestation of control over women (Simmonds et al. 2013). Institutions may also impede a nurse's advocacy efforts if policy mandates particular care practices that interfere with women's goals for labor and birth. Yet, Simmonds and Peter (2007) argue that nurses still have a moral responsibility to advocate in some way, such as changing policy or being active in a professional organization, as these forms of advocacy can result in eventual change. In other words, advocacy can take the form of renegotiating the moral-social orders of institutionalized birthing settings (Simmonds 2008), and the particularities of any given situation require attention (Simmonds and Peter 2007).

Also building on feminists' conception of the relational self, Catlin (2005) offers the novel recommendation of encouraging prenatal advance directives for women and their partners to prepare them for the possibility of giving birth to an infant who is extremely premature. Parents are generally in a crisis and unprepared to make decisions regarding life-supporting interventions for their preterm infants. While most commonly these types of decisions are guided by the concept of the best interests of the infant only, she suggests that a woman considers the birth of a premature infant while she is pregnant so that she can consider the entire context of her life, the infant's life, and those of her other loved ones. In this way, the relational ontology of feminist ethics makes possible a rethinking of the best interests of the infant to consider the entire family. This kind of conceptual shift can result in better ways for nurses to support women prenatally.

## 5 Importance of Context

Feminist ethics has also made possible a rich articulation of the ethical significance of the context of nursing practice across many settings, including that of the institution. Without this theorization, the term "context" can be rather vague and its more nuanced character and influence can be invisible. From a feminist perspective, context specifies the particulars of the social and political. For example, Walker (1998) states that morality is “a socially embodied medium of mutual understandings and negotiation between people over their responsibility for things open to human care and response” (p. 9). In other words, morality is not socially modular, because it is a dimension of everyday social life and cannot be stripped from all of the facets of social life that establish social roles and responsibilities. The social aspect is also marked by shifting power differences and the particulars of people’s identities that play a role in how practices of responsibility are negotiated (Walker 1998).

Especially noteworthy are the number of insights into the moral nature of nursing work and nursing work environments that feminist ethics has supported. For example, Walker’s (1998) notion of the social nature of moral responsibility has facilitated the identification of the inadequacies of conceptualizing nursing strictly as a profession, given the moral challenges nurses face in modern complex work environments. The characteristics that have socially defined professionals, including the possession of a unique body of knowledge, the delivery of an altruistic service to the public, and occupational autonomy in terms of having control over one’s work and working conditions, do not fully reflect current healthcare work. The ethics associated with this notion of professionalism tends to restrict what counts as a moral problem and who has the authority to address it. Instead, “an ethics of work would see morality as practices of responsibility that are context-specific and continually renegotiated” (Liaschenko and Peter 2004, p. 494).

Similarly, Walker’s (1998) concept of moral habitability has also had significant impact. Walker (1998) maintains that moral-social orders, such as nursing work environments, must be made transparent to assess their moral habitability from the vantage points of differentially situated people. Morally habitable environments foster recognition, cooperation, and shared benefits and people existing in them must experience their responsibilities as intelligible and coherent. This theorizing helped to identify and understand the impact of health restructuring, with its reduction in staffing and focus on efficiencies, on the moral habitability of the work environments of nurses. Nurses’ positioning in the healthcare system has created the vulnerability of being overburdened and unclear of their moral responsibilities (Peter et al. 2004b; Liaschenko 2010), although clearly nurses are not the only healthcare workers experiencing moral constraints (Peter and Liaschenko 2013; McCarthy and Deady 2008). The use of Walker’s (1998) work, however, made possible a nuanced recognition of nurses’ moral resistance and influence over their work environments (Peter et al. 2004b) in a fashion that could avoid casting nurses as powerless.

Austin (2007), drawing on the work of Walker (1998), further developed the notion of the moral habitability of nursing work environments by arguing for the need to develop moral communities that enhance the moral agency of nurses. Because this agency is relational, dialogical, and contextual, traditional principle-based approaches to bioethics that are based on impartiality and objectivity are not adequate for nursing ethics according to Austin (2007). Consequently, she recommends that attention be given to institutional factors that shape ethical dialogue and practice. This dialogue can enhance healthcare environments to become moral communities in which not only highly publicized medical issues can be attended to, but also the everyday issues such as interdisciplinary conflict and systemic problems can be addressed.

Vanderheide et al. (2013) also continued to develop the concept of moral habitability by creating a framework to illustrate a number of related sub-concepts. Through an integrative literature review of publications related to nursing environments and moral climate, they identified relationships among a number of related concepts, such as moral climate, moral community, moral identity, moral distress, moral sensitivity, moral agency, and moral integrity to moral habitability. They recognized that many of these terms have varying and ambiguous definitions leading to limitations in the research conducted using them. By bringing together a number of important concepts in nursing under the umbrella of Walker's (1998) conceptualization of moral habitability, they were able to begin to bring additional clarity to this area of nursing research. They concluded that "conceptually mapping and synthesizing the literature related to moral habitability suggests a focus that encompasses the environment, the individual participant within the environment, their capacity to adapt and how the environment impinges upon the individual" (Vanderheide et al. 2013, p. 111).

We also wrote two manuscripts (Peter and Liaschenko 2013; Liaschenko and Peter 2016) that used the work of Walker (1998) along with that of Lindemann (2001) to further develop the concept of nurses' moral identity, linking it to moral agency and moral distress to offer recommendations to foster moral agency and moral community in healthcare organizations. Of particular importance in our writing was Lindemann's notion of a master narrative which aided in our explication of the impact of healthcare institutions on the moral agency of all of their inhabitants. A master narrative represents a dominant portrayal of a social group that works as a snapshot of shared social beliefs of the characteristics and expectations of that group. For example, Lindemann (2001) suggested that nurses have been portrayed as overly touchy-feely which is a stereotype of the inferiority of women. This form of master narrative depicts nurses as being emotional, but not capable of reason. Master narratives can be very destructive to the moral identities of group members when they are portrayed as substandard socially or morally. Counternarratives, on the other hand, can be one way for groups with damaged identities, such as nurses, to work on altering their collective identity, thereby increasing their positive moral influence. We argued that "nurses, themselves, and others need to see nurses as morally and epistemically trustworthy for the repair of their moral identities to occur. Counterstories are needed that portray nurses as skilled caregivers with serious responsibilities that require knowledge, skill, and virtue" (Peter and Liaschenko 2013, p. 343).

## 6 Conclusion

Feminist ethics has inspired numerous conceptual, normative, and empirical developments in nursing and midwifery ethics. Importantly, scholars have adopted, even if not deliberately, an approach to ethics that represents a feminist equilibrium which endorses a process in which theoretical and practical endeavours are not distinct. By conducting empirical work that has been informed by feminist ethics, they have brought theoretical insights to further the understanding of the everyday lives of patients, families, and nurses. At other times, they have brought these empirical findings to bear on theory, by furthering conceptual work in feminist ethics. In doing so, they have avoided what Sherwin (1996) has described as a "bifurcated ethics landscape" (p. 188) and have developed both practical and theoretical insights that have influenced the work of nurses, midwives, and other practitioners both in academia and in practice. Nevertheless, feminist ethics plays only a minor role in nursing ethics. Perhaps the next generation of nurses and midwives will be better able to demonstrate its relevance and its relationship to other more dominant perspectives in bioethics.

## References

Austin, Wendy. 2007. The ethics of everyday practice: Healthcare environments as moral communities. *Advances in Nursing Science* 30 (1): 81–88.

Baier, Annette. 1986. Trust and antitrust. *Ethics* 96: 231–260.

Bjorklund, Pamela. 2006. Taking responsibility: Toward an understanding of morality in practice: A critical review of the empirical and selected philosophical literature on the social organization of responsibility. *Advances in Nursing Science* 29 (2): E56–E73.

Card, Claudia. 1990. Caring and evil. *Hypatia* 5 (1): 101–108.

Catlin, Anita. 2005. Thinking outside the box: Prenatal care and the call for a prenatal advance directive. *Journal of Perinatal & Neonatal Nursing* 19 (2): 169–176.

Cloyes, Kristin G. 2002. Agonizing care: Care ethics, agonistic feminism and a political theory of care. *Nursing Inquiry* 9 (3): 203–214. https://doi.org/10.1046/j.1440-1800.2002.00147.x.

Crigger, Nancy J. 1997. The trouble with caring: A review of eight arguments against an ethic of care. *Journal of Professional Nursing* 13 (4): 217–222. https://doi.org/10.1016/S8755-7223(97)80091-9.

Davis, Anne J., and Mila Ann Aroskar. 1978. *Ethical Dilemmas and Nursing Practice*. New York: Appleton-Century-Crofts.

Dillon, Robin S. 1992. Respect and care: Toward moral integration. *Canadian Journal of Philosophy* 22 (1): 105–131.

Dreyer, Anne, and Anita Strom. 2019. Involving relatives in consultations for patients with long-term illnesses: Nurses and physicians' experiences. *Nursing Ethics* 26 (7-8): 2124–2134. https://doi.org/10.1177/0969733018819125.

Ferrell, Betty. 2005. Ethical perspectives on pain and suffering. *Pain Management Nursing* 6 (3): 83–90. https://doi.org/10.1016/j.pmn.2005.06.001.

Fry, Sara T. 1989. The role of caring in a theory of nursing ethics. *Hypatia* 4 (2): 89–103. https://doi.org/10.1111/j.1527-2001.1989.tb00575.x.

Gallagher, Ann. 1995. Medical and nursing ethics: Never the Twain? *Nursing Ethics* 2 (2): 95–102. https://doi.org/10.1177/096973309500200202.

———. 2014. Moral boundaries and nursing ethics. In *Moral Boundaries Redrawn: The Significance of Joan Tronto's Argument for Political Theory, Professional Ethics, and Care as Practice*, ed. Gert Olthuis, Helen Kohlen, and Jorma Heier, 133–149. Leuven: Peeters.

Gilligan, Carol. 1982. *In a Different Voice: Psychological Theory and Women's Development*. Cambridge: Harvard University Press.

Jacobs, Gaby. 2018. *Patient Autonomy in Home Care: Nurses' Relational Practices of Responsibility*. Vol. 26, 1638. Nursing Ethics. https://doi.org/10.1177/0969733018772070.

Killackey, Tieghan, Elizabeth Peter, Jane MacIver, and Shan Mohammed. 2020. Advance care planning for the chronically ill: The merits of a relational autonomy approach. *Nursing Ethics* 27 (2): 360–371. https://doi.org/10.1177/0969733019848031.

Kohlen, Helen. 2009. *Conflicts of Care: Hospital Ethics Committees in the USA and Germany*. Frankfurt: Campus Verlag GmbH.

Lago, Rozilaine R., Elizabeth Peter, and Cláudia Maria Bógus. 2017. Harm reduction and tensions in trust and distrust in a mental health service: A qualitative approach. *Substance Abuse Treatment, Prevention, and Policy* 12 (12): 12. https://doi.org/10.1186/s13011-017-0098-1.

Liaschenko, Joan. 1993. Feminist ethics and cultural ethos: Revisiting a nursing debate. *Advances in Nursing Science* 15 (4): 71–78.

———. 1997. Ethics and the geography of the nurse-patient relationship: Spatial vulnerability and gendered space. *Scholarly Inquiry for Nursing Practice* 11 (1): 45–63.

———. 2010. … To take one's place … and the right to have one's part matter. In *Bioethics, Care and Gender. Challenges for Medicine, Nursing and Politics*, ed. Harmut Remmers and Helen Kohlen, 35–42. Göttingen: V&R Unipress.

Liaschenko, Joan, and Elizabeth Peter. 2004. Nursing ethics and conceptualizations of nursing: Profession, practice and work. *Journal of Advanced Nursing* 46 (5): 488–495. https://doi.org/10.1111/j.1365-2648.2004.03011.x.

———. 2016. Fostering nurses' moral agency and moral identity: The importance of moral communities. *Hastings Center Report* 46 (5): S18–S21. https://doi.org/10.1002/hast.626.

Lindemann, Hilde Nelson. 2001. Identity and free agency. In *Feminists Doing Ethics*, ed. Peggy DesAutels and Joanne Waugh, 45–61. Lanham: Rowman and Littlefield Publishers.

Lunardi, Valeria Lerch, Elizabeth Peter, and Denise Gastaldo. 2002. Are submissive nurses ethical? Reflecting on power anorexia. *Revista Brasileira de Enfermagem* 55 (2): 183–188. https://doi.org/10.1590/S0034-71672002000200012.

Lützén, Kim. 1997. Nursing ethics into the next millennium: A context-sensitive approach for nursing ethics. *Nursing Ethics* 4 (3): 218–226. https://doi.org/10.1177/096973309700400306.

MacLellan, Jennifer. 2014. Claiming an ethic of care for midwifery. *Nursing Ethics* 21 (7): 803–811. https://doi.org/10.1177/0969733014534878.

Massey, Doreen. 1991. A global sense of place. Marxism Today: 24–29.

McCarthy, Joan, and Rick Deady. 2008. Moral distress reconsidered. *Nursing Ethics* 15 (2): 254–262. https://doi.org/10.1177/0969733007086023.

Mohammed, Shan, and Elizabeth Peter. 2009. Rituals, death, and the moral practice of medical futility. *Nursing Ethics* 16 (3): 292–302. https://doi.org/10.1177/0969733009102691.

Noddings, Nel. 1984. *Caring: A Feminine Approach to Ethics & Education*. Berkeley: University of California Press.

O'Keefe-McCarthy, Sheila. 2009. Technologically-mediated nursing care: The impact on moral agency. *Nursing Ethics* 16 (6): 786–796. https://doi.org/10.1177/0969733009343249.

Peter, Elizabeth, and Ruth Gallop. 1994. The ethic of care: A comparison of nursing and medical students. *Image: Journal of Nursing Scholarship* 26 (1): 47–52. https://doi.org/10.1111/j.1547-5069.1994.tb00293.x.

Peter, Elizabeth, and Joan Liaschenko. 2013. Moral distress re-examined: A feminist interpretation of nurses' identities, relationships and responsibilities. *Journal of Bioethical Inquiry* 10 (3): 337–345. https://doi.org/10.1007/s11673-013-9456-5.

———. 2014. Care and society/public policy. In *Bioethics*, ed. Bruce Jennings, vol. 2, 4th ed., 504–512. Farmington Hills: Macmillan Reference USA.

Peter, Elizabeth, and Kathryn Morgan. 2001. Explorations of a trust approach for nursing ethics. *Nursing Inquiry* 8 (1): 3–10. https://doi.org/10.1046/j.1440-1800.2001.00083.x.

Peter, Elizabeth, Valeria Lerch Lunardi, and Amy Macfarlane. 2004a. Nursing resistance as ethical action: Examining the possibilities & problems. *Journal of Advanced Nursing* 46 (4): 403–416. https://doi.org/10.1111/j.1365-2648.2004.03008.x.

Peter, Elizabeth, Amy Macfarlane, and Linda L. O'Brien-Pallas. 2004b. An analysis of the moral habitability of the nursing work environment. *Journal of Advanced Nursing* 47 (4): 356–364. https://doi.org/10.1111/j.1365-2648.2004.03113_1.x.

Peter, Elizabeth, Shan Mohammed, and Anne Simmonds. 2014. Narratives of aggressive care: Knowledge, time & responsibility. *Nursing Ethics* 21 (4): 461–472. https://doi.org/10.1177/0969733013502804.

———. 2015. Sustaining hope as a moral competency in the context of aggressive care. *Nursing Ethics* 22 (7): 743–753. https://doi.org/10.1177/0969733014549884.

Rafael, Adeline R. 1996. Power and caring: A dialectic in nursing. *Advances in Nursing Science* 19 (1): 3–17.

Ramvi, Ellen, and Venke Irene Ueland. 2019. Between the patient and the next of kin in end-of-life care: A critical study based on feminist theory. *Nursing Ethics* 26 (1): 201–211. https://doi.org/10.1177/0969733016688939.

Rankin, Janet, and Marie Campbell. 2014. Care and gender in nurses' institutionally organized work. In *Moral Boundaries Redrawn: The Significance of Joan Tronto's Argument for Political Theory, Professional Ethics, and Care as Practice*, ed. Gert Olthuis, Helen Kohlen, and Jorma Heier, 153–173. Leuven: Peeters.

Rose, Donald N. 2005. Respect for patient autonomy in forensic psychiatric nursing. *Journal of Forensic Nursing* 1 (1): 23–37.

Rose, Donald N., Elizabeth Peter, Jan Angus, Ruth Gallop, and Joan Liaschenko. 2011. Respect in forensic psychiatric nurse-patient relationships: A practical compromise. *Journal of Forensic Nursing* 7 (1): 3–16. https://doi.org/10.1111/j.1939-3938.2010.01090.x.

Sherwin, Susan. 1992. *No Longer Patient: Feminist Ethics & Health Care*. Philadelphia: Temple University Press.

———. 1996. Theory versus practice in ethics: A feminist perspective on justice in healthcare. In *Philosophical Perspectives in Bioethics*, ed. Wayne Sumner and Joseph Boyle, 187–209. Toronto: University of Toronto Press.

Simmonds, Anne H. 2008. Autonomy and advocacy in perinatal nursing practice. *Nursing Ethics* 15 (3): 360–370. https://doi.org/10.1177/0969733007088360.

Simmonds, Anne H., and Elizabeth Peter. 2007. Understanding the everyday moral practices of intrapartum nurses and midwives. *Canadian Journal Nursing Research* 39 (4): 116–129.

Simmonds, Anne H., Elizabeth Peter, Ellen D. Hodnett, and Linda McGillis Hall. 2013. Understanding the moral nature of intrapartum nursing. *Journal of Obstetric, Gynecologic & Neonatal Nursing* 42: 148–156. https://doi.org/10.1111/1552-6909.12016.

Thompson, Faye E. 2002. Moving from codes of ethics to ethical relationships for midwifery practice. *Nursing Ethics* 9 (5): 522–536. https://doi.org/10.1191/0969733002ne542oa.

Tronto, Joan C. 1993. *Moral Boundaries: A Political Argument for an Ethic of Care*. New York: Routledge.

Vanderheide, Rebecca, Cheryle Moss, and Susan Lee. 2013. Understanding moral habitability: A framework to enhance the quality of the clinical environment as a workplace. *Contemporary Nurse* 45 (1): 101–113. https://doi.org/10.5172/conu.2013.45.1.101.

Walker, Margaret Urban. 1998. *Moral Understandings: A Feminist Study in Ethics*. New York: Routledge.

Woods, Martin. 2014. Tronto's legacy: The socio-ethical practitioner in contemporary current socio-political contexts of health care. In *Moral Boundaries Redrawn: The Significance of Joan Tronto's Argument for Political Theory, Professional Ethics, and Care as Practice*, ed. Gert Olthuis, Helen Kohlen, and Jorma Heier, 93–111. Leuven: Peeters.

Yarling, Roland R., and Beverly J. McElmurry. 1986. The moral foundation of nursing. *Advances in Nursing Science* 8 (2): 63–73.

# Piecing Together a Puzzle: Feminist Materialist Philosophy and Nursing Ethics

Janice L. Thompson

## 1 Introduction

In her 2011 article, *Piecing Together a Genealogical Puzzle: Intersectionality and American Pragmatism*, Patricia Hill Collins (2011) presents a very helpful analysis of discourses in intersectionality and pragmatism. Her work, including the metaphor and method of "piecing together a genealogical puzzle"—has been an inspiration and I appreciatively borrow that metaphor of "piecing together" here. I have chosen to organize the experience of assembling this analysis as a process of working out/on a puzzle. In that approach, I'm explicitly remembering the imagery and process of feminist literary methods (Anderson 2017), i.e., "piecing together" or assembling work that is part of a greater whole. Here I hope to move toward something still not clear (to me) about nursing ethics, a hope for pattern recognition in a larger field of understanding that addresses moral agency and praxis in nursing.

To circle a feminist pragmatist/critical theory of nursing ethics, I move within and between some selected fields of work. At the outset and perimeter of this analysis, I review in broad stitch the work of feminist materialist philosopher Nancy Fraser. I privilege Fraser's analysis to create an opening, a discursive space. Within that opening, I explore key elements and implications of her critical pragmatist, materialist feminist philosophy, relating these to nursing ethics. I view Fraser's work as inviting a productive epistemic shift (not a rupture) in knowledge development for nursing ethics. That shift requires nurses to reconsider and engage/act on political-economic contexts of practice that are directly relevant to nursing ethics, taking into account the context of transnational corporate capitalism. Fraser's work helps with this by providing analysis of political-economic contexts that influence moral agency. I argue that her work has important relevance for nursing ethics.

---

J. L. Thompson (✉)
Faculty of Nursing, University of New Brunswick, Fredericton, New Brunswick, Canada
e-mail: jthomps@unb.ca

H. Kohlen, J. McCarthy (eds.), *Nursing Ethics: Feminist Perspectives*,
https://doi.org/10.1007/978-3-030-49104-8_3

After reviewing Fraser's work—I move to reflect on the complexity involved in engaging Fraser's analysis in nursing. I consider some reasons for why it may be both helpful and difficult to use Fraser's work in nursing ethics. This reflective bracketing includes some discussion of anti-socialist feminist ambivalence, tendencies Fraser identifies, that make it complicated for some nurse scholars to speak about nursing ethics using Fraser's analysis. I counter this with reflections on the history of a critical social ethic in nursing, also identifying the presence of contemporary discourses in nursing ethics that could point toward more alignment with Fraser's critical theory. That reflection considers how and why it may be productive at this moment to examine and use feminist materialist philosophy, as one approach (among others) that can support a critical nursing ethics.

Finally, I move on to piece together some connections between Fraser's work and different discourses of moral agency in nursing ethics. I first consider some connections between her philosophy and the ethics of care. I take up selected pieces of work from theorists of care in nursing along with selected examples of work from feminist care ethicists. The analysis suggests that a feminist ethics of care may be coherently consistent for some feminist commitments in nursing, yielding reflective equilibrium in some cases. As Fraser suggests, however, a feminist ethic of caring risks continuing a trend of mostly "post-socialist feminist" moral reasoning, evading the critique of capitalism. To address this, I suggest that a feminist ethics of care in nursing is productively deepened/strengthened by addressing intersections with Fraser's feminist materialist philosophy. The discussion next similarly considers discourses of the ethics of social justice in nursing. This analysis includes a brief discussion of some contemporary theoretical approaches for the ethics of social justice in nursing in Canada and the United States. While these approaches can be understood as consistent with a legacy ethics of social justice in nursing, they also are largely silent about capitalism, continuing a "post-socialist feminist" imaginary for moral agency around social justice. These discourses in nursing are viewed as being productively deepened and strengthened by addressing feminist materialist philosophy, as this is demonstrated in Fraser's work.

Given these opportunities for connections between nursing ethics and Fraser's critical theory, I conclude by commenting on some implications for a critical nursing ethics. I find the absence of a critique of capitalism in nursing ethics puzzling. To address this, I invite more dialogue about the emancipatory potential of using feminist materialist philosophy as one theoretical tool (among others) with relevance for a critical nursing ethics.

## 2 Nancy Fraser's Feminist Materialist Philosophy

U.S. critical theorist Nancy Fraser has worked carefully over three decades to articulate a complex and hopeful feminist ethics. In her moral and political philosophy, Fraser insists that gender matters in the struggles and wishes of our times—and that an adequate understanding of gender must be located historically and accurately within political-economic contexts of capitalism (Fraser 1985, 1989, 1990, 1995a, b, 1997, 2005, 2009, 2017; Fraser and Honneth 2003; Fraser and Jaeggi 2018; Fraser and Sunkara 2019; Arruzza et al. 2019). Feminist materialist leanings in her work insist that intersections of social, political, and economic relations under capitalism are deeply organizing, i.e., that capitalism contextually shapes phronesis/or ethical conceptions of what is right and what is good in our current age. This sensitivity to capitalism acknowledges that power relations (like sexism, racism, classism, heteronormativity, ableism, ageism) do intersect to produce institutionalized social practices in democracies. She argues that the intersections of class, race, and gender are best explained by locating them in the political-economic context of capitalism—with an adequate understanding of how capitalism operates.

> Unlike theories of intersectionality, which tend to be descriptive, focused on ways in which extant subject positions crosscut one another, my account is explanatory. Looking beyond those subject positions, to the social order that generates them, I identify the institutional mechanisms through which capitalist society produces gender, race and class as transecting axes of domination. (Fraser and Jaeggi 2018, p. 109)

Fraser's political philosophy is a critical theoretical approach, a strand of moral and political philosophy that focuses on how power is constituted and reproduced in capitalist democracies. While not agreeing fully with Marxist materialist philosophy, her work nevertheless does draw on materialist influences in critical theory. She emphasizes the effects of capitalism, focusing on relations that exist in capitalist modes of production and their influence. She also insists that gender matters deeply in how power relations are constituted under capitalism—thus providing a feminist materialist perspective. In this, she has challenged masculinist assumptions in critical theory (Fraser 1985, 1989) while also disagreeing with assumptions in the liberal feminist analysis (Fraser 1990, 1995a, b).

In the last decades of the twentieth century, Fraser (along with other feminist thinkers) was focused on political and moral questions about how best to correct gender injustice. An ally of women's liberation, she nevertheless challenged several assumptions present within second wave and radical feminist activism (Fraser 1995b). This included questioning the presumption of a unified, single, and common group-based identity among all women. Fraser argued that under capitalism, important differences exist between women, based on political-economic group identity as well as sociocultural group identities. She argued that gender injustices based in sociocultural group or political-economic group identity could not be effectively addressed in activism that superficially celebrates the common gender identity for all women. In her articulation of a feminist materialist alternative analysis, Fraser proposed the need to address gender injustices by tending to capitalism and the differentiated ways in which it operates. She specifically emphasized the need to consider sociocultural group-based identities among women, simultaneously accounting for their political-economic group-based identities. She emphasized that these two types of identity are associated with interests that do not synchronously align (Fraser 1995b).

To address gender justice, Fraser proposed three interrelated "scales" or components of social justice. She named these elements "moral recognition," "redistribution," and "representation" (Fraser 1995a, b, 1997, 2005, 2009, 2017; Fraser and Honneth 2003). The scale of moral recognition addresses institutionalized relations of status subordination. This element of justice corrects for status inequality. Moral recognition includes social practices of "empowerment" and related approaches that cultivate shared moral respect of persons as social, political, and cultural peers. Fraser also emphasizes that moral recognition focuses on institutionalized power relations, and as such, it contributes to full and equal political and social participation in democracies (i.e., what she terms *participatory parity*) (Fraser and Honneth 2003, p. 101 note 39).

The scale of redistribution addresses economic inequality. By focusing on institutionalized class relations in the political economy of capitalism, Fraser addresses injustices that reproduce economic disadvantage. In this element of her materialist feminist perspective, she describes economic redistribution as an important and necessary counterpart to moral recognition. Redistribution is described as a transformative practice, rather than an affirmative one. Fraser is especially concerned that under capitalism, the affirmative outcomes of moral recognition are not in themselves capable of correcting economic disadvantage. She argues that economic redistribution must be considered for how it aligns with or synergizes political efforts to achieve moral respect; also that redistribution must be considered for how it competes with, challenges or impedes prospects for moral recognition. Her analysis presents a more complex and differentiated understanding of how simultaneous remedies of moral recognition and redistribution are both needed (Fraser 1995a, b; Fraser and Honneth 2003).

Finally, concerning a third scale of justice, Fraser addressed the element of representation. Representation includes institutionalized symbolic practices that legitimate political participation among subordinated groups. These institutionalized practices include symbolic strategies of deconstruction needed to undo stereotypes, encourage political participation among members of subordinated groups, and achieving full parity in political representation (Fraser 1995b, p. 180; Fraser and Honneth 2003, pp. 73–88; Fraser 2005, p. 305). In considering representation, Fraser emphasizes that parity in political representation is complicated by an increasingly globalized world. The relevance of Fraser's complex analysis of gender justice becomes clear in nursing practice when considering contemporary challenges related to women's health in global contexts, refugee health, population health related to forced migration/immigration, human trafficking, and other transnational phenomena. Health equity in these contexts would require consideration of the dynamic reinforcing effects of moral respect, correcting for maldistribution, and parity in political representation.

This more complex transnational understanding of twenty-first-century capitalism is taken up in Fraser's later work, reflected for example in *Scales of Justice* (Fraser 2009) and *Capitalism: A Conversation* (Fraser and Jaeggi 2018). In these publications, Fraser traces a decline in the twentieth century of a Westphalian economic paradigm where autonomous corporations were regulated by individual sovereign nation-states. She also discusses the related decline and loss of the international Breton Woods Agreement which had temporarily stabilized post-WWII economies in Europe and the United States. In the second half of the twentieth century, those agreements were replaced with entities like the International Monetary Fund (IMF), the World Bank, central banks, and Trade-Related Intellectual Property Regimes (TRIPS), created to “govern” or regulate international/global trade.

Fraser explains that given the support of these entities, financialized global capitalist economic expansion has produced starkly different outcomes in the twenty-first century. She refers to this twenty-first-century reality as a new phase of capitalism, “financialized transnational corporate capitalism” (Fraser and Jaeggi 2018, pp. 75–77). Fraser insists that this new phase of capitalism has been accompanied by radical change in scales of justice. She points to growing challenges among many nation-states. These are defined by increasing popular unrest, also growing populist movements linking social and economic justice to transformative tasks of correcting economic maldistribution. Fraser cautions about diminishing capabilities among individual nation-states to adequately address these challenges within their own borders—given transnational financialized corporate arrangements. She also identifies steadily growing gaps in wealth, precarious economic conditions, predatory debt, and increasing political complexity as influencing the international emergence of conservative populist movements.

Most recently, Fraser coauthored three texts with analyses of current political and economic challenges relevant to this chapter (Fraser and Jaeggi 2018; Fraser and Sunkara 2019; Arruzza et al. 2019). In these texts, Fraser carries forward earlier analyses of social justice, but her work demonstrates an important and noticeable epistemic shift (Fraser and Jaeggi 2018, pp. 29–31). This shift depicts capitalism by metaphorically describing it, in part, as a “front story” of political-economic activity that is related to other necessary noneconomic backstories (Fraser and Jaeggi 2018, pp. 48–50). She analyzes how the front story of capitalism influences and is influenced by “backstories” that operate in interconnected ways to perpetuate the social relations and practices of capitalist political economies. Specifically, Fraser describes storied struggles as occurring in four spheres: Between (1) *production and social reproduction*; (2) between *polity and economy*; (3) between *human and nonhuman nature*; and (4) between *exploitation and expropriation.* Her critical theory suggests that capitalism is characterized at a system level by “inter-realm struggles” within, among, and between these four spheres of activity (Fraser and Jaeggi 2018, pp. 143–144). Her theory also suggests that understanding these struggles or “backstories” produces better explanations of the structural or root causes of capitalism’s oppressions.

In relation to struggles occurring between production versus social reproduction, Fraser explains that commodity production (wage labor) is not a stand-alone sphere of institutionalized economic relations. Rather, commodity production under capitalism emerged historically as institutionalized activity in social practices that were stereotypically gendered and male. Also historically, the sphere of activity involving social reproduction emerged under capitalism as an institutionalized realm of activity conforming to practices that were stereotypically gendered and female. Fraser describes the sphere of social reproduction as including all

> "forms of provisioning, care giving and interacting that produce and maintain social bonds. Variously called "care," affective labor," or subjectivation, this activity forms capitalism's human subjects, sustaining them as embodied, natural beings while also constituting them as social beings, forming their *habitus* and the socio-ethical substance in which they move. Central here is the work of socializing the young, building communities and producing reproducing the shared meanings, affective dispositions, and horizons of value that underpin social cooperation, including the forms of cooperation-cum-domination that characterize commodity production." (Fraser and Jaeggi 2018, p. 31)

Like other feminists, Fraser critiques the dominant/subordinate gendered assumptions and essentialized stereotypes historically tied to activities of production and social reproduction. Her critical theory is more than gender-sensitive; she is explicitly critical of institutionalized power relations demonstrated in these stereotypes and her work is animated by a strong justice critique of that institutionalized array of power. She argues that far from being subordinate to production, social reproduction is essential and necessary, i.e., production could not exist without the paid and unpaid activities of social reproduction.

Sharing analytic ground with socialist and Marxist feminists, she explains social reproduction as a necessary backstory in capitalism. The activity of social reproduction ensures that human beings are fed, protected, nurtured, sustained in health, and returned to health from illness. But beyond this embodied care activity, social reproduction also forms human beings as human subjects; it ensures that individuals are socialized as "human," that they internalize common social norms, e.g., norms of cooperation, mutual aid, justice, and freedom from oppression. The effects of social reproduction are crucial then not only to the sustained activity of commodity production. They are a necessary backstory contributing to species being, ensuring that for a period of history, there is sustained normative agreement about enduring political, economic, and environmental relations.

From one angle of vision, social reproduction could be understood to ensure the replenishment of a sustained workforce. But Fraser's conceptualization of social reproduction is not functionalist in this way. She argues that social reproduction creates and sustains capitalism's common shared ethical sphere:

> I am deliberately casting a broad net here. My aim is to develop an expanded conception of capitalism that can incorporate the insights of (several) paradigms…I would argue that insights of (philosophers) who focus on "ethical life" only receive their full meaning and importance when they are situated in relation to capitalism as a historically elaborated social totality. I think a full account of social reproduction must integrate the concerns of Marxist-feminists and socialist-feminists with those of theorists of subjectivation, *habitus*, culture, lifeworld and "ethical life." (Fraser and Jaeggi 2018, p. 33)

Fraser deploys this wider conception of capitalism and social reproduction to explain how socioethical dimensions of capitalism are challenged and how capitalism changes at a system level. She suggests that socioethical crises and transitions for capitalism emerge at intersections where front story and backstories meet. Those intersections include "boundary struggles" at sites were *production meets* *reproduction*, where *polity meets economy,* where struggles of *exploitation and expropriation* meet, and where *human society meets nonhuman nature* (Fraser and Jaeggi 2018, p. 167).

A recurring example of boundary struggles between production and social reproduction is presented in Fraser's analysis of current times. She describes changes that have occurred under financialized corporate capitalism resulting in the now widespread requirement for two incomes in most households. For those who are working poor, working class or middle class, the post-WWII norm of a single income household is no longer common. When added to this, intersecting influences of race and gender find women and minorities disproportionately employed in service sector jobs, experiencing wage stagnation and the erosion of benefits such as private or public health care insurance and other sources of public support. In this context, the norm has shifted to widespread prevalence of multiple individuals in a household working multiple jobs (McJobs) without social benefits. As Fraser explains, time constraints involved in this economic arrangement produce "crises" around care for children, care for elders or parents, or care for disabled or ill family members living in the household. Among two income households, these "care" responsibilities grow increasingly difficult or unsustainable. In contrast, for those individuals in upper middle-class or wealthy households, "care" activities can be commodified by employing others (usually women who are economically or socially disadvantaged) to provide housework, provisioning, food preparation, child/elder care, etc.).

While Fraser's analysis preceded the context of the COVID19 pandemic, her explanation of boundary struggles between commodity production and social reproduction has profound relevance for the present moment. One example of that relevance is found in the challenges experienced among personal care workers employed in home care or congregate elderly care settings. These settings would be home for senior residents and patients from many income categories, including those whose investments have provided resources to pay for residential care outside of their families' homes as well as those who rely on their families or public funding. In the United States, elder care has become increasingly marketized and in that context, personal care assistants (still largely women) frequently carry the challenges of two income households that Fraser discusses. Among them, the norm may involve juggling multiple jobs or multiple shifts at more than one setting to make ends meet, while ironically and tragically not being able to afford health care insurance themselves. The time constraints of this arrangement for caregivers produce ubiquitous challenges for managing their own childcare requirements, provisioning their own homes, or caring for their own aging parents. The struggles involved in these backstories are extraordinarily challenging.

Most recently, the related pattern among elder care providers giving close personal care to vulnerable elders during the COVID-19 pandemic has produced profoundly complex "boundary struggles" with devastating unanticipated effects. Those effects in the United States have included early unintended asymptomatic transmission of the SARS–CoV-2 virus both by visitors and caregivers in elder congregate care settings. These effects have been due at least in part to consequences of insufficient production, planning, and implementation of pandemic-related testing—another example of how crises in spheres of production and social reproduction are related. Given a corporatized model of staffing with personal care assistants necessarily moving between more than one employment context, and the asymptomatic transmission risks of this arrangement, a "storied struggle" in the sphere of caring can be understood as tied tragically to the institutionalized practices of capitalism.

This backstory illustrates how a corporatized model of commodified "care" among personal care providers can intersect with stagnated wage arrangements and the realities of two+ income households under this phase of capitalism. Corporatized arrangements produce crises in more than one sphere of activity, i.e., production, social reproduction, and as the pandemic continues, in the sphere where polity–economy meet. Emerging news confirms growing disparities in COVID 19-related infections and deaths among racialized minorities in the United States (African Americans, Latinyx, Native Americans). These data provide catalytic evidence of how the exploitation of structural racism yields health inequity under capitalism. Finally relevant are the geopolitical contexts of many elements of this as a pandemic story, e.g., involving globalized production chains for vaccines, personal protective equipment, testing and treatments, patterns of international transmission via leisure or business-related travel, the fate of international caregivers, and finally the financialized transnational corporate capitalist economic landscape and framework for addressing global economic stability. (Referenced in "Health Care Workers Risk Spreading Covid-19," Eleanor Laise, (Barrons) April 9, 2020, retrieved 4/9/2020 at https://apple.news/ApW_.)

Moving next to Fraser's discussion of intersections between polity and economy, she notes that capitalism relies on the polity (public political powers) to establish and enforce its norms. She explains that a market economy is inconceivable in the absence of a legal framework that enforces private enterprise and market exchange. These arrangements include guaranteed property rights, enforced contracts, adjudication of contractual disputes, managing or preventing labor unrest, and other politically institutionalized practices focused on maintaining the financial arrangements that constitute capitalism's existence (Fraser and Jaeggi 2018, p. 38). Fraser explains that struggles at the interface of polity and economy have been essential in transitions from feudal capitalism to mercantile, liberal-market capitalism, and to financialized transnational corporate capitalism. Addressing the "backstory" of struggles at this interface, she emphasizes growing contradictions between an increasingly globalized, transnational capitalist economy, organized as a "world system," and a political world order still organized as an international system of sovereign, territorial nation-states.

Fraser names a third sphere or backstory of struggle as capitalism's "annexation of nature." She discusses this as a sphere of activity based on socially, politically, and economically constituted divisions between human and nonhuman nature. In describing this sphere, she emphasizes the necessity of normative understandings that constitute nature as "nonhuman." Activity in this sphere is metaphorically described by invoking the image of faucet and sink—with nature operating both in the form of a "tap providing inputs to production" and as a sink "to absorb the waste" of production.

> Nature here is made into a resource for capital, one whose value is both presupposed and disavowed. Capitalists expropriate it without compensation or replenishment and treat it as costless in their accounts. So they implicitly assume it to be infinite. In fact, nature's capacity to support life and renew itself constitutes yet another necessary background condition for commodity production and capital accumulation …. After three centuries of capital's predation, capped by neoliberalism's current assault on what remains of the ecological commons, the natural conditions of accumulation have now become a central node of capitalist crisis. (Fraser and Jaeggi 2018, pp. 35–36)

Finally, in relation to a fourth backstory necessary for capitalism's existence, Fraser focuses on struggles occurring in the sphere where *exploitation* intersects with *expropriation*. She describes these struggles as "racialized regimes of capitalist accumulation." Occurring in different geographies (geopolitical core and periphery) simultaneously, both regimes have operated in early historical stages of capitalism and today. Expropriation involves confiscation, enclosure, and plunder of land along with confiscation of human beings (e.g., racialized slavery, war, and genocide). Exploitation involves abusive practices of replenishing labor at wages unacceptably less than those necessary to sustain life. Economic predation and political subjugation show up structurally in both regimes (Fraser and Jaeggi 2018, pp. 104–108).

Fraser asserts that these regimes of accumulation and their remnants continue today. The storied struggles of colonization, exploitation, and expropriation under capitalism reflect root causes of racist oppression. Those oppressions show up in contemporary injustices centuries later, e.g., in ongoing struggles for decolonization among indigenous people, in persistent health inequities linked to structural racism and income inequality, in innumerable acts of racialized hatred, structural and individual racism. This structural explanation of expropriation and exploitation produces an understanding of racism that differs from an intersectional description of racist domination or oppression. It brings into focus an additional explanation of why intersectional aspects of racialized domination persist. That foregrounding of capitalism also draws attention to ongoing exploitation—now arranged in a fully transnational corporate context. Given that context, contemporary features of human trafficking, complex waves of refugee migration, global health crises, deepening health inequity, human rights violations of migrant workers, and other transnational phenomena come into view differently. And their resolution is better understood as requiring something more and different than neoliberal political engagement by individuals in sovereign nation-states.

Taken together, Fraser's analysis of "backstories" in polity/economy, production/reproduction, human/nonhuman nature, and exploitation/expropriation does more than describe the intersection of gender, race, and class. Her theory explains how and why those institutionalized relations are tied to a "front story" that is fully transnational. While affirming the descriptive insights of intersectionality, and its insistence on the articulating axes of class, race, and gender, Fraser calls for more:

> I am proposing s unified theory in which all three modes of oppression (gender 'race' class) are structurally grounded in a single social formation—capitalism broadly conceived, as an institutionalized social order. And unlike theories of intersectionality which tend to be

> descriptive, focused on the ways in which extant subject positions crosscut one another, my account is explanatory. Looking behind those subject positions, to the social order that generates them, I identify the institutional mechanism through which capitalist society produces gender, race and class as transecting axes of domination. (Fraser and Jaeggi 2018, p. 109)

Fraser's philosophy finally offers a complex oppositional or liberatory discourse, a way of understanding what would be at stake in the process of achieving widescale transformation and liberation. Her work looks to the four spheres or "backstories" to identify specific sites where potential exists to transform the present constellation of capitalism. She argues that emancipatory social movements do still have the potential to intervene at these points of crisis, creating momentum at locations where these spheres of struggle meet. In her latest work, she insists that in liberatory projects, *progressive populist* movements can act at these sites, having determined that the life being led presently under capitalism is a life requiring transformation. In those movements, she suggests that a feminist materialist explanation of capitalism holds the potential to produce deep, democratic, and ethically mediated structural transformation. Her proposed criteria for engaging these transformational, emancipatory struggles are "non-domination, functional sustainability, and democracy" (Fraser and Jaeggi 2018, p. 178).

These criteria of Fraser's critical theory bring her work into alignment with feminist materialist and critical pragmatist commitments. While her work provides socio-ethical critique of capitalism and while she integrates neo-Marxist analysis of class divisions in capitalism, her work is not accurately characterized as classically Marxist. What she provides is coherent critical and feminist understanding of ethical challenges that reside in capitalism, refusing to evade these. Her work includes an explicit critique of failed attempts at state-managed socialism. And she provides a framework to reconsider what a progressive populist, anti-imperialist, democratic, ecofeminist, and anti-racist political-economic reality would entail. I argue here that her philosophy is relevant as one component of a critical approach to nursing ethics. I see her approach as decisive in addressing the transformation of root causes of oppression in capitalism, including the exploitation of care activities. And I view that approach, not as disorienting, but rather as helpful in strengthening and deepening already existing approaches in nursing ethics. Later sections of this chapter return to discuss how these contributions of Fraser's critical theory have relevance for nursing ethics.

Finally, Fraser's most recent coauthored texts from 2019 point more explicitly to current transnational contexts (Fraser and Sunkara 2019; Arruzza et al. 2019). Commenting on current political-economic consequences of transnational capitalism, Fraser and colleagues comment on the effects of neoliberalism. These include:

> the removal of barriers to the 'free movement of capital,' deregulating banking, encouraging ballooning and predatory debt, weakening unions, deindustrializing, and spreading precarious, badly paid work… these policies have hollowed out working class and middle class living standards while transferring wealth and value upward, chiefly to the 1 percent … but also to the upper reaches of the professional managerial classes. (Fraser and Sunkara 2019, p. 12)

Fraser and colleagues argue that in tandem with neoliberalism, this shift in the distribution of wealth has been accompanied by the international rise of conservative right populist movements. Responding to precariousness, and specifically opposing progressive liberal politics, reactionary conservative populism holds explicitly nationalist assumptions and commitments. It protests against immigration and insists on more rigid national borders, opposes left-liberal economic and social priorities, valorizes right conservative views as the views of ordinary people, opposes “elite” identity politics of multicultural difference, and takes up the rhetoric of White supremacist, heteronormative, and racist antagonism or hatred (Fraser and Jaeggi 2018; Fraser and Sunkara 2019; Arruzza et al. 2019). Fraser and colleagues insist that the international rise of this reactionary conservative populism is directly tied to economic and political effects resulting from transnational expansions in corporate capitalism.

They also argue that the symbolic and political tenor of the times is currently defined by growing tensions between this political-economic divide: between “conservative right reactionary populism” and “progressive coalition-based neoliberalism.” They argue that progressive, “diversity” oriented neoliberal politics will continue to be challenged by the appeal of conservative right populist movements, calling instead for an explicitly *progressive populist* movement, an example of which is their discussion of *Feminism for the 99%* (Arruzza et al. 2019). This feminist materialist alternative is presented as a complex and necessary response to capitalism’s current crises, relying on anti-racist, anti-imperialist, queer, and material feminist analyses to transform the backstories of capitalism. This vision rests on achieving a more egalitarian economic order and democratic effects, including moral recognition, redistribution, and parity in representation. These latest examples from Fraser’s long line of work again demonstrate her concern to transform political-economic factors that persistently and structurally influence moral life under capitalism.

## 3 Toward a Critical Theory of Nursing Ethics

### 3.1 Prolegomenon

Why should this matter to nursing? The easy answer would be to say that, without understanding these structural-ethical analyses of “context or background,” nurses, nursing scholars, and nursing leaders underestimate or miss a frame of reference that matters. If we are to base nursing practice and nursing ethics firmly in anti-oppressive, anti-racist, anti-imperialist, egalitarian, democratically just, environmentally respectful, and caring values, it is important to continue to study deeply and to reach out to work with others whose practice and analysis strengthens our understanding, even if that may trouble prevailing assumptions. In that spirit, this section provides some reflection about how/why feminist materialist analysis might be relevant for nursing ethics.

Taking up Fraser's work in this way is complex, invoking contradictory thoughts and feelings for many nurses in the way it invites a closer look at capitalism. For nurse ethicists and scholars, this invitation to use feminist materialist philosophy also raises important genealogical questions about what can be asked, spoken, represented, or discursively engaged in nursing. Asking a critical discourse analytic question, why is it that *capitalism* is largely unnamed as a meta-economic context that matters for nursing ethics? Taking up Fraser's critical theory of capitalism especially at this point in history may be challenging, in that it will be perceived by some as too political, too radical, not moving in professionally respectable directions, not supportive of nursing scholarship, and not aligned with the professional or disciplinary mandate of nursing. These reactions speak to "ambivalence" among some (not all) nurses about the focus and content of Fraser's critical theory.

When the subject of the "economic context" is taken up in discussions relevant to nursing ethics, an analysis of capitalism is usually not present. Where there are anecdotal references to macroeconomic context, that analysis frequently is represented by using terms such as "the market economy" or by describing the "corporate" bureaucratic contexts of health care/hospitals (Watson 2006; Ray 1989a; Turkel and Ray 2000; Ray and Turkel 2012). While these analyses of "market forces" invite and sometimes engage an analysis of corporate bureaucratic effects on nurses, they do not address or explain, as Fraser does, these bureaucratic effects as tied to the commodification of caring. Nor do they take up an analysis of how the "corporatization" of care is linked to the backstories of capitalism. In noticing this silence, I ask reflectively about the extent to which "ambivalence" in nursing, even and perhaps most importantly among second-wave liberal feminists, prevents us from critically considering the ethical contradictions of capitalism. An important task then in taking up Fraser's work is to ask why a feminist materialist approach may produce ambivalence in nursing. It may be that use of the term "capitalism" is perceived as an "unspeakable" (Georges 2011), for a ubiquitous silence or refusal to use the term "capitalism" suggests that the term cannot be said. The thesis of this chapter is that silence about capitalism is not helpful for nursing, having discursive and practical consequences that leave important contextual influences unaddressed.

Whether capitalism can be named depends on the availability and use of academically and professionally sanctioned discourses, in this instance, one that is capable of bringing attention to capitalism's influence in ways deemed productive for the discipline and the profession. As Foucauldian scholars would clarify, the extent to which capitalism can be named, spoken about, considered, engaged, or thought of using Fraser's feminist materialist philosophy depends on the "credibility" or "respectability" of a discourse that makes capitalism visible/recognizable. The academic status/power of that discourse also points to its discursive and practical consequences, what it brings into view and what it obscures among its professionalized members in nation-states where nurses practice.

There are reasons that nurses may have ambivalence about examining capitalism. Fraser's work (Fraser 1989, 1990, 1995a, 1997, 2005, 2009, 2017; Fraser and Jaeggi 2018) clarifies that we have inherited and live in a "post-socialist" discursive era. In that world, the term "capitalism" is semiotically (post-structurally) associated in opposition to its “failed” historical challenge, “socialism.” And so, in this discursive space, among privileged persons, the critique of capitalism is understood to be an act of positing socialist solutions. For more than a generation, the historical failures of oppressive state-managed socialist economic regimes have been rightfully remembered, critiqued, and spoken of disparagingly. That discursive era has produced what Fraser terms a “post-socialist” political imaginary—a world where among “ordinary people” “there is no alternative” to capitalism. Living in a “post-socialist” era means that liberatory movements do not speak as strongly as they once did in discourses that address capitalism’s contradictions of economic maldistribution through actions among organized labor (for example). As Fraser explains, progressive liberatory movements have turned instead to an agenda that celebrates/affirms diversity in cultural-based group identities and neoliberal affirmations of identity politics. While acknowledging that a politics affirming positive cultural identity is an important element of moral recognition, Fraser insists that the “ethos” of many of these liberatory movements also has evaded widespread transformation of structural economic disadvantage, leaving in place maldistribution that supports classist, White supremacist, and sexist social, political, and economic arrangements.

In short, Fraser’s argument is that a “post-socialist” era and its neoliberal approach to moral respect and recognition fails to account for maldistribution in ways that could democratically transform capitalism. The conceptions of social justice circulating in this “post-socialist” context all too easily speak in terms that celebrate problematic group-based identity (e.g., “lean-in-feminism” and White supremacy). These are discursive and practical landscapes that matter, influenced by losing site of and not having language ready to hand, that would clarify interlocking requirements for recognition–redistribution–representation. In this context, the very notion of considering democratic socialist commitments is unthinkable, for some. Similarly, the process of envisioning a more democratically constituted and regulated “moral capitalism” (Cohen 2020) may address questions today that were engaged with populist support two generations ago. Progressive populist economic struggles that previously did engage capitalism (e.g., during the Great Depression) have been less common during an era of “post-socialist” neoliberal progressive social movements, animated as they have been by a primary concern with communitarian ethics of recognition in cultural-based diversity.

Given this “post-socialist imaginary” context, ambivalence about what is perceived as “socialist” leanings in critical theory is real. Perhaps a small introductory step may be helpful—beginning with a critical pragmatist approach to truth provides some invitation to dialogical engagement. From that democratic pragmatist standpoint, it is theory that determines what can be observed. And it is those observations and their interpretations that influence what is practically worked out in engagement in a field of practice or study (Sherwin 2011). These insights are perhaps more useful for some nurses in circling a critical nursing ethics. Probing which discourses can be spoken, which theories are most productive for nursing, what questions cannot be asked, and which questions will be engaged to advance moral agency in nursing ethics is an important task for a critical nursing ethics.

I am arguing that obscuring or not addressing the context of capitalism is unhelpful for nursing. If part of being silent about capitalism comes from a post-socialist (largely White, middle-class professionalized, heteronormative) liberal feminist imaginary about the ethics of care and social justice, an important project for nursing ethics is to engage a reflective dialogue about that professionalized standpoint and its contradictory amalgam of privilege. More helpful to that project would be a dialogical examination of Fraser's socio-ethical critique and political philosophy, using it to examine the world we inhabit and to understand how the practices we engage could be transformative in contributing to caring and social justice.

## 3.2 Is this New?

An invitation to seriously engage feminist materialist analysis in nursing in this way is also consistent with some elements of a legacy history of nursing ethics. That legacy demonstrates a history of social ethics, engaged with socio-ethical critique and animated by a wider understanding of social justice. Fowler's (2015) studies of legacy nursing ethics "challenge the notion that nursing's ethics is simply bioethics or biomedical ethics (in part or at all) when its history would instead place it within the broader sphere of social ethics" (p. 14). In responding to Fowler's invitation that nursing "stands in need of a thicker account of its ethics," this analysis argues that Fraser's critical theory contributes productively to such an account. Her socio-ethical critique of capitalism provides an important corrective, helpful among other approaches, in addressing the root causes of ethical dilemmas, moral crises, social injustice, suffering, and their effects on moral agency in nursing.

In reading the work of nurse historians (Christy 1969, 1970; Burnam 1998), it is instructive to recognize that nurse leaders like Lavinia Dock and Lillian Wald who worked in the early twentieth century U.S. settlement house tradition, possessed something other than a "post-socialist" feminist imaginary. They shared a kind of ethical literacy concerned simultaneously with democratic justice and caring. Their work included practices of seeing, naming, and engaging the oppressive effects of industrialization, supporting immigrants and their inclusion in organized labor movements, activism in reforming hospital practice, addressing workers' health-related challenges, leading the establishment of community-based models of nursing and health care, and actively working for women's suffrage. They shared a wider vision of the social ethics needed in that early twentieth-century urban, industrialized, pre-suffrage context of capitalism. That capacity included the ability to see and engage with others in democratic struggles addressing what Fraser would name moral recognition, redistribution, and representation. It seems clear that Dock and Wald—working as they did in the settlement house contexts of New York—were acutely aware of capitalism and how it operated in their time. Their contexts and communities provided them with access to and use of democratizing languages of resistance, care, and social justice and they used those languages/theories in their practices of clinical care and advocacy. In considering the democratically transformative practices of these historical leaders, it again becomes clear that discourses of a wider social ethic of care and social justice are not new in nursing.

Second-wave feminist commitments continued to evolve in nursing in North America during the twentieth century. A generation of scholars in nursing then was influenced by transitions in feminist analysis, including intersections between liberal, socialist, cultural, Black feminist, then postmodern, post-structuralist, LGBTQ+ queer theoretical, and postcolonial feminist analysis. It is important to recall that these discourses included early critiques pointing toward the influences of capitalism, patriarchy, and paternalism. Examples of that early work in the United States in the 1970s, 1980s, and 1990s include analysis by Jo Ann Ashley (1975, 1976, 1980), Susan Jo Roberts (1983), Peggy Chinn and Charlene Wheeler (1985), Denise Connors (1980), Nancy Greenleaf (1980), Kathlyn MacPherson (1983), Theresa Chopoorian (1986), Susan Reverby (1987), and Judith Wuest (1994).

In more contemporary times, a critical theoretical "emancipatory" paradigm for nursing ethics (research and practice) has been demonstrated in North America, in both Canada and the United States, with an ongoing commitment to an ethic of social justice (Kagan et al. 2009, 2014; Chinn and Kramer 2011; Georges 2013; Ray and Turkel 2014; Walter 2017; Wesp et al. 2018). The extent to which these examples of critical theoretical approaches in nursing ethics reflect and support the use of Fraser's feminist materialist philosophy is a compelling question. Having established in this discussion interest in engaging that question, the following section of this chapter moves on to piece together some analysis about how the ethics of caring and social justice in nursing, can be strengthened by using Fraser's work.

## 4 Examining the Ethics of Care and Social Justice in Nursing

### 4.1 Ethics of Care in Nursing

In the last 50 years, as nursing scholars have focused on articulating "authentic" knowledge, they have worked steadily to explicate knowledge that defines the discipline and the profession. This has included an important period of theorizing about what defines key elements of nursing ethics, including the ethics of care in nursing. In these efforts, several nurse ethicists and scholars have maintained that an ethics of care and its evolution in nursing are significant influences for the discipline and the profession. These scholars of care ethics include Barbara Carper (1979), Delores Gaut (1983), Sally Gadow (1985), Jane Brody (1988), Sara Fry (1989), Anne Bishop and John Scudder (1991), Chris Gastmans (1999), and Peggy Chinn (2018). Others in nursing have also argued that care is central to the discipline, focusing more closely on the generation of nursing's scientific knowledge base. In this "paradigm" view, care has been understood as a humanistic, transcendent, metaphysical, or transcultural ethos—a way of "being-doing-knowing" that shapes nursing knowledge development, nursing science, research, and theory generation as well as professional values and ethics. Theorists and philosophers in nursing in the United States who have articulated this view of the centrality of care in the discipline have included Jean Watson (1979, 1985, 2012), Madeline Leininger (1988a, b), Dorothea Orem (1980), Margaret Newman et al. (1991), Marilyn Ray (1989b), Jane Sumner (2001), and many others. A comprehensive taxonomy of care theory in nursing is found in the work of Zane Wolf and Nancy France (2017).

Within this discourse of care in nursing, others have addressed the ethics of care by focusing on nursing as a practice discipline. In this perspective, the sociology of practice is emphasized, with attention to the way in which professional and social practices shape ethics and disciplinary knowledge. For example, nursing scholars Patricia Benner (1984, 1997) and Benner and Judith Wrubel (1989) provide phenomenological analysis of the "primacy of caring" in nursing through their descriptions of expert practice. Their philosophical treatment of care ethics in nursing is oriented by several theoretical influences, including Pierre Bourdieu's (1977) practice philosophy, the virtue ethics philosophy of Alasdair MacIntyre (1981), and integrations of care ethics (Benner and Gordon 1996) including the work of Carol Gilligan (1982) and Joan Tronto (1993). In Benner's approach to caring, one's "practice" is understood to develop over time and with experience, integrating knowledge, skill, and ethical comportment in a professional field of social practices (habitus). In theorizing care as a practice, Benner endorsed the capacity of virtue ethics as one ethical tradition that can more adequately and coherently account for practice/nursing ethics. She drew on virtue ethics to explain how "the good" is ethically constituted in the particularities of practicing well. Finally, her understanding of care ethics also influenced her understanding of the primacy of care. She relied on the groundbreaking feminist work of Carol Gilligan (1982) who disclosed the centrality of relational ethics in women's ways of knowing.

Though not emphasizing an alignment of her work with feminist care ethics, Benner did propose that virtue ethics should be combined with care ethics to adequately account for a virtue ethic of caring in nursing.

> [M]edicine and nursing are good candidates for the restoration of virtue ethics, because notions of the good are essential to clinical and ethical comportment and reasoning, and because it is impossible to separate clinical and ethical reasoning in a practice. When my colleagues and I study the practice of nurses, we find that they are working out their notions of good practice in their daily encounters with patients. […] we need to articulate and attend to the moral art of attentiveness and caring relationships that protect patients in their vulnerability while fostering growth and limiting vulnerability. This calls for bringing caring practices in from the margins of our thinking about practice and combining care and virtue ethics. (Benner 1997, p. 59)

While Benner's work was not primarily grounded in the then-current discourses of feminist care ethics, she clearly intended to integrate an ethics of care, along with virtue ethics, in her philosophy of nursing practice. Her analysis of the primacy of care, however, was taken up in a way that positions her work in an important feminist debate. Benner's approach to care as a moral practice can be understood as a gender-sensitive understanding of nursing ethics, though she never emphasizes that point explicitly. Using practice philosophy, virtue ethics, and gender-neutral references to relational care, Benner provided an empowerment approach, valorizing nurses' institutionalized practices, animated by a concern that nurses themselves may misunderstand the significance and complexity of their clinical practice as a moral practice (Benner 2001, pp. 207–209). While those intentions are laudable, she did this in ways that can unintentionally obscure gendered relations of power, and as feminists have cautioned, inadvertently contribute to the ongoing subordination of nurses' practice.

Commenting on this, feminist ethicists Rosemary Tong (1989), Joan Liaschenko (1993), and Peta Bowden (2000a) have argued that a valorization of caring in the absence of explicit gender justice critiques risks romanticizing "feminine" stereotypes. They critique a depoliticized "feminine" ethics of care, refusing to equate caring with prevailing stereotypical notions of "feminine" etiquette. They call instead for a feminist care ethics, one that explicitly critiques power relations, identifies gender-based domination and subordination, and critiques oppressive institutionalized social relations that subordinate care. In contrast to a gender-neutral embrace of care and virtue ethics, and explicitly deploying this kind of feminist critique, Maureen Sander-Staudt (2006) considers risks of combining virtue ethics and care ethics and recommends against their wholesale combination. Similarly, Patricia Rodney et al. (2013) provide a comparable critique of foregrounding an ethics of care in nursing. They argue that

> Care, with its gendered connotation in Western culture, is all too easily, in our view, reduced to feminine character and virtue and evaluation of what it means to be a "good nurse." Attention is neither paid to the sociopolitical context of that work nor to the apparent unreasonableness of being overworked. For these reasons, care and the related social practices it entails become problematic as the moral foundation for nursing when issues of power, social justice and domination remain obscured and unaccounted for. (p. 167)

The extent to which care ethics approaches have been capable of transforming contexts in ways that support nurses' moral practice is an important question. The emphasis on care and caring in nursing may be considered as occurring in a period when nurse scholars of care were increasingly concerned about the institutional settings of clinical practice, organized as they are within "bureaucratic contexts of managed care." Drawing attention to the effects of "managerialism" in the United States—some care theory rightly focused on the bureaucratizing effects of diagnostic-related categories (DRGs) and the meso-economic managerial strategies that have changed clinical environments. Watson (2006) and Marilyn Ray and Marian Turkel (Ray 1989a; Turkel and Ray 2000; Ray and Turkel 2012) have drawn attention to the ways in which economic contexts can erode an ethic of care. Consistent with a post-socialist feminist, liberal feminist or postmodern feminist paradigm, these analyses focus on meso-level economic influences, locating those in the context of organizational culture and *bureaucracy.* In not engaging meta-analytic analysis of corporate capitalism, this approach misses an angle of vision that could theorize the corporatization of care differently. It also has the effect (perhaps unintended) of reinforcing a post-socialist feminist vision of caring. An important question is the extent to which that perspective about care could be engaged differently using Fraser's philosophy.

Also consistent with prevailing notions of care in nursing, Benner's research program took what appears to be a comparable post-socialist feminist approach to an ethic of care. Her work addressed cultural recognition among nurses themselves, helping nurses to appreciate caring as a complex moral practice (Benner 2001, pp. 207–220). But the extent to which this "practice-centric," "virtue ethic of care" provides the profession and the discipline with a "radically" transformative blueprint for practice (Sullivan and Benner 2005) is again a compelling question. In the spirit of probing that question, it is worth asking how a feminist "virtue ethics of care" understanding of professional nursing is capable of calling attention to political-economic contexts that corporatize and commodify caring. In interesting ways, Benner's practice-centric work did indirectly name or "call out" distorting influences of corporatized contexts, pointing to their negative effects on caring. She specifically referred to "market forces" and "commodity production"—as institutionalized practices that obscure, erase, or erode nurses' moral practices.

> Bureaucratized market models of production achieve their efficiency by separating means and ends and substituting means for ends. This approach overlooks the craft, judgment, and relationship required for health care. (They) assume that attentiveness and excellent comportment require no more than commercial relationships based upon simple exchanges. But caring for vulnerable and ill persons requires more than a profit motive. Compassion and caring practices are required. […] Health care does not act like a commodity, in that the people most needing health care services are often least able to pay, or even request those services. The ethos of the buyer–seller relationship does not adequately capture the moral demands of caring for the disenfranchised, the vulnerable, and the suffering (Benner 1997, pp. 51, 58).

Just here, a surprising coherence with Fraser's feminist materialist analysis is or could have been possible. Fraser's analysis would suggest that the problem with "market" models of commodified caring is not that they are insufficient, but rather that they are structurally inconsistent with an ethos suited to the moral demands of caring. Benner's ethics of care may have come closer to approximating a critical ethics of care, had it been strengthened by the use of feminist materialist philosophy. That integration would directly point to the predominance of gendered, classed, racialized, and heteronormative power relations in the backstories of social reproduction and "caring" work and the replication of that institutionalized array of power in nursing.

Consequences of this explanatory aspect of Fraser's work point to the salience of using feminist materialist philosophy to recognize the effects of the macroeconomic context of capitalism. This suggests a need to be informed and to cue into sites of struggle where the political-economic contexts of capitalism can be transformed. Obscuring or not accounting for those sites of transformation in capitalism is unhelpful. In the long view, evading an analysis of capitalism may not contribute as we imagine to a "respectable" image of the profession. Instead, evading the analysis of macroeconomic context diminishes opportunities for nursing to contribute productively to democratic, progressive populist movements, advocating for transformations that are linked to the moral practice of caring and social justice. Far from being irrelevant to the social and civic mandate of nursing, this specific critical theory provides a socio-ethical critique that is directly relevant to understanding nursing's moral practice. And in providing that socio-ethical critique, Fraser's work makes an important contribution to helping nurses achieve the civic mandate of social justice in the profession, supporting democratic professionalism in nursing.

## 4.2 Feminist Ethics of Care

Contemporaneously and in parallel with the theorization of "care" in nursing, related work in a feminist relational ethics of care emerged elsewhere during the 1980s, 1990s, and early twenty-first century. In psychology and philosophy, women's moral agency was the subject of early research by Gilligan (1982), Sarah Ruddick (1989), Nel Noddings (1984) (among others). These early scholars explicated gendered differences between men's and women's moral agency, a prelude to "founding" (Klaver et al. 2014) a feminist *relational ethics of care.* Proposing complimentary comparisons between a more logocentric, principled moral paradigm of justice among men and a relational ethic of care among women, this early feminist "ethics of care" work has continued through important critiques and elaborations, leading to what is now recognized as a formalized branch of feminist (care) ethics. Feminist care ethicists have emphasized the moral status of relational caring as a normative ethic. Recognized scholars in this field include Peta Bowden (1995, 1997, 2000a), Eva Kittay (2020; Ethics of Care 2013), Virginia Held (2006), Joan Tronto (1993, 2013; Fisher and Tronto 1990), and Ann Gallagher (2017) among others. They have provided important feminist analysis, theorizing the centrality of relational care practices in society (including in citizenship), in everyday life (mothering, friendship), and also in professional caring practices, including among nurses.

Feminist care ethicists have offered important analyses that situate care in social, political, economic, and global contexts. What is striking about this history of care ethics in feminist philosophy is that it has progressed well beyond a separation of care and justice, rejecting a "gender-sensitive ethics" based on stereotypically "feminine" images of caring. Feminist ethicists of care have insisted on placing care within contexts that include institutionalized power relations, including gender, and also have emphasized the importance of critiquing the injustice of those power relations. In this work, feminist ethicists have steadfastly rejected a binary separation between the ethics of justice and the ethics of caring, as well as any gendered and essentialist assumptions about the way in which women and men care. They understand care as comprised of practices, relations, and values that are based in and that contribute to moral respect and moral recognition. They locate caring as central to democratic arrangements in civic society. And they insist that wider contexts of social, political, and economic injustice matter for caring.

In her recent work, Tronto (2013) extends her previous discussion of caring. While having consistently located caring in social and political contexts (Tronto 1993), her book, *Caring Democracy: Markets, Equality, and Justice*, moves into more explicit feminist critique of intersecting contexts where polity–economy are relevant. The direction of Tronto's analysis has emphasized the importance of different types of caring, their attributes, and the contexts of these. Those types of caring identified in 1993 included: "Caring About" (attentiveness), "Caring For" (responsibility), "Care Giving" (competence), "Care Receiving" (responsiveness). Her analysis clarifies that these types of care are not restricted to processes between individuals (whether in public or private realms); they involve relational caring with/in communities and are influenced by and have consequences for social, economic, and political arrangements.

The direction of this feminist care ethic takes guidance from earlier work having conceptualized care in ways that resemble philosophical anthropology, viewing caring as a species activity, a requirement for species survival (Tronto 1993, p. 103). Tronto, however, argues more explicitly that the ethics of care has important consequences for the organization of the polis/public sphere, for conceptions of democracies and democratic life, and for the focus of political philosophy. She holds that caring (more than production) has or should have moral prominence in the political organization of democracies and that a central task of democracies is the political assignment of responsibility for caring writ large. The fifth element or type of caring emerging from this philosophy of care is *democratic caring* ("caring with"). In theorizing this form of caring, Tronto's work does more than "add social justice and stir" for the ethics of care. In theorizing caring democracies, she defines democratic caring as a shared ethical commitment, but more forcefully, she holds that democratic caring should be the constitutive steering mechanism of the polity. Emphasizing the shared political commitment to equality and care in caring democracies, she argues that

> [I]n democracies [...] democratic politics should center on assigning responsibilities for care, and for ensuring that democratic citizens are as capable as possible of participating in this assignment of responsibilities. [...] Caring democracies thus require a commitment to equality of voice and of reducing power differentials [...] to create the conditions for a meaningful democratic discussion of the nature of responsibility (for care) in society. [...] Politically, the feminist democratic ethic of care seeks to expose how social and political institutions permit some to bear the burdens (and joys) of care and allow others to escape them. (Tronto, 2013, pp. 30, 32–33)

Tronto's understanding of the commodification of care in market economies clarifies that a feminist explanation of "the economy" has relevance for democratic caring. For Tronto, caring about and with others in addressing structural sources of oppression is or should be a responsibility in caring democracies. This view of social and political structures and their influence on caring has much in common with recent feminist and communitarian commitments in critical paradigms for nursing ethics (Kagan et al. 2009; Chinn and Kramer 2011). Here I argue that between Tronto and Fraser, an important dialogue about structural influences on democratic caring is needed. That conversation would have relevance for a critical theory of nursing ethics by addressing structures of oppression under capitalism and how these may be addressed among nurses.

Fraser's work adds explanatory depth by clarifying how those struggles are located at the intersections of polity and economy, including private, marketized, corporatized, and state-managed caring activity. Her work further explains how those global "care" struggles are being influenced by exploitation, expropriation, and the annexation of nature under capitalism. Her work clarifies the need for simultaneous scales of justice that address recognition, redistribution, and representation. And finally, Fraser raises awareness about the rise of reactionary conservative populist movements and the prospects of progressive populist movements to engage "democratic caring" under capitalism.

While Tronto's latest work on caring democracies addresses several of these details, she does so in a different field of analysis, by focusing her political philosophy on the ethos of the polis. For nurses, these treatments of the significance of "the economy" versus "democracy" do matter in forming our vision of and understanding of care and social justice. A dialogue or deliberative conversation engaging the respective work of Fraser and Tronto would contribute to a deeper understanding of those visions in nursing ethics. In considering prospects for that kind of transdisciplinary dialogue, e.g., a conversation between Tronto and Fraser, an important point of clarification is needed. That point concerns the extent to which a "post-socialist feminist imaginary" is still present in feminist care ethics. When the subject of a feminist ethic of democratic care is considered in nursing, it is fair to ask specifically what "caring democracies" look like *in the context of* "financialized transnational corporate capitalism." That feminist materialist problematique speaks differently to nursing, challenging some unspoken assumption about the imbrication of care and social justice in nursing under capitalism. And if that work is to be taken up in nursing, it is important to ask whether and how a post-socialist feminist imaginary can be examined, challenged, or transformed in our deliberations.

## 4.3 The Ethics of Social Justice in Nursing

A final section of this analysis takes up the ethics of social justice in nursing and how that ethical discourse contributes to a critical theory of nursing ethics.

As Fowler (2015, 2016, 2017) has argued, nursing ethics is best understood as having demonstrated a legacy of social ethics, including a rich history of concerns for social justice. In agreement with that legacy ethic, there has been recent acknowledgment (Woods 2012; Peter 2011; Liaschenko 1999; Watson 2008; Doane 2014) that nursing ethics encompasses an imbricated connection between relational ethics/the ethics of care and the ethics of social justice. How the ethics of care and the ethics of social justice "go together" in nursing is an important and compelling question, perhaps a puzzle, addressed differently by different scholars in nursing and by their use of different feminist, moral, and political perspectives. For example, the work of feminist moral and political philosopher Iris Marion Young (1990, 2011) has been used heavily in nursing to examine the ethics of social justice. That approach, now common in nursing, foregrounds the ethics of moral recognition, emphasizing mutual respect across different "intersectional" social identities. Yet in discussions of social justice in nursing, Fraser's insight about simultaneously addressing the ethics of redistribution under capitalism is largely missing. I suggest that Fraser's feminist materialist philosophy deserves more specific consideration in nursing ethics, contributing to better understanding how social justice is achieved under capitalism. That relevance is derived from her insistence that three scales of justice (recognition, redistribution, and representation) are relevant in capitalist democracies.

A review of codes of ethics in nursing in Canada and the United States supports the assertion that the discipline and the profession understand the ethics of care and the ethics of social justice to be connected in nursing. Both codes identify commitments to relational caring and social justice. In the United States (in 2015), the American Nurses Association followed the Canadian Nurses Association (in 2006 and 2010) in revising its code and social policy statement to reclaim and emphasize the ethics of social justice (Fowler 2016). A relevant detail includes the observation that while the Canadian Nurses Association has insisted on the importance of emphasizing the ethics of social justice, regulators in Canada expressed more ambivalence about that invocation of social justice in the code (Peter 2011).

Using Fraser's work, it is helpful to consider how these codes rely on a paradigm of social justice based strongly on moral respect and moral recognition, speaking less directly about correcting for maldistribution (economic disadvantage) and infrequently about the ethics of representation (parity in political participation). Whether and the extent to which codes of ethics in nursing conceptualize social justice as addressing redistribution in capitalist contexts is an important question. Fraser's work speaks productively to these questions. Her explanations focus directly on growing inequality in income distribution, predatory debt, precarious employment, and growing health inequity under capitalism. Given this, she also cautions about the prevalence of a "post-socialist" feminist imaginary, a feminist vision that retains the "there is no alternative" to capitalism standpoint. These contradictions present compelling questions about what type of feminist moral philosophy resonates most comfortably for nursing ethics.

In the last 10 years in North America, two concept analyses have produced different working definitions of the concept of social justice in nursing. First appearing in 2012 from U.S. scholars Kelly Buettner-Schmidt and Marie Lobo (2012), social justice was defined as:

> Full participation in society and the balancing of benefits and burdens by all citizens, resulting in equitable living and a just ordering of society. […]The attributes of social justice are: (1) fairness; (2) equity in the distribution of power, resources and processes that affect the sufficiency of the social determinants of health; (3) just institutions, systems, structures, policies and processes; (4) equity in human development, rights and sustainability; and (5) sufficiency of well-being. (p. 954)

This definition foregrounds fairness, equity and a balance of burdens and benefits among citizens, echoing what some may view as aspects of Rawlsian distributive justice. However, influenced perhaps by more contemporary movements for social justice, this definition also moves on to attributes that break away from a "veil" of detached impartiality. It acknowledges wider democratic commitments to fairness in the distribution of power, resources and processes that affect "sufficiency" of the social determinants of health and "sufficiency" of well-being. While stated in somewhat detached language, those attributes speak to understanding the structural nature of oppression, and if interpreted using a materialist feminist perspective, would account for social injustices under capitalism. A more explicit use of feminist materialist philosophy would strengthen the capacity of this definition to adequately address the ethics of recognition, redistribution and representation. Next appearing in 2017 from Canadian scholars Angela Matwick and Roberta Woodgate (2017), social justice in nursing was defined as:

> a state of health equity characterized by both the equitable distribution of services affecting health and helping relationships. Social justice is achieved through the recognition and acknowledgment of social oppression and inequity and nurses' caring actions toward social reform. (p. 182)

This definition more clearly demonstrates language consistent with democratic caring. It points directly and indirectly to the importance of moral recognition and respect in overcoming oppression and inequity, also to acts of democratic caring to achieve social reform. Mostly missing from this definition are explications of how social justice in nursing addresses structural sources of maldistribution or misrepresentation. These concerns can be clarified by engaging feminist materialist philosophy.

These recent definitions of social justice in North American nursing illustrate how democratic caring and social justice may be related in nursing ethics. That understanding is also helped by considering some recent examples of scholarship that address the ethics of social justice in nursing.

### 4.3.1 Examples of Social Justice Scholarship in Nursing

Literature addressing the scholarship of social justice in nursing has been very productive during the last 30 years in North America. In the face of provocative challenges about the justification of social justice discourse in nursing (Lipscomb 2012), the nursing literature continues to include compelling work on the ethics of social justice. Some (but not all) of this work would be located in what Paula Kagan, Marlaine Smith, Peggy Chinn, and Maeona Kramer have referred to as an "emancipatory" paradigm for nursing (Chinn and Kramer 2011; Kagan et al. 2014). While a robust integrative review of this and related social justice discourse in nursing is beyond the focus of this chapter, a brief review of some recent examples of social justice scholarship in nursing in North America is relevant.

In Canada, social justice discourse has been prominent in nursing scholarship. Canadian work demonstrates several theoretical influences relevant to social justice including: Intersectionality (Van Herk et al. 2011; Smye et al. 2011); Intersectionality/feminist post-colonial philosophy (Varcoe et al. 2014); Critical theory (Reimer Kirkham and Browne 2006); Feminist moral and political philosophy (Peter 2011); Feminist post-colonial philosophy (Anderson 2000; Racine 2003, 2009; Racine and Petrucka 2011; Denison et al. 2013); Feminist anti-racist pedagogy (Garneau et al. 2018); Cultural safety/anti-racist pedagogy (Browne et al. 2009; Gregory et al. 2010; Racine 2014; Browne 2017); Gender diversity/trans-visibility and cultural safety (MacDonnell 2014; Kellett and Fitton 2017); Action on the social determinants of health (SDH) and political activism (Reutter and Kushner 2010; Browne and Tarlier 2008; Falk-Rafael and Betker 2012; Falk-Rafael and Bradley 2014; Buck-McFadyen and MacDonnell 2017); and Feminist postcolonial interventions in Indigenous women's health (McKenzie et al. 2018; Varcoe et al. 2019). (These "categories" are not meant to denote discreet thematic areas of emphasis since they frequently overlap/intersect.) Finally, Canadian authors Annette Browne and Sheryl Reimer-Kirkham (2014) respectfully problematize some aspects of social justice discourse in nursing. These authors recommend continued examination of tensions in the ethics of social justice in nursing, also inviting a disciplinary "refocusing" in ways that are relevant for nursing (p. 35).

In the United States, another diverse theoretical landscape has informed discussions of the ethics of social justice in nursing. This work includes years of scholarship leading up to and following the 2015 updated emphasis on social justice in the ANA code of ethics (Fowler 2016). Some theoretical influences in social justice literature in the United States include: Upstream action and activism on SDH/structural inequity (Bekemeier and Butterfield 2005; Butterfield 2017; Thurman and Pfitzinger-Lippe 2017); Philosophies and ethics of social justice in nursing (Liaschenko 1999; Boutain 2005, 2020; Drevdahl 2013, 2018); Critical research methodologies (Dexheimer Pharris & Pavlish 2014; Boutain 2014; Evans-Agnew et al. 2014, 2016); Pedagogy: Critical Race theory and Cultural Safety; (Puzan 2003; Fahrenwald 2003; Fahrenwald et al. 2007; Hassouneh 2006; Allen 2006; Campesino 2008; Canales and Drevdahl 2014); Feminist Intersectionality (Rogers and Kelly 2011); Postcolonial feminist praxis (Mkandawire-Valhmu et al. 2014); Anti-racist, post-colonial, intersectional populist activism: (Walter 2017; Weitzell et al. 2020).

Lastly, relevant is a recent critical discourse analysis by U.S. author, Claire Valderama-Wallace (2017) addressing social justice ethics as demonstrated in the revised ANA Code of Ethics and related documents. This discussion focuses on revisions to the 2015 code that make more visible the ANA social mandate for social justice in nursing. Given this important revision, Valderama-Wallace locates continuing sites of contradiction concerning poverty and racism in the ANA documents. She also identifies ongoing ambivalence in the documents about how the social mandate for social justice aligns with prevailing conceptions of professionalism. The extent to which practicing nurses "at the bedside" see professional practice as including an internalized professional responsibility to address social justice continues to be a crucial point of conversation. The analysis suggests that ambivalence is expressed in response to emphasis on social justice, in calls for political advocacy—where individual nurses are called to support policy-level work among nursing's professional organizations and also to address for themselves their individual responsibilities in engaging social justice.

Taken together, these analyses demonstrate conversations in nursing in Canada and the United States over the last 20 years, grappling with the moral terrain of social justice in practice, research, and education. Increasingly, the literature reflects contradictions being recognized—across what Fraser calls axes of moral respect, redistribution, and representation. These contradictions reflect growing awareness of the structural nature of social injustice, including micro-level interpersonal consequences, meso-level organizational effects, and macro-level structural persistence. It is noticeable that Fraser's work is mostly not considered in these analyses. This lacuna is an important area of work for a critical theory of nursing ethics and addressing it will provide justifications (Lipscomb 2012) for how and why nurses have important social justice contributions to make.

## 5 Conclusion

In arguing that Fraser's critical theory has relevance for nursing ethics, I have suggested that her work provides productive analysis for nursing, explaining as she does why capitalism presents persistent structural challenges for caring and social justice in nursing. I am not suggesting that feminist materialist philosophy is a panacea or that it can in-itself adequately account for all the moral challenges nurses' experience. But I am insisting that without this critical theory, the profession and the discipline miss an opportunity to reengage an important analytic tool—one that is ultimately consistent with the history of legacy ethics in nursing.

This paper has reviewed Fraser's philosophy, piecing together points of analysis that are relevant for nursing ethics. The discussion examines (a) the ethics of recognition, redistribution, and representation explicated in Fraser's work; (b) her critique of a post-socialist feminist imaginary and its relevance for nursing ethics; and (c) her explanation of contemporary financialized transnational corporate capitalism and the relevance of that explanation for democratic transformation of the economics and politics of care and social justice.

Next, the paper probes the extent to which feminist commitments to caring and care ethics in nursing can be strengthened by taking Fraser's explanation of capitalism and three scales of justice into account. In examining feminist care ethics, the paper also invites a closer comparison of Tronto's philosophy of democratic caring in market economies and Fraser's feminist materialist philosophy of capitalism. Overlap and points of connection in this section of analysis invite a more focused conversation between the feminist philosophies of Joan Tronto and Nancy Fraser for nursing ethics.

Finally, the discussion takes up a review of recent scholarship in North America related to the ethics of social justice in nursing. That analysis demonstrates some common themes in recent research in Canada and the U.S. Responding to mandates for social justice found in both professional codes of ethics, researchers in both nations have addressed common theoretical approaches to understanding social justice. These include intersectional, feminist post-colonial, feminist anti-racist theory, and calls for social justice activism, present in the scholarship of nurses in both nations. Even given crucial differences in their public versus privatized health care systems, this analysis nevertheless suggests that the mandate for social justice in nursing codes of ethics continues to produce compelling questions among nurse scholars, educators, and leaders. Those questions emerge from grappling with the structural origins of injustices, their micro-personal and interpersonal expression, and ethical reflection on what forms of professional practice are necessary to adequately respond to these. In reviewing this scholarship, a compelling conversation about nursing codes of ethics, the ethics of social justice, and professional practices seems nascent: for scholars—what kinds of knowledge projects are needed and for what kind of professionalism?

The analysis in this chapter finally suggests that these conversations can be helpfully informed by a deeper consideration of Fraser's feminist materialist philosophy. In its insistence on the need to examine capitalism as a context that shapes the ways we live and the ways we practice, Fraser's work provides something other than a "rupture" or disorientation for nursing ethics. Her critical theory instead supports the ability to recall a legacy of social ethics in nursing.

Echoes of that ethic have been part of nursing's professionalization, despite increasingly undemocratic influences of privilege in a "democratically racist," heteronormative, corporatized, biomedically oriented, and environmentally unmindful health care industry—whether in a public Welfare state or Liberal and partially privatized arrangement.

Especially relevant are Fraser's analyses of how the present times will compel political advocacy, invoking new awareness, convergence with allies, and activism in/among progressive populist movements. Fraser and her colleagues point to the need for a new emerging kind of progressive populist response to the social injustices that are consequences of financialized transnational corporatized capitalism. There is evidence in reviews of recent social justice literature in nursing that this kind of understanding of nursing's social justice mandate is emerging. How nurses will reengage with this progressive form of professional advocacy and how that is understood to be consistent with democratic professionalism in nursing is an important question. It may help to keep reminding ourselves that this is not new and that other generations of nurses have led the way before us.

Ambivalence in nursing about progressive activism linked with caring social justice movements may be a function of uncertainty, disputes, or hostility (among some) about what kind of professionalism nurses understand themselves to be enacting. It is the thesis of this chapter that the kind of democratic caring and democratic professionalism demonstrated in nursing's legacy ethics are a preferred paradigm for professionalism for nursing under twenty-first-century capitalism. Understanding that form of professionalism requires a robust respect for the knowledge and wisdom of those we serve, recognizing and respecting their experiences as peers, also engaging as allies in non-elite relations of advocacy, social justice activism, and caring with them, their communities, and others to address the structural injustices of our world. As I have suggested (Thompson, 2014), this form of "civic" professionalism requires a more radical awareness of how power operates in democracies under capitalism and how we are positioned in it to be the moral agents we want to be.

## References

Allen, David. 2006. Whiteness and difference in nursing. *Nursing Philosophy* 7: 65–78.

Anderson, Joan. 2000. Gender, 'race', poverty, health and discourses of health reform in the context of globalization: A postcolonial feminist perspective in policy research. *Nursing Inquiry* 7: 220–229.

Anderson, Elizabeth. 2017. H.D.'s Tapestry: Embroidery, William Morris and *The Sword Went Out to Sea*. *Modernist Cultures* 12 (2): 226–248.

Arruzza, Cinzia, Tithi Bhattacharya, and Nancy Fraser. 2019. *Feminism for the 99%*. London: Verso Press.

Ashley, Jo Ann. 1975. Nurses in American history: Nursing and early feminism. *The American Journal of Nursing* 75 (9): 1465–1467.

———. 1976. *Hospitals, Paternalism and the Role of the Nurse*. New York: Teachers College Press.

———. 1980. Power in structured misogyny: Implications for the politics of care. *Advances in Nursing Science* 2 (3): 2–22.

Bekemeier, Betty, and Patricia Butterfield. 2005. A critical review of the concept of social justice in 3 national nursing documents. *Advances in Nursing Science* 28 (2): 152–162.

Benner, Patricia. 1984. *From Novice to Expert: Excellence and Power in Clinical Nursing Practice*. Menlo Park: Addison-Wesley.

———. 1997. A dialogue between virtue ethics and care ethics. *Theoretical Medicine* 18: 47–61.

———. 2001. *From Novice to Expert: Excellence and Power in Clinical Nursing Practice*. 2nd ed. Upper Saddle River: Prentice Hall Health.

Benner, Patricia, and Suzanne Gordon. 1996. Caring practice. In *Caregiving: Readings in Knowledge, Practice, Ethics and Politics*, ed. Suzanne Gordon, Patricia Benner, and Nel Noddings, 40–55. Philadelphia: University of Pennsylvania Press.

Benner, Patricia, and Judith Wrubel. 1989. *The Primacy of Caring: Stress and Coping in Health and Illness*. Menlo Park: Addison-Wesley.

Bishop, Anne, and John Scudder. 1991. *Nursing: The Practice of Caring*. New York: National League for Nursing.

Bourdieu, Pierre. 1977. *Outline of a Theory of Practice*. Cambridge: Cambridge University Press.

Boutain, Doris. 2005. Social justice as a framework for professional nursing. *Journal of Nursing Education* 44 (3): 404–408.

———. 2014. The identity, research and health dialogic interview: Its significance for social justice-oriented research. In *Philosophies and Practices of Emancipatory Nursing: Social Justice as Praxis*, ed. Paula Kagan, Marlaine Smith, and Peggy Chinn, 124–135. New York: Routledge Taylor Francis.

———. 2020. Social justice: A review of literature. In *Caring for the Vulnerable: Perspectives in Nursing Theory, Practice, and Research*, ed. Mary de Chesnay and Barbara Anderson, 5th ed. Boston: Jones and Bartlett.

Bowden, Peta. 1995. The ethics of nursing care and ‘the ethic of care’. *Nursing Inquiry* 2: 10–21.

———. 1997. *Caring: Gender Sensitive Ethics*. New York: Routledge.

———. 2000a. An “ethic of care” in clinical settings: Encompassing “feminine” and “feminist” perspectives. *Nursing Philosophy* 1: 36–49.

Brody, Jane. 1988. Virtue ethics, caring and nursing. *Scholarly Inquiry for Nursing Practice* 2 (2): 87–96.

Browne, Annette. 2017. Moving beyond description: Closing the health equity gap by redressing racism impacting indigenous populations. *Social Science & Medicine* 184: 23–26.

Browne, Annette, and Sheryl Reimer-Kirkham. 2014. Problematizing social justice discourses in nursing. In *Philosophies and Practices of Emancipatory Nursing: Social Justice as Practice*, ed. Paula Kagan, Marlaine Smith, and Peggy Chinn. 20–29. New York: Routledge Taylor Francis.

Browne, Annette, and Denise Tarlier. 2008. Examining the potential of nurse practitioners from a critical social justice perspective. *Nursing Inquiry* 15: 83–93.

Browne, Annette, Colleen Varcoe, Victoria Smye, Sheryl Reimer-Kirkham, Judith Lynam, and Sabrina Wong. 2009. Cultural safety and the challenge of translating critically oriented knowledge in practice. *Nursing Philosophy* 10: 167–179.

Buck-McFadyen, Ellen, and Judith MacDonnell. 2017. Contested practice: Political activism in nursing and implications for nursing education. *International Journal of Nursing Education Scholarship* 14.

Buettner-Schmidt, Kelly, and Marie Lobo. 2012. Social justice: A concept analysis. *Journal of Advanced Nursing* 68 (4): 948–958.

Burnam, Mary Ann. 1998. *Lavinia Lloyd Dock: An Activist in Nursing and Social Reform*. Ph.D. Dissertation. Ohio State University.

Butterfield, Patricia. 2017. Thinking upstream: A 25-year retrospective and conceptual model aimed as reducing health inequities. *Advances in Nursing Science* 40 (1): 2–11.

Campesino, Maureen. 2008. Beyond transculturalism: Critiques of cultural education in nursing. *Journal of Nursing Education* 7 (7): 298–304.

Canales, Mary, and Denise Drevdahl. 2014. Social justice: From educational mandate to transformative core value. In *Philosophies and Practices of Emancipatory Nursing: Social Justice as Praxis*, ed. Paula Kagan, Marlaine Smith, and Peggy Chinn, 153–174. New York: Routledge Taylor Francis.

Carper, Barbara. 1979. The ethics of caring. *Advances in Nursing Science* 1 (3): 11–20.

Chinn, Peggy. 2018. The evolution of nursing's ethics of caring. In *A Handbook for Caring Science: Expanding the Paradigm*, ed. William Rosa, Sara Horton-Deutsch, and Jean Watson, 39–52. New York: Springer Publishing Company.

Chinn, Peggy, and Maeona Kramer. 2011. *Integrated Theory and Knowledge Development in Nursing*. 8th ed. St. Louis: Mosby Elsevier.

Chinn, Peggy, and Charlene Wheeler. 1985. Feminism and nursing: Can nursing afford to remain aloof from the women's movement? *Nursing Outlook* 33 (2): 74–77.

Chopoorian, Theresa. 1986. Reconceptualizing the environment. *National League for Nursing Publications* (15-1992): 39–54.

Christy, Theresa. 1969. Portrait of a leader: Lavinia Lloyd Dock. *Nursing Outlook* 17 (6): 72–75.

———. 1970. Portrait of a leader: Lillian D. Wald. *Nursing Outlook* 18 (3): 50–54.

Cohen, Lizabeth. 2020. Renew the deal. *The Atlantic* 17: 2020. https://www.theatlantic.com/ideas/archive/2020/05/how-rebuild-nation/611704/.

Collins, Patricia Hill. 2011. Piecing together a genealogical puzzle. *European Journal of Pragmatism and American Philosophy* 3 (2): 88–112.

Connors, Denise D. 1980. Sickness unto death: Medicine as mythic, necrophilic and iatrogenic. *Advances in Nursing Science* 2 (3): 39–51.

Denison, Jacqueline, Colleen Varcoe, and Annette Browne. 2013. Aboriginal women's experiences of accessing health care when state apprehension of children is being threatened. *Journal of Advanced Nursing* 70 (5): 1105–1116.

Dexheimer Pharris, Margaret, and Carol Pilsbury Pavlish. 2014. Community-based collaborative action research: Giving birth to emancipatory knowing. In *Philosophies and Practices of Emancipatory Nursing: Social Justice as Praxis*, ed. Paula Kagan, Marlaine Smith, and Peggy Chinn, 93–107. New York: Routledge Taylor Francis.

Doane, Gweneth Hartrick. 2014. Cultivating relational consciousness in social justice practice. In *Philosophies and Practices of Emancipatory Nursing: Social Justice as Praxis*, ed. Paula Kagan, Marlaine Smith and Peggy Chinn, 241–250. New York: Routledge Taylor Francis.

Drevdahl, Denise. 2013. Injustice, suffering, difference: How can community health nursing address the suffering of others? *Journal of Community Health Nursing* 30 (1): 49–58.

———. 2018. Cultural shifts: From cultural to structural theorizing in nursing. *Nursing Research* 67 (2): 146–160.

Ethics of Care: Care Ethicists Network. 2013. Interview with Eva Fedar Kittay. https://ethicsofcare.org/eva-fedar-kittay/.

Evans-Agnew, Robin, Marie-Anne Sanon, and Doris Boutain. 2014. Critical research methodologies and social justice issues: A methodological example using photovoice. In *Philosophies and Practices of Emancipatory Nursing: Social Justice as Praxis*, ed. Paula Kagan, Marlaine Smith, and Peggy Chinn, 136–149. New York: Routledge Taylor Francis.

Evans-Agnew, Robin, Susan Johnson, Fugin Liu, and Doris Boutain. 2016. Applying critical discourse analysis in health policy research: Case studies in regional organization and global health. *Policy, Politics and Nursing Practice* 17 (3): 136–146.

Fahrenwald, Nancy. 2003. Teaching social justice. *Nurse Educator* 28 (5): 222–226.

Fahrenwald, Nancy, Janette Taylor, Shawn Kneipp, and Mary Canales. 2007. Academic freedom and academic duty to teach social justice: A perspective and pedagogy for public health nursing faculty. *Public Health Nursing* 24 (2): 190–197.

Falk-Rafael, Adeline, and Claire Betker. 2012. Witnessing social injustice downstream and advocating for health equity upstream. 'The trombone slide' in nursing. *Advances in Nursing Science* 35 (2): 98–112.

Falk-Rafael, Adeline, and Patricia Bradley. 2014. Towards justice in health; An exemplar of speaking truth to power. *Advances in Nursing Science* 37 (3): 224–234.

Fisher, Berenice, and Joan Tronto. 1990. Toward a feminist theory of caring. In *Circles of Care: Work and Identity in Women's Lives*, ed. Emily Abel and Margaret Nels, 35–62. Albany: SUNY Press.

Fowler, Marsha. 2015. Heritage ethics: Toward a thicker account of nursing ethics. *Nursing Ethics* 25 (1): 7–21.

———. 2016. Nursing's codes of ethics, social ethics, and social policy. *In Nurses at the Table: Nursing, Ethics and Health Policy.* Hastings Center Report 46(5): S9–S12.

———. 2017. Why the history of nursing ethics matters. *Nursing Ethics* 24 (3): 292–304.

Fraser, Nancy. 1985. What's critical about critical theory? The case of Habermas and gender. *New German Critique, Special Issue on Jurgen Habermas* (Spring-Summer, No 3), 97–131. Published by Duke University Press.

———. 1989. Struggle over needs: Outline of a socialist-feminist critical theory of late capitalist political culture. In *Unruly Practices: Power, Discourse, and Gender in Contemporary Social Theory*, 161–188. Minneapolis: University of Minnesota Press.

———. 1990. Rethinking the Public Sphere: A Contribution to the Critique of Actually Existing Democracy, *Social Text,* (No. 25/26). 56–80.

———. 1995a. From redistribution to recognition? Dilemmas of justice in a 'post-socialist' age. *New Left Review* (212): 68–93.

———. 1995b. Recognition or redistribution? A critical reading of iris young's justice and the politics of difference. *The Journal of Political Philosophy* 3 (2): 166–180.

———. 1997. *Justice Interruptus: Reflections on the "Post-Socialist" Condition*. New York: Routledge.

———. 2005. Mapping the feminist imagination: From redistribution to recognition to representation. *Constellations* 12 (3): 295–307.

———. 2009. *Scales of Justice: Reimagining Political Space in a Globalizing World*. New York: Columbia University Press.

———. 2017. A triple movement? Parsing the politics of crisis after Polanyi. In *Beyond Neoliberalism. Approaches to Social Inequality and Difference*, ed. M. Burchardt and G. Kirn. London: Palgrave Macmillan. https://doi.org/10.1007/978-3-319-45590-7_3.

Fraser, Nancy, and Axel Honneth. 2003. *Redistribution or Recognition? A Political-Philosophical Exchange*. London: Verso.

Fraser, Nancy, and Rahel Jaeggi. 2018. *Capitalism: A Conversation in Critical Theory*. Medford: Polity Press.

Fraser, Nancy, and Bhaskar Sunkara. 2019. *The Old is Dying and the New Cannot be Born*. London: Verso Press.

Fry, Sara. 1989. The role of caring in a theory of nursing ethics. *Hypatia* 4 (2): 88–102.

Gadow, Sally. 1985. The nurse and patient: The caring relationship. In *Caring, Curing and Coping: Nurse, Physician and Patient Relationships*, ed. Anne Bishop and John Scudder, 31–43. Tuscaloosa: University of Alabama Press.

Gallagher, Ann. 2017. Care ethics and nursing practice. In *Key Concepts and Issues in Nursing Ethics*, ed. P. A. Scott, 55–68. Springer International Publishing.

Blanchet Garneau, Amelie, Annette Browne, and Colleen Varcoe. 2018. Drawing on antiracist approaches toward a critical anti-discriminatory pedagogy for nursing. *Nursing Inquiry* 25: 1–9.

Gastmans, Chris. 1999. Care as a moral attitude in nursing. *Nursing Ethics* 6 (3): 214–223.

Gaut, Delores. 1983. Development of a theoretically adequate description of caring. *Western Journal of Nursing Research* 5 (4): 313–324.

Georges, Jane. 2011. Evidence of the unspeakable: Biopower, compassion, and nursing. *Advances in Nursing Science* 34 (2): 130–135.

———. 2013. An emancipatory theory of compassion for nursing. *Advances in Nursing Science* 36 (1): 2–9.

Gilligan, Carol. 1982. *In a Different Voice: Psychological Theory and Women's Development*. Cambridge: Harvard University Press.

Greenleaf, Nancy. 1980. Sex-segregated occupations: Relevance for nursing. *Advances in Nursing Science* 2 (3): 23–37.

Gregory, David, Jean Harrowing, Bonnie Lee, Lisa Doolittle, and Patrick O'Sullivan. 2010. Pedagogy as influencing nursing students' essentialized understanding of culture. *International Journal of Nursing Education Scholarship* 7 (1): 1–17.

Hassouneh, Dena. 2006. Challenges faced by faculty of color in predominantly white schools of nursing. *Journal of Nursing Education* 45 (7): 255–262.

Held, Virginia. 2006. *The Ethics of Care: Personal, Political and Global*. Oxford: Oxford University Press.

Kagan, Paula, Marlaine Smith, W. Richard Cowling, and Peggy Chinn. 2009. A nursing manifesto: An emancipatory call for knowledge development, conscience, and praxis. *Nursing Philosophy* 11: 67–84.

Kagan, Paula, Marlaine Smith, and Peggy Chinn. 2014. *Philosophies and Practices of Emancipatory Nursing: Social Justice as Praxis*. New York: Routledge Taylor Francis.

Kellett, Peter, and Chantelle Fitton. 2017. Supporting transvisibiltiy and gender diversity in nursing practice and education: Embracing cultural safety. *Nursing Inquiry* 24: 1–7.

Kittay, Eva. 2020. *Love's Labor: Essays on Women, Equality and Dependency*. 2nd ed. New York: Routledge.

Klaver, Klaartje, Eric van Elst, and Andries Baart. 2014. Demarcation of the ethics of care as a discipline: Discussion article. *Nursing Ethics* 21 (7): 755–765.

Leininger, Madeleine. 1988a. *Care: The Essence of Nursing and Health*. Detroit: Wayne State University Press.

———. 1988b. Leininger's theory of nursing: Cultural care diversity and universality. *Nursing Science Quarterly* 1 (4): 152–160.

Liaschenko, Joan. 1993. Feminist ethics and cultural ethos: Revisiting a nursing debate. *Advances in Nursing Science* 15 (4): 71–81.

———. 1999. Can justice coexist with the supremacy of personal values in nursing practice? *Western Journal of Nursing Research* 21 (1): 35–50.

Lipscomb, Martin. 2012. Social justice special issue editorial. *Nursing Philosophy* 13: 1–5.

MacDonnell, Judith. 2014. Enhancing our understanding of emancipatory nursing: A reflection on the use of critical feminist methodologies. *Advances in Nursing Science* 37 (3): 271–280.

MacIntyre, Alasdair. 1981. *After Virtue: A Study in Moral Theory*. Notre Dame: Notre Dame University Press.

MacPherson, Kathleen. 1983. Feminist methods. A new paradigm for nursing research. *Advances in Nursing Science* 5 (2): 17–26.

Matwick, Angela, and Roberta Woodgate. 2017. Social justice: Concept analysis. *Public Health Nursing* 34 (2): 176–184.

McKenzie, Holly, Colleen Varcoe, Annette Browne, Marilyn Ford-Gilboe, Madeleine Dion Stout, Roberta Price, Linda Day, and Jane Inyallie. 2018. Context matters: Promoting inclusion with indigenous women. In *Toward Equity and Inclusion in Canadian Cities: Lessons from Critical Praxis-Oriented Research*, ed. Frank Klodawsky, Janet Stiltanen, and Caroline Andrews, 83–109. Montreal: McGill-Queens University Press.

Mkandawire-Valhmu, Lucy, Patricia Stevens, and Peninnah Kako. 2014. Teaching, research, and service synthesized as postcolonial feminist praxis. In *Philosophies and Practices of Emancipatory Nursing: Social Justice as Praxis*, ed. Paula Kagan, Marlaine Smith, and Peggy Chinn, 231-238. New York: Routledge Taylor Francis.

Newman, Margaret, A. Marilyn Sime, and Sheila Corcoran-Perry. 1991. The focus of the discipline of nursing. *Advances in Nursing Science* 14 (1): 1–6.

Noddings, Nel. 1984. *Caring: A Feminine Approach to Ethics and Moral Education*. Berkeley: University of California Press.

Orem, Dorothea. 1980. *Nursing: Concepts of Practice*. 2nd ed. New York: McGraw-Hill.

Peter, Elizabeth. 2011. Fostering social justice: The possibility of a socially connected model of moral agency. *Canadian Journal of Nursing Research* 43 (2): 11–17.

Puzan, Elayne. 2003. The unbearable whiteness of being (in nursing). *Nursing Inquiry* 10 (3): 193–200.

Racine, Louise. 2003. Implementing a postcolonial feminist perspective in nursing research related to non-Western populations. *Nursing Inquiry* 10(2): 91–102.

———. 2009. Applying Antonio Gramsci's philosophy to postcolonial feminist social and political activism in nursing. *Nursing Philosophy* 10(3): 180–190.

———. 2014. The enduring challenge of cultural safety in nursing. *Canadian Journal of Nursing Research* 46 (2): 6–9.

Racine, Louise, and Pammla Petrucka. 2011. Enhancing decolonization and knowledge transfer in nursing research with non-western populations: Examining the congruence between primary healthcare and postcolonial feminist approaches. *Nursing Inquiry* 18(1): 12–20.

Ray, Marilyn. 1989a. Transcultural caring: Political and economic visions. *Journal of Transcultural Nursing* 1 (1): 17–21.

Ray, Marilyn A. 1989b. A theory of bureaucratic caring for nursing practice in the organizational culture. *Nursing Administration Quarterly* 13 (2): 31–42.

Ray, Marilyn, and Marian Turkel. 2012. A transtheoretical evolution of caring science within complex systems. *International Journal of Human Caring* 16 (2): 28–39.

———. 2014. Caring as emancipatory nursing praxis: The theory of relational caring complexity. *Advances in Nursing Science* 37 (2): 132–146.

Reimer Kirkham, Sheryl, and Annette Browne. 2006. Toward a critical theoretical interpretation of social justice discourses in nursing. *Advances in Nursing Science* 29 (4): 324–339.

Reutter, Linda, and Kaysi Kushner. 2010. Health equity through action on the social determinants of health: Taking up the challenge in nursing. *Nursing Inquiry* 17: 269–280.

Reverby, Susan. 1987. *Ordered to Care: The Dilemma of American Nursing 1850–1945*. New York: Cambridge University Press.

Roberts, Susan Jo. 1983. Oppressed group behavior: Implications for nursing. *Advances in Nursing Science* 5 (4): 21–30.

Rodney, Patricia, Susan Kadyschuk, Joan Liaschenko, Helen Brown, Lynn Musto, and Nickie Snyder. 2013. Moral agency: Relational connections and support. In *Toward a Moral Horizon: Nursing Ethics for Leadership and Practice*, 160–187, (ed.) Janet Storch, Patricia Rodney, and Rosalie Starzomski. Toronto: Pearson.

Rogers, Jamie, and Ursula Kelly. 2011. Feminist intersectionality: Bringing social justice to health disparities research. *Nursing Ethics* 18 (3): 397–407.

Ruddick, Sarah. 1989. *Maternal Thinking: Toward a Politics of Peace*. Boston: Beacon Press.

Sander-Staudt, Maureen. 2006. The unhappy marriage of care ethics and virtue ethics. *Hypatia* 21 (4): 21–39.

Sherwin, Susan. 2011. Looking backwards, looking forward: Hopes for bioethics' next twenty-five years. *Bioethics* 25 (2): 75–82.

Smye, Victoria, Annette Browne, Colleen Varcoe, and Viviane Josewski. 2011. Harm reduction, methadone maintenance treatment and the root causes of health and social inequities: An intersections lens in the Canadian context. *Harm Reduction Journal* 8: 17, 1–12.

Sullivan, William, and Patricia Benner. 2005. Challenges to professionalism: Work integrity and the call to renew and strengthen the social contract of the professions. *American Journal of Critical Care* 14: 78–84.

Sumner, Jane. 2001. Caring in nursing: A different interpretation. *Journal of Advanced Nursing* 35: 926–932.

Thompson, Janice. 2014. Discourses of social justice: Examining the ethics of democratic professionalism in nursing. *Advances in Nursing Science* 37 (3): 17–34.

Thurman, Whitney, and Megan Pfitzinger-Lippe. 2017. Returning to the profession's roots: Social justice in nursing education for the 21st century. *Advances in Nursing Science* 40 (2): 184–193.

Tong, Rosemarie. 1989. The ethics of care: A feminist virtue ethics of care for healthcare. *Journal of Medicine and Philosophy* 23 (2): 131–151.

Tronto, Joan. 1993. *Moral Boundaries: A Political Argument for an Ethic of Care*. New York: Routledge.

———. 2013. *Caring Democracy: Markets, Equality, and Justice*. New York: NYU Press.

Turkel, Marian, and Marilyn Ray. 2000. Relational complexity: A theory of the nurse-patient relationship within an economic context. *Nursing Science Quarterly* 13 (4): 307–313.

Valderama-Wallace, Claire. 2017. Critical discourse analysis of social justice in nursing's foundational documents. *Public Health Nursing* 34: 363–369.

Van Herk, Kimberly, Dawn Smith, and Caroline Andrew. 2011. Examining our privileges and oppressions: Incorporating an intersectionality paradigm into nursing. *Nursing Inquiry* 18: 29–39.

Varcoe, Colleen, Annette Browne, and Laurie Cender. 2014. Promoting social justice and equity by practicing nursing to address structural inequities and structural violence. In *Philosophies and Practices of Emancipatory Nursing: Social Justice as Praxis*, ed. Paula Kagan, Marlaine Smith and Peggy Chinn, 266–284. New York: Routledge Taylor Francis.

Varcoe, Colleen, Marilyn Ford-Gilboe, Annette Browne, Nancy Perrin, Vicky Bungay, Holly McKenzie, Victoria Smye, Jane Inyallie, Koushambhi Khan, and Madeleine Dion Stout. 2019. The efficacy of a health promotion intervention for indigenous women: Reclaiming our spirits. *Journal of Interpersonal Violence* 1–31. https://doi.org/10.1177/0886260518820818.

Walter, Robin. 2017. Emancipatory nursing praxis: A theory of social justice in nursing. *Advances in Nursing Science* 40 (3): 225–243.

Watson, Jean. 1979. *Nursing: The Philosophy and Science of Caring*. Boston: Little, Brown and Company.

———. 1985. *Nursing: Human Science and Human Care: A Theory of Nursing*. Norwalk: Appleton Century Crofts.

———. 2006. Caring theory as an ethical guide to administrative and clinical practices. *Nursing Administration Quarterly* 30 (1): 48–55.

———. 2008. Social justice and human caring: A model of caring science as a hopeful paradigm for moral justice for humanity. *Creative Nursing* 14 (2): 54–61.

———. 2012. *Human Caring Science: A Theory of Nursing*. 2nd ed. Sudbury: Jones & Bartlett Learning.

Weitzell, Jennifer, Jeneile Luebke, Linda West, Maria Del Carmen Graf, Ashley Ruiz, Anne Dressel, and Lucy Mkandawire-Valhmu. 2020. The role of nurses as allies against racism and discrimination. *Advances in Nursing Science* 43 (2): 102–113.

Wesp, Linda, Victoria Scheer, Ashley Ruiz, Kimberly Walker, Jennifer Weitzel, Leslie Shaw, Peninnah Kako, and Lucy Mkandawire-Valhmu. 2018. An emancipatory approach to cultural competency: The application of critical race, postcolonial, and intersectionality theories. *Advances in Nursing Science* 41 (4): 316–326.

Wolf, Zane, and Nancey France. 2017. Caring in nursing theory. *International Journal of Human Caring* 21 (2): 95–108.

Woods, Martin. 2012. Exploring the relevance of social justice within a relational nursing ethic. *Nursing Philosophy* 13: 56–65.

Wuest, Judith. 1994. Professionalism and the evolution of nursing as a discipline: A feminist perspective. *Journal of Professional Nursing* 10 (6): 357–367.

Young, Iris Marion. 1990. *Justice and the Politics of Difference*. Princeton: Princeton University Press.

———. 2011. *Responsibility for Justice*. Oxford: Oxford University Press.

# Bearing Witness and Testimony in Nursing: An Ethical-Political Practice

Christine Ceci, Mikelle Djkowich, and Olga Petrovskaya

## 1 Introduction

Bearing witness has been described in the nursing literature as a method of caring and a way to validate another's experience (Cody 2007). Nurses frequently work with vulnerable and marginalized populations and are present with people while they are facing major changes in their lives. The act of bearing witness is said to help authenticate these experiences and to help people find meaning in their suffering (Cody 2001a). Nurse scholars have tended to focus on the moral obligation that comes with bearing witness, with an emphasis on the individual choice that nurses must make either to bear witness or to not bear witness in the context of a humanistic nurse-patient encounter (Cody 2001a, 2007).

The notion of testimony described outside of the nursing literature is similar to the concept of bearing witness in several important ways. Receiving testimony is the act of listening to and validating another's story, but here it is often discussed in relation to injustice, specifically the possibility of *epistemic injustice*. The possibility of epistemic injustice arises because testimony, more than merely a moral obligation to listen, is understood as an interactive practice of knowledge exchange that happens between people in the real world, with all the complications that ensue

---

An early version of this chapter was originally published in Nursing Philosophy, 2019 Jan 20(1):e12232. https://doi.org/10.1111/nup.12232. Epub 2018 Nov 18.

C. Ceci (✉) · O. Petrovskaya
Faculty of Nursing, University of Alberta, Edmonton, AB, Canada
e-mail: christine.ceci@ualberta.ca; olga.petrovskaya@ualberta.ca

M. Djkowich
Stollery Children's Hospital, Edmonton, AB, Canada
e-mail: djkowich@ualberta.ca

H. Kohlen, J. McCarthy (eds.), *Nursing Ethics: Feminist Perspectives*,
https://doi.org/10.1007/978-3-030-49104-8_4

from this[1] (Code 2014). Miranda Fricker, a contemporary feminist philosopher, was among the first to draw attention to and name the problem of epistemic injustice by showing that knowing is always patterned through social relations of power and privilege (Fricker 2007). According to her analysis epistemic injustice can take two forms. Testimonial injustice, wherein in interpersonal exchanges the specific social identities of speakers position them as not credible or not worthy of a hearing, and hermeneutic injustice, which refers to the broader ways that socially available and collective resources for understanding and interpretation influence our ability to know. Lorraine Code, drawing on the work of both Fricker and Cornelius Castoriadis, a Greek-French philosopher and psychoanalyst writing in the 1970s–1980s, describes this "repository" of resources for understanding as the social imaginary: an "implicit but effective systems of images, meanings, metaphors, and interlocking explanation-expectations woven through a social-political order" (Code 2010, p. 36). The social imaginary, the setting or situation in which all members of a particular social world are immersed, constitutes the social, cultural, historical contexts through which knowledge is both made and enacted. It is not something we can rid ourselves of as it makes understanding, including self-understanding, possible (Code 2010).

It is the reality of immersion in a social imaginary, and the contributions of this to the persistence of inequitable relations of power and privilege in society, which frame our ability to authentically or fairly receive testimony, thus highlighting the need to attend to issues of epistemic injustice (Fricker 2007; Code 2010). Analyses that attend to relations of power, privilege, and thus the possibilities of testimonial and hermeneutic injustice complicate the nursing practice of "bearing witness" suggesting that more than mere "presence" is required. Individual nurses may "bear witness" to the suffering of their patients and indeed, often witness the injustice that creates this suffering. However, a continuing conceptualization of bearing witness as an individual nurse's moral obligation seems not only remarkably limited but also as encouraging a harmful complacency grounded by an uncritical, and possibly unwarranted, confidence in the adequacy of one's own understanding. Code describes this as a kind of epistemic inertia, a reluctance to "look beyond the instituted imaginings that hold received views in place" (Code 2010, p. 37). An alternative account of bearing witness, understood as testimony, draws together ethical and epistemological concerns and highlights the actual work required to create the conditions for understanding the other. Such an account may help nurses think through witnessing as a social and political practice, a conception well established in other academic fields.

In this chapter then, we work to reframe bearing witness or receiving testimony as a social practice, blurring boundaries between ethical-political and epistemic issues. To show the difference an analysis that takes account of "the social" makes, we first discuss the work of William Cody, a nurse theorist from the United States, who draws on Rosemarie Parse's theory of Humanbecoming and presents the idea

---

[1] We just draw attention here the unfortunate similarity in names—Cody and Code—of our primary sources for this paper, as way to hopefully counter confusion as the paper progresses.

of bearing witness in nursing practice as a moral obligation of the humanistic nurse, a figure who appears in these writings as a seemingly autonomous, a-social subject. We then turn to Lorraine Code, a Canadian feminist philosopher and social epistemologist, who utilizes the work of Michel Foucault to inform her writing on testimony. We use Code's and other social epistemologists' ideas to position bearing witness and testimony as a politicized practice in the sense that knowing is always a political activity. We then look to the work of the Truth and Reconciliation Commission of Canada (TRC), specifically the inclusion of honorary witnesses in a nation-wide process of trying to understand and address the historical injustices done to Indigenous peoples in Canada, as an instructive enactment of the ethical-political meanings of bearing witness. In particular we highlight Canadian journalist, Shelagh Rogers', experience as an honorary witness and her conclusion from this experience that witnessing entails a responsibility to respond in the face of injustice. We ultimately argue that bearing witness as a nurse entails both moral and political obligations and that this has important implications for nursing practice.

## 2 Bearing Witness as a Moral Obligation

The three main sources discussed in this paper describe the notion of bearing witness in different but overlapping ways. In nursing literature, bearing witness is described as an individualized moral obligation, mainly by William Cody (2001a, b, 2007) following Parse's theory of Humanbecoming (Parse 1997, 2016). The central idea is that bearing witness involves attesting to the authenticity of another's experience by being present and by listening to their story (Cody 2001a). Nurses are assumed to have access to these stories and experiences by virtue of their positioning near to patients. As Cody writes, nurses may bear "witness to the reality of the person's life as lived, to the extent that the person wishes to disclose it" (Cody 2001a, p. 292). This understanding of bearing witness suggests that by offering presence, nurses are able to help patients find meaning in their experiences. As noted above, Cody's position draws heavily on the work of Parse for whom true presence is "an unconditional loving, non-routinized way of being with, in which the nurse bears witness to… persons and families" (Parse 2016, p. 34). This is said to help patients find meaning through a "face-to-face discussion" (Parse 1997, p. 35) with the nurse being truly present. Echoing Cody, some nurse authors also describe bearing witness as a moral obligation based on nonintrusive and authentic presence, in particular when a nurse comes face-to-face with another's suffering (Bunkers 2014; Campbell and Davis 2011; Naef 2006).

It is important to note, however, that in Cody's work bearing witness does not occur automatically; instead a nurse must choose to either bear witness or not. Bearing witness here denotes a moral way of relating to the patient, understood as (potentially) providing legitimacy to the patient's experience. In contrast, not bearing witness entails a refusal to acknowledge the unique experience of the patient, resulting in a violation of the nurse's moral obligation. Cody suggests that by choosing to not bear witness, nurses are dismissing their moral responsibility to their patients and may even be abandoning them (Cody, 2001a, 2007). Evoking Levinas,[2] Cody warns that the nurse's refusal to bear witness is an act of violence toward the patient (Cody 2007). Thus, and perhaps paradoxically, the apparent passivity of "being with" in "true presence" is transformed into an active and consequential relationship, albeit one enacted by the nurse who appears as an anonymous, autonomous choosing subject—she or he may choose to bear witness, or not.

However, this nurse is apparently not completely autonomous in her or his choosing activities as Cody also writes that bearing witness, or openness to a lived experience of another human being, is not easily achieved in a busy environment dominated by biomedical, "objectivistic" science (Cody 2001a). But despite the strained contexts or conditions of practice settings, according to Cody bearing witness is still possible through "genuine human-to-human relating" (Cody 2001a, p. 290), evident in a nurse's attentive listening, small kindnesses, or simple comfort measures. Such practices may be seen as outward manifestations of the nurse's choice to understand and accept the subjective world of the patient.

While Cody's conceptualization of bearing witness prioritizes the moral obligation of the individualized nurse to treat her or his patients in a humanizing way, Cody is also concerned with bearing witness on a larger scale, frequently addressing societal obligations to ameliorate social ills such as homelessness: "Communities that choose not to provide sufficient shelter to allow thousands of people a safer, warmer alternative to sleeping on sidewalks in winter are *not bearing witness* to the human dignity of those persons; meanwhile, their policies regarding loitering and so forth *bear witness* to their values of safety, order, and appearance" (Cody 2001b, p.99, emphasis added). Here bearing witness, or not doing so, is linked to other sorts of actions, with a community's choices about what to value, and with how these values are related to what comes to be—people sleeping on sidewalks in winter versus tidy and safe parks. This seems a fairly straightforward calculation recognizing the ways that any community will shape life in line with what it attends to, and that there are practical mechanisms involved, i.e., policy tools. It could be assumed that embedded here might be some sort of call to social or political action, and there is, in a way—although the way is not entirely clear: "Cotranscending with the possibles is a (cocreated) process uniquely experienced by each individual…. Through making choices and living with the consequences of choice, persons engage in pushing-resisting rhythms with other people and other events, situations, and processes in the universe. In making these choices, a member of a community may choose to conduct oneself or go down a certain path to be like or unlike other people, according to one's shared and un-shared values in relation to the others" (Cody 2001b, p. 99). This represents Cody's "conceptual exposition" (Cody 2001b, p. 100) offered as an extension of Parse's theory to community nursing practice. Here Cody's recognition and discussion of a concrete social ill shifts to a

---

[2] In his articles, Cody (2001a, b, 2007) cites French phenomenologists and existential philosophers including Sartre, Derrida, and Levinas. Nevertheless, our exposition of Cody's ideas is based purely on his own claims about those primary philosophical sources. In other words, we do not wish to extend our argument and critiques to Levinasian ethics, for instance.

Humanbecoming-inspired, nonjudgmental stance acknowledging differences, values, and consequences—all of which each person is individually responsible for, i.e., the choice to be like or unlike other people. As a rendering of community, this may or may not be the case. However, more to the point, it is not clear how this might guide a nurse's work in the community.

Moreover, though beginning with concern about a complex social problem, such an exposition tends to take social issues revealed in a process of bearing witness into the realm of existential psychology where social action and understanding retains its individual and individualizing character. Thus despite a shift in the site of analysis to the community setting, the view of bearing witness as a moral obligation of an individual nurse in the context of an individual nurse-patient encounter is sustained. What seems to be missing here is any analysis of the social-political dimensions of both nurse and patient/community and thus of the practice of bearing witness itself.

More recently, Humanbecoming scholars have identified the possibility that bearing witness actually does entail a call to action, albeit that "action may simply be standing with or naming what is happening, or it may be more—much more" (Bunkers 2014, p. 194). Here again, it appears that the choice to bear witness is sufficient to fulfill a nurse's moral obligation, and that although this choice may function as a call to action, further response is not a necessary element of the practice of bearing witness. Indeed, the proponents of the Humanbecoming school of thought have been criticized for both their lack of explicit attention to social justice issues and their principled view of nurses as noninterventionist (Thorne et al. 1998; Sally et al. 2004). Contra Humanbecoming scholars, Thorne et al. argue that nursing is a socially and politically engaged profession and that it has a mandate beyond simply offering true presence (Thorne et al. 1998). Nurses do not work in isolation, and must be able to take into consideration, and do some good in relation to, the social and political forces influencing nursing practices (Sally et al. 2004).

Our observations about the problematic assumptions embedded in Cody's discussions of bearing witness extend the concerns expressed by Thorne and colleagues (Sally et al. 2004). Though presented as a uniquely *moral* obligation, bearing witness is described by Cody using terms such as attending, attesting, listening, acknowledging as well as reporting and documenting—thus revealing the unexamined epistemic practices upon which Cody's account of witnessing relies (Cody 2001a, 2007). Even more so is the claim that it is only by bearing witness that a nurse can "really come to know" the person (Cody 2007, p. 20). Bearing witness is clearly knowledge work, yet in these accounts the apprehension of "truth"—of experience or of the person—appears entirely unproblematic. Most concerning in these expositions of bearing witness in nursing literature is the lack of attention to what feminist epistemologists describe as the "complexities of sociality" (Code 2010, p. 33): we are neither neutral nor unmarked "transmitters" and "receivers" of communications. Thus developing some understanding of the workings of "the social" in epistemic practices of witnessing and testimony seems quite necessary.

A recent Canadian example underlines this concern. In 2008, Brian Sinclair, a middle-aged Indigenous man, died after spending 34 h—untreated, unattended to and uncared for—in a Winnipeg hospital emergency room (McCallum and Perry

2018). He had been directed there by his usual physician to receive treatment for an infection. While there, his presence was noted by a number of different healthcare personnel, including several nurses, but he was never truly "seen" in the sense that he was not triaged, talked with, assessed, monitored, and perhaps most important here, acknowledged as a person in need of care. As McCallum and Perry describe, "he was visible as an Indigenous man, not as a patient—despite being in a wheelchair, in an ER, with obvious signs of medical distress that were recognized by other patients" (McCallum and Perry 2018, p. 26). This might be explained, in Cody's idiom, as an example of the violence done to patients when nurses refuse to bear witness to their suffering (Cody 2007). However, this seems entirely inadequate. Rather, as Sinclair's family suggested, Brian Sinclair was "ignored to death" [cited in McCallum and Perry 2018, p. 25]. Interestingly, Code analyzes ignorance not as the absence of knowledge, but as "a force all its own which often blocks knowledge, stands in its place, and tacitly or more explicitly affirms a need or commitment not to know" (Code 2014, p. 154). Brian Sinclair and his suffering, though perfectly visible, was made invisible to health providers through long-established and highly activated "structures of indifference"—historical, cultural, social, and political practices that both produce the suffering of Indigenous Canadians and explain it away (McCallum and Perry 2018, p. 127).

In Code's terms discussed earlier, we can see in this example the workings of an "instituted" social imaginary—norms, systems of judgment, assumptions, and values—which frame, or work to constrain, our capacities to know and respond (Code 2010). Not attending to these, or overlooking their significance, leads to grievous consequences for people in need of care (Browne et al. 2011; Tang and Browne 2008). Romanticized, naive notions of bearing witness in nursing practice are simply not enough.

## 3 Bearing Witness as Epistemological Practice

What kind of thinking is necessary to understand bearing witness as more than or different from an individualized nurse's moral obligation? Turning to literature outside of the discipline of nursing, we find bearing witness analyzed in a way that foregrounds the social practice of witnessing and/or receiving testimony such that concern for issues of social justice creates a political responsibility to respond and/or to take action. Two points, aligned with Fricker's (2007) discussions of the hermeneutic and testimonial aspects of epistemic injustice, are most relevant to this position. First, recognition of witnessing and/or testimony as socially informed practices of knowledge acquisition, and second, understanding of nurses (and others) as socially located knowers. As may be apparent, we see the neglect of these epistemological details as notable absences in Cody's writing.

Perhaps the reader may wonder, on what ground are we bringing together bearing witness and testimony? Is there affinity between these two notions? For some authors, witnessing encompasses both "eyewitness testimony and bearing witness to what cannot be seen" (Oliver 2005, p. 475). Code however, contrasts testimony with direct experience describing it as essentially interactive, involving “a range of practices from simply telling each other the time of day to the complex verbal and written reports that are the substance of knowledge-conveying exchanges between and among people in the real world” (Code 2014, p. 152). Thus, bearing witness and testimony share common characteristics: both are social practices that involve the sharing and receiving of experientially based stories. As we have suggested, discussions of bearing witness in nursing literature recognize its experiential component—a necessity for a nurse to attend to (a story of) a life as lived. Similarly, the interactional nature of bearing witness is implicit in nursing literature. Bearing witness involves an interaction between at least two people, one who shares their experience (usually a story of their life as lived) and one who receives it—a person who bears witness and/or receives a testimony. What is missing, however, in nursing accounts is the full appreciation of what *interactive* entails. Nursing’s gloss on the notion of the interactive appears to be truncated and a-social, mistakenly reducing interaction to a psychological domain of communicational clarity—a concern with precision of messages sent or received without much consideration of how this may or may not occur.

Outside of nursing, more critical discussions of witnessing and testimony have gained prominence in certain philosophical circles since the end of the twentieth century (Kidd et al. 2017; Kramer and Weigel 2017), including in feminist scholarship (Code 2010, 2014). Often, the Holocaust survivor testimony serves as a paradigm case in these discussions, used to emphasize the two-sided nature of testimony—its epistemic and ethical aspects (Code 2010; Schmidt 2011, 2017). Briefly, in contrast to traditional epistemology (e.g., Plato), which rejected testimony as an unreliable source of knowledge, contemporary social epistemology recognizes testimony as an important epistemic source. For example, Schmidt describes knowledge acquisition in everyday life as a form of testimony, such as when children learn by listening to their parents and teachers (Schmidt 2011). Indeed, for social epistemologists, human beings rely on the testimony of others for most of our knowledge or as Code writes, testimony is the “stuff of which knowledge is made” (Code 2010, p. 31). Recognizing the inescapably social and situated nature of knowledge acquisition draws analytical attention to the influences that structured differences such as those of gender, race, and class play in the production and circulation of knowledge (Code 2010, 2014). Thus the sociality of testimony, its necessarily interactive nature, brings to the forefront its ethical and political aspects. In other words, epistemic encounters entail judgments—made by both those who speak and those who listen—about trust (worthiness), credibility, social authority, and truthfulness (Code 2010; Schmidt 2011). Other authors also draw attention to the politicized nature of witnessing/testimony, distinguishing the practices of everyday testimony, a primary source of empirical knowledge, from “testimonies that bear witness to the inhuman, the atrocious, and the elusive” (Givoni 2011, p. 149). Importantly, all of these perspectives underline epistemic issues that arise from the positioning of subjects in a social space.

As described by Code, receiving testimony, like bearing witness, requires listening to another’s story and attesting to the authenticity of another’s experience (Code

2010, 2014). Testimony is an interactive practice that requires the receiver to make an effort to understand what is being shared with them. The key point is that in order to authentically receive testimony, one must not only acknowledge the structuring effects of power and privilege in society but also must be aware of the potential for prejudice that can prevent the receiver from understanding the testimony shared with them (Code 2010, 2014). Not only can understanding not be assumed, but meaning itself is not transparent. It is this point in particular, as well as the argument that receiving testimony should be conceived as the beginning of a political practice, that distinguishes Code's analysis of testimony from nursing's predominantly individualistic and psychologized conception of bearing witness. As we described above, Cody's conception of bearing witness prioritizes the moral obligation of an individual nurse to treat her or his patients in a humanizing way and assumes that a nurse is able to recognize and understand the experience of the other. This latter point seems somewhat problematic in the absence of a critical discussion of how the social positioning of both nurses and patients works to shape understanding. Without this analysis, the nurse is seen to inhabit an unmarked social position, or what is described as a "gaze from nowhere" (Haraway 1988, p. 581), one that somehow allows her or him to directly and accurately apprehend the meaning of another's experience.

In contrast to conceptions of bearing witness in nursing literature, the notion of testimony central to the work of feminist epistemologists like Code recognizes the full force of what interactive means. "Testimony is by definition interactive; it brings such complex matters as trust, credibility, responsiveness and responsibility… and 'situation' into focus in knowledge-making and knowledge-circulating practices. Often testimonial exchanges have to negotiate structures of power and privilege" (Code 2014, p. 152). Similar to Haraway's concern with claims-making as a power-sensitive conversation (Haraway 1988), Code highlights the nontransparency of receiving testimony, challenging assumptions about the ease and neutrality of communicative practices, and locates the ethics of these practices not in simple reception (or "true presence") but in critical interrogation of meaning (Code 2014).

Approaching testimony as a power-sensitive conversation, Code emphasizes the structuring effects of power and privilege in society and the influence of these in how testimony is able to be received and understood. She also stresses the responsibility for action that results from receiving another's testimony (Code 2010, 2014). As noted above, Code describes testimony as an interactive process—the sharing of knowledge and experiences between people. At a glance, this is similar to Cody's idea of bearing witness to another's experience, which involves listening to and validating another's story (Cody, 2001a, b, 2007). However, Code argues that in order for testimony to be fully understood, the person receiving the testimony must be authentic and able to understand what is being shared with them (Code 2014). Importantly, the ability to understand another's experience depends on the listener's awareness of a possibility of prejudice against the speaker. Prejudice is inevitable, flowing from situatedness in a social world and the structured and structuring effects of difference. Here however, the danger is not so much the failure to understand the other, but the failure to recognize that any understanding is an accomplishment and will be necessarily partial. Or as Haraway suggests, we start from recognizing that we have a point of view and then cultivate a desire to learn how to see from the perspective of others (Haraway 1988).

For Code, to authentically receive testimony in a context shaped by prejudice, one must critically and continually examine one's own understanding. Notably, Code's idea of authenticity differs from that of Cody (2007). Whereas Code might agree with Cody's suggestion that authenticity requires the offering of true presence, she would insist that an authentic response also requires taking action to critically examine the influence of power and privilege on ourselves and others. To explain the importance of authentically receiving testimony and the critical reflection it requires, Code draws on Fricker's concept of testimonial injustice. As noted previously, Fricker explains that testimonial injustice occurs when testimony is not considered credible due to prejudice that prevents the testifier from being heard and understood (Fricker 2007). Both Code and Fricker emphasize that in order to authentically receive testimony, we must not only be open to it but must also be aware of how our own prejudice might influence us (Code 2014; Fricker 2007). Discussing privilege, Code suggests that the giving, receiving, and understanding of testimony requires a willingness to examine one's own positionality, as well as that of the other, and its effects on what one is able to understand (Code 2010).

The negotiation of potential differences and social boundaries is a complex process requiring a critical examination of not only one's individual beliefs and values but societal values as well. Both Code and Fricker gesture outwards from an individual's thoughts and feelings and attend to the possibilities of hermeneutic as well as testimonial injustice, with the former arising through the instituted social imaginary in which we are all immersed (Code 2010, 2014; Fricker 2007). As described previously, these "interlocking explanations-expectations" are threaded through the social order, shaping "individual" values, beliefs, and actions (Code 2010). Recognizing that societal values can be responsible for perpetuating injustice, the effects of these values need to be acknowledged when receiving testimony. This concern makes the context of bearing witness far larger and more complex than that suggested by descriptions of somehow isolated and self-contained nurse-patient encounters.

Certainly in the example of Brian Sinclair, the interacting forces of both testimonial and hermeneutic injustice are clearly seen. Historical and current practices of racism meant that as an Indigenous man in a Canadian emergency department, Brian Sinclair would have been assigned little credibility before he even spoke. He was positioned from the outset on the losing side of an equation that weighted the privileges of whiteness, particular presentations of self, structural norms of professional expertise and systems of judgment as more trustworthy than his request for care. Everybody in that time and place enacted what "everybody knows," those "interlocking explanations-expectations" (Code 2010) that produced the "knowledge" that Brian Sinclair was merely homeless, intoxicated, or sleeping, and justified and sustained the active ignorance, or commitment not to "know" otherwise, that produced his death.

How to counter such "inertia" when it is clear that we need to know better? In addition to demanding attention to the effects of relations of power and privilege in shaping understanding, the process of receiving and understanding testimony calls forth a responsibility to take action that extends beyond individual self-reflection (Code 2010, 2014). For Code this is realized through what she calls advocacy practices—actively *doing*, or trying to do, *epistemic justice*. Advocacy, though difficult to enact fairly, as it is subject to all of the same issues as any other knowledge practice (i.e., we may be wrong in what or how we advocate), may be required to help testimony to "go through." That is, advocacy may support the possibilities of acknowledgment (Code 2010). We can well imagine a different outcome for Brian Sinclair if even one nurse had advocated on his behalf.

Thus advocacy can take the form of representing and supporting marginalized groups, or countering the systems of ignorance that put people at risk, as patients often are, of not being heard. Code recognizes that advocacy can be difficult, especially if it goes against the dominant interests in society; however, she maintains that it is a crucial part of receiving testimony if that testimony, as well as its reception, is going to be something that matters (Code 2010). Thus, the receiving of testimony is active rather than passive, a beginning rather than an end in itself. For Code, awareness that social inequalities complicate the practice of testimony, and may lead to testimonial injustice, does not release us from a responsibility to act against the perpetuation of social injustice (Code 2010, 2014). Recognizing the existence of injustice is, in fact, part of what is required to respond authentically and effectively to other people.

## 4 Responding to Testimony: The Truth and Reconciliation Commission of Canada

If we authentically receive another's testimony, have borne witness to their experience, and recognize that they are suffering from an injustice, what is our responsibility? Recent events in Canada draw renewed and public attention to the importance of bearing witness and offer an instructive example of a social practice of witnessing. The Truth and Reconciliation Commission (TRC) was created to bring to light, and begin the process of addressing, the injustices done to Indigenous peoples as a result of the colonial practices of the residential school system in Canada (Truth and Reconciliation Commission of Canada 2015a). The formation of the TRC was grounded in the view that reconciliation between Canadian settler and Indigenous peoples could only happen once the truth was made public, heard and responded to—a process simultaneously epistemic and ethical (Truth and Reconciliation Commission of Canada 2015a). TRC events happened across Canada with the goal to give voice to Indigenous peoples and emphasize the importance of publicizing the truth about the residential school system. At these events, honorary witnesses listened to the experiences of the Survivors of the residential school system. The role of these honorary participants was to "bear official witness to the testimonies of Survivors and their families" (Truth and Reconciliation Commission of Canada

2015a, p. 117), a process consistent with the Indigenous principle of witnessing. Shelagh Rogers, a journalist with the Canadian Broadcasting Corporation (CBC) was one of these honorary witnesses.

Bearing witness as a response to human suffering is a necessary beginning, the first step in the approach taken by the TRC in a nationwide process of trying to understand and address the historical injustices done to Indigenous peoples in Canada. But even here, witnessing is conceptualized not as an end in itself, but as an active process that results in an obligation to act to correct injustice (Truth and Reconciliation Commission of Canada 2015a, b). Rogers describes her participation in the TRC events, stressing both the honor and responsibility conferred on her by the role of bearing witness (Rogers 2014). She suggests that through bearing witness, through socially engaged and critical listening, she has also accepted a responsibility to take action both to facilitate change, and to share the experience with others. She talks specifically about her social positioning and how the associated power and privilege enable and require her to fulfill a responsibility to take action (Rogers 2014). For Rogers, taking action includes sharing the stories of residential school Survivors with people across Canada who might not have been otherwise informed and advocating publicly for reconciliation.

Undoubtedly, raising awareness about the TRC and its findings is only the first step toward reconciliation. In the example of Rogers and the TRC, we are encountering both the politicized and socially engaged notion of bearing witness; one that suggests that as witnesses we have a responsibility to respond to what we have witnessed. The thinness of the notion of bearing witness as found in much of the nursing literature, most familiar to nurses in the context of Humanbecoming theory, would have limited capacity to guide nurses to fulfill their roles in, for example, the enactment of TRC recommendations in relation to the Indigenous peoples of Canada.

The responsibility to take action when we bear witness is both ethical and political in nature. Not only does bearing witness require a willingness to critically examine our own beliefs in order to first understand and then to begin to facilitate change, it also directs nurses to approach social arrangements and structures with eyes wide open. By juxtaposing the political ideas of a feminist philosopher and social epistemologist Code—the ideas resonating with the aspirations of the TRC—and an individualistic conception of bearing witness by nurse theorist Cody, we have suggested that bearing witness gives rise not only to a moral obligation to listen but also to the ethical-political obligation to work to address injustices. If bearing witness is more than a moral obligation but also includes a political component, what implications does this have for nurses in practice?

## 5 Beyond "True Presence": Implications for Nurses' Practices

Are we asking too much of nurses? Certainly, some have argued for limits to nurses' responsibilities for social justice (Lipscomb 2011). Yet at the same time, nurses care for patients from diverse backgrounds, with different views and experiences of the world. Nurses are present for times of joy and suffering and are called to bear witness to these experiences. Nurses also frequently witness the profound health effects of social marginalization and oppression and may also be active participants in their perpetuation as we could see in the case of Brian Sinclair. Rather than listening passively and uncritically, how could nurses work to understand the ways relations of power and privilege in society structure the experiences of their patients? How can we, as nurses, ensure that we are open to actually and effectively hearing what our patients have to say? To see how their experiences have been made?

Being open to and hearing our patients starts with being present. We agree with Cody that nurses have a moral responsibility to be present, to bear witness to the experiences of our patients, and to help them through the difficult experiences they are facing (Cody, 2001a, b, 2007). In contrast with Cody however, we argue that as nursing is a socially embedded practice, so is the practice of bearing witness. Using the work of Code, we argue that it is also nurses' responsibility to be aware of the effects of social positioning, our own situatedness in relations of power and privilege, and importantly, how these will influence our ability to hear what patients have to say to us (Code 2010, 2014). According to Code marginalized societal groups may be unable to communicate effectively across differences and their testimony may not be heard or understood by those with more power in society (Code 2010). In the same way, Code recognizes the difficulty in being able to discern how one's ability to hear and understand is shaped through social relations of power and privilege. She acknowledges that authentically receiving testimony, when we are positioned to do so, raises complex ethical issues, including the possibility of complicity in injustice (Code 2014).

To be complicit is defined as "helping to … do wrong in some way" (Merriam-Webster Dictionary 2018). Whitt uses the phrase *complicit injustice* to refer to the ways that both ignorance and a passive attitude can perpetuate injustice in society (Whitt 2015). He describes ignorance as implicated in the maintenance of power and privilege in society—a dangerous state of affairs that needs to be challenged by greater knowledge of injustices. Similarly, Code writes, "ignorance maintained and sustained is a powerful force of resistance to testimonial knowledge 'going through'" (Code 2010, p. 27) and strongly argues that ignorance can be damaging to society. Many nurse educators in Canada consider social justice an important concept in nursing curricula and advocate for its explicit and meaningful inclusion (Rozenda et al. 2017). In order to begin to address social justice issues in nursing, we must begin with knowledge. As identified by Whitt, one strategy to prevent injustice is to address the issue of ignorance (Whitt 2015). This is echoed by the TRC and its calls to action, which specifically include the need for education on the injustices done to Canada's Indigenous peoples to be included in curricula (Truth and Reconciliation Commission of Canada 2015b). This call to action is beginning to be realized at the University of Alberta, where discussion about the recommendations of the TRC is included at all levels of nursing education.

What would the active, politically charged approach to bearing witness, outlined by Code and Rogers, look like in nursing practice? Nurses are meant to advocate for their patients. We are tempted to say that this could be as simple as ensuring that patients from marginalized populations receive the same quality of care as other patients. However, the word *simple* is utterly inappropriate. Considering the realities of contemporary nursing practice, nurses' decisions for resource allocation as well as timeliness and extent of services are often driven by organizational priorities for efficiency, whereby justice-based advocacy may be backgrounded (Allen 2014). In addition, when allocating scarce resources—such as acute care beds—nurses find themselves operating within the discourse of "undeserving patients." This discourse suggests that these patients—often from marginalized groups—have inflicted their problems upon themselves and thus they are not as deserving as others (Allen 2014; Hillman 2013). These examples suggest that nurses' responsibility to advocate for marginalized patients, arising from bearing witness to their stories and experiences, is not *simple*.

Nurses can share the experiences and the stories of injustice that they have borne witness to with individuals and organizations involved in shaping public policy. Perhaps the most effective mechanism is actually getting involved in the creation of policies affecting health and thus helping to tackle injustice on a bigger scale. This responsibility for advocacy can be difficult to realize, but nurses are well positioned to work with marginalized groups in society and provide some of the support and resources that they need. It can be difficult to meaningfully advocate for social justice, especially in healthcare, where fiscal restraint is always a priority. However, the Canadian Nurses Association (CNA) specifically outlines the ethical responsibility that nurses have to advocate for social justice issues and emphasizes the importance of promoting justice in nursing practice (Canadian Nurses Association 2017).

Nurses aiming to foreground issues of social justice in their practices may find these alternative conceptualization of bearing witness, informed by the ethical-politics of testimony, useful as they strive to shape nursing practice in more active and engaged ways, and particularly to challenge the conditions that hold us in place as passive witnesses. By striving to authentically bear witness and accepting the resulting responsibility to take action, we can fulfill both the moral and the political obligations that we have suggested are central to the concept of bearing witness in nursing practice.

## 6 Conclusion

The concept of bearing witness has been discussed as it appears both inside and outside of the discipline of nursing alongside the practice of testimony. In nursing, Cody suggests that bearing witness is a moral obligation for nurses assumed to be autonomous, choosing subjects. This obligation is fulfilled by being with, communicating humanely, and offering true presence to patients. This is said to authenticate the experience of the patient, and to help them find meaning in their suffering (Cody 2001a, b, 2007). In contrast, a feminist social epistemologist Code describes a related idea of testimony as an explicitly political concept. Receiving testimony entails a twofold political obligation. First, it requires navigating power and privilege in society to ensure that testimonial injustice does not occur and that the receivers of testimony truly understand what has been shared with them. Second, it results in a responsibility to respond to the injustice in society (Code 2010, 2014). Thus, authentically receiving testimony requires a critical examination of one's own values and beliefs and an understanding of how these are produced and sustained in an inequitable social world. But an ethical-political understanding requires more than the examination of one's personal position in society. Patterned inequalities mean receiving testimony often results in witnessing injustice, which in turn calls forth a response and a political responsibility to take action (Code 2010, 2014). Shelagh Rogers' experience as an honorary witness for the TRC illustrates the political possibilities for action upon receiving testimony. Bearing witness, both as a moral and as a political responsibility, has several implications for nursing practice. These implications can be summarized, in Rogers' words, as "a collective responsibility to make things better. To act. Because if we do nothing, nothing will change" (Rogers 2014, p. 3).

## References

Allen, Davina. 2014. *The Invisible Work of Nurses: Hospitals, Organisation and Healthcare*. London: Routledge.

Browne, Annette J., Victoria Smye, Patricia Rodney, Sannie Tang, Bill Mussell, and John O'Neil. 2011. Access to primary care from the perspective of aboriginal patients at an urban emergency department. *Qualitative Health Research.* 21 (3): 333–348. https://doi.org/10.1177/1049732310385824.

Bunkers, Sandra S. 2014. Witnessing. *Nursing Science Quarterly.* 27 (3): 190–194. https://doi.org/10.1177/089431453448.

Campbell, Michelle E., and Lisa Davis. 2011. An exploration of the concepts of bearing witness as a constituent of caring practice. *International Journal for Human Caring.* 15 (1): 7–12.

Canadian Nurses Association. [Internet]. 2017. Code of ethics for registered nurses. https://www.cna-aiic.ca/~/media/cna/page-content/pdf-en/code-of-ethics-2017-edition-secure-interactive.

Code, Lorraine. 2010. Testimony, advocacy, ignorance: Thinking ecologically about social knowledge. In *Social Epistemology*, ed. A. Haddock, A. Millar, and D. Pritchard, 1–31. Oxford: Oxford University Press.

———. 2014. Ignorance, injustice and the politics of knowledge. *Australian Feminist Studies.* 29 (80): 148–160. https://doi.org/10.1080/08164649.2014.928186.

Cody, William K. 2001a. The ethics of bearing witness in healthcare: A beginning exploration. *Nursing Science Quarterly.* 14 (4): 288–296.

———. 2001b. Bearing witness-not bearing witness as synergistic individual-community becoming. *Nursing Science Quarterly* 14 (2): 94–100.

———. 2007. Bearing witness to suffering: Participating in cotranscendence. *International Journal for Human Caring* 11 (2): 17–21.

Fricker, Miranda. 2007. *Epistemic Injustice: Power and the Ethics of Knowing*. Oxford: Oxford University Press.

Givoni, Michal. 2011. Witnessing/testimony. *Mafte'akh.* 2: 147–170.

Haraway, Donna. 1988. Situated knowledges: The science question in feminism and the privilege of partial perspectives. *Feminist Studies.* 14 (3): 575–599.

Hillman, Alexandra. 2013. "Why must I wait?" The performance of legitimacy in a hospital emergency department. *Sociology of Health & Illness.* 36 (4): 485–499.

Kidd, Ian J., Jose Medina, and Gaile Pohlhaus, eds. 2017. *The Routledge Handbook of Epistemic Injustice*. New York: Routledge.

Kramer, Sybille, and Sigrid Weigel, eds. 2017. *Testimony/Bearing Witness: Epistemology, Ethics, History and Culture*. London: Rowman & Littlefield.

Lipscomb, Martin. 2011. Challenging the coherence of social justice as a shared nursing value. *Nursing Philosophy.* 12 (1): 4–11.

McCallum, Mary Jane, and Adele Perry. 2018. *Structures of Indifference: An Indigenous Life and Death in a Canadian City*. Winnipeg: University of Manitoba Press.

Merriam-Webster Dictionary [Internet]. 2018. Complicit. https://www.merriam-webster.com/dictionary/complicit.

Naef, Rahel. 2006. Bearing witness: A moral way of engaging in the nurse-patient relationship. *Nursing Philosophy.* 7 (3): 146–156.

Oliver, Kelly. 2005. Witnessing, recognition, and response ethics. *Philosophy & Rhetoric.* 48 (4): 473–493.

Parse, Rosemary R. 1997. The human becoming theory: The was, is, and will be. *Nursing Science Quarterly.* 10 (1): 32–38.

———. 2016. Witnessing. *Illuminations* 25 (1): 1.

Rogers, Shelagh. 2014. Reflections on being an honorary witness for the TRC. CBC News [Internet]. http://www.cbc.ca/news/indigenous/reflections-on-being-an-honorary-witness-for-the-trc-1.2587064.

Rozenda, Célia Alves, Anna Santos Salas, and Brenda Cameron. 2017. A critical review of social and health inequalities in the nursing curriculum. *Nurse Education Today* 50: 62–71. https://doi.org/10.1016/j.nedt.2016.12.006.

Sally, Thorne, Angela Henderson, Gladys McPherson, and Barbara Pesut. 2004. The problematic allure of the binary in nursing theoretical discourse. *Nursing Philosophy.* 5 (3): 208–215.

Schmidt, Sibylle. 2011. Trauma Testimony Discourses/the Philosophy of Testimony: Between Epistemology and Ethics [Internet]. Youtube: 2011 Feb 23. Video. https://www.youtube.com/watch?v=nmzHa1dGH8c.

———. 2017. The philosophy of testimony—between epistemology and ethics. In *Testimony/Bearing Witness: Epistemology, Ethics, History and Culture*, ed. Sybille Kramer and Sigrid Weigel, 259–274. London: Rowman & Littlefield.

Tang, Sannie, and Annette Browne. 2008. "Race" matters: Racialization and egalitarian discourses involving aboriginal people in the Canadian health care context. *Ethnicity & Health* 13 (2): 109–127.

Thorne, Sally, Connie Canam, Susan Dahinten, Wendy Hall, Angela Henderson, and Sheryl Kirkham. 1998. Nursing's metaparadigm concepts: Disimpacting the debates. *Journal of Advanced Nursing.* 27 (6): 1257–1268. https://doi.org/10.1046/j.1365-2648.1998.00623.x.

Truth and Reconciliation Commission of Canada (TRC). [Internet]. 2015a. What we have learned: Principles of truth and reconciliation. http://www.trc.ca/websites/trcinstitution/File/2015/Findings/Principles_2015_05_31_web_o.pdf.

——— (TRC). [Internet]. 2015b. Truth and reconciliation commission of Canada: Calls to action. http://www.trc.ca/websites/trcinstitution/File/2015/Findings/Calls_to_Action_English2.pdf.

Whitt, Matt S. 2015. Other people's problems: Student distancing, epistemic responsibility, and injustice. *Studies in Philosophy & Education* 35: 427–444. https://doi.org/10.1007/s11217-015-9484.

# Intercultural Perspectives

Dianne Wepa

## 1 Introduction

As healthcare practitioners, nurses are strongly positioned to influence families and communities. Each interaction with a patient provides nurses with the opportunity to engage meaningfully in order to improve the healthcare journey and outcome. Nursing has long been concerned about the importance of context in understanding health behaviour. Nurses were among the first to question a preference for the objective view of the patient and to emphasise the lived experience (Goodrich and Cornwall 2008). Consequently, the principles of treating people regardful of their differences and building a therapeutic relationship within a social justice framework underpin most models of nursing within the twenty-first century (Racine 2017; Wepa 2015). Nurses have challenged the very nature of science and how knowledge is gained (Benner 1984; Benner et al. 2008; Burns and Grove 2009); however, the reductionism remains dominant within Western science (Beresford 2010).

Ethics is a part of all our actions as humans and as nurses (De Souza 2015). There are many ethical issues that can arise for nurses working within a health context. Because nurses work with people, ethical considerations can be varied and complex, societal, personal and cultural. The cultural dimension of ethical clinical practice and the way in which feminist perspectives and strategies interface with culture is the focus of this chapter. This cultural dimension will be considered in relation to the following themes; Pre-colonisation and gender roles; We-dentity and ethical decision-making; inter-culturalism, ethics and research.

---

D. Wepa (✉)
Clinical and Health Sciences, University of South Australia, Adelaide, SA, Australia
e-mail: Dianne.wepa@unisa.edu.au

H. Kohlen, J. McCarthy (eds.), *Nursing Ethics: Feminist Perspectives*,
https://doi.org/10.1007/978-3-030-49104-8_5

## 2 Pre-colonisation and Gender Roles

Although feminism is considered a western construct and social movement, First Nation peoples traditionally supported clearly defined *and* complimentary roles for men and women. On the marae (cultural meeting place) in New Zealand, the woman's voice is the first to be heard before people can approach as visitors. Women traditionally and in modern times in New Zealand provide a waiata (song) to support the ceremonial speeches normally provided by a male. If the woman decides that they do not agree with what has been conveyed, then the woman or women will not stand to sing in support of the speaker. I have witnessed this occurring first-hand whereby the act of *not* taking action provided a clear indication of disagreement of the words that have been spoken.

With the introduction of colonisation in the 1700s, the role of men changed and this had a detrimental effect on the family (whānau) unit (Durie 2007). Traditionally Māori men would contribute to the collective well-being of the tribe (iwi) through the provision of their labour. When European men arrived in New Zealand, Māori men observed key differences between European men and their own. For example, European men provided labour outside of the whānau unit and were paid a wage. This practice was alluring to Māori men as they could see that status could be gained within the new evolving society by selling their means of production. Over a relatively short period of time, Māori men became more aligned to European men's values and practices and they began to view Māori women quite differently (Pihama 2001; Wepa 2016).

Finally, language can be considered the *window* to a culture because it provides insights and understandings that cannot be acquired elsewhere. It can explain why certain aspects are privileged in one culture and not another. The language that identifies gender roles between males and females has been fluid for First Nations' people. For example, for the Inuit people, when a soul leaves a man's body his gender is no longer of importance. The soul itself is neither male nor female (Waldram James et al. 2006). Within the Māori language in New Zealand, the word 'ia' is gender neutral and means he or she. Most of the phrasing does not distinguish between genders. Other examples include parent or parents which is 'matua'. The male and female-specific terms are 'tuahine' sister or 'tungane' brother. A girl is called 'hine' and a boy 'tama'.

The gender-neutral language used by Māori in traditional and modern times provides an insight into the gender-balanced nature of the culture. Both males and females were considered with equal merit in terms of roles within the whānau unit and females were revered within many origin stories as the giver and taker of life. For example, the well-known demi-god called Maui who demonstrated great strengths and prowess came to an early demise because of his hedonistic tendencies. Despite his many achievements, he wanted the one thing that eluded him the most—eternal life. As the story goes, Maui was able to change his form into a variety of creatures. In order to live forever, he decided to turn himself into a small insect and proceeded to enter the womb of the goddess of death—Hine-ahu-one. Upon feeling the insect crawling up her thigh, Hine-ahu-one immediately closed her legs and killed the insect—hence the demise of the great man—Maui!

## 3 We-dentity and Ethical Decision-Making

First Peoples' perspectives of reality emphasise a collective view point where the term 'we', not 'I' is referenced (Wepa 2016). The use by Māori of 'we' and 'us' is indicative of a collective cultural orientation. In my research on the experiences of Māori people using healthcare services, I found the participants ($n$ = 20 families), the majority of which were women frequently used the term 'we' when referring to their health care experiences (Wepa 2016). Speaking from this collective viewpoint, other phrases were also included in their discourse such as 'as Māori', or 'whānau' in addition to 'we'.

> 'We don't do anything on our own'

> 'We are just worrying about whanau being cared for'

> 'We are having to arrange whanau to come and be with the patient'

> 'All Māori do that—making sure someone's checking up on them'

Authors who have examined the concept of we-dentity refer to the *Te Kakano* model which privileges cultural world views and practices when assessing and planning interventions (Wilson 2004). Within this model, whānau are kept at the centre of clinical practice as opposed to a person-centred approach that focused on the individual (Rogers 1951). Edward's (2009) research also captured the dynamic 'I am because we are', a key premise of we-dentity. His study confirms Davey and Dwyer's (1984) assertion that the Māori world view, and I would argue, First Nations' world view, is de-centred whereby the universe is viewed as dynamic, complex and continuous with no single centre. Within this paradigm, human beings are not the centre of consciousness and knowledge. Viewed from a communication stance, this perspective is supported by Durie (2003) who argues that Māori attempt to find meaning in bigger pictures and higher order relationships. Durie examined the use of metaphor which is commonly used by Māori, as it avoids a focus on the individual and positions the person within a broader context as members of *whānau, hapū* (sub-tribes) and *iwi* (tribes). Similarly, Penetito (2000) proposed Māori identity is a collective process where they acclaim their Māori-ness in relation to one another.

In a culture that is mostly dominated by *verbs* reflecting the view that existence is defined by energy and spirit that is in constant transformation, First Peoples attend to the 'relationship between things'. In contrast, Westernised peoples, who in the main in New Zealand, are the providers of healthcare, use language that is dominated by *nouns*. As a consequence, they focus on the 'characteristics of things' that are evident in the noun-driven English language.

What that means for nursing practice is that the we-dentity of First Peoples needs to be recognised and acknowledged when engaging with Māori patients, clients and families. Incorporating the collective identity of Māori and their whānau is essential for those planning and delivering health services. Rather than defaulting to the dominant bio-medical models which privilege the *individual and independence*, there must be a realignment towards collective orientation and ways of functioning which are *interdependent.* What we have now is not working for Māori whānau and other First Peoples populations that have been colonised. Compared to others, the disparities in health between them and the general population are consistent globally with Indigenous people's disproportionate high rates of morbidity and mortality (Browne et al. 2012; Kirmayer 2015; Lowe et al. 2012).

Differences in world views translate uneasily into ethical decision-making in clinical practice. Similar to Western bio-medical models of clinical decision-making, a key feature of Western principle-based theories of ethical decision-making is their focus on individual accountability. A principled approach to ethical decision-making evaluates the morality of actions in terms of their consistency with abstract moral principles. Right actions are those which are based on moral principles such as truth-telling and justice (Beauchamps and James 2001). Each moral chooser is seen as an individual making his/her moral choices in an autonomous way. *Virtue-based theories*, on the other hand, evaluate judgments and decisions in terms of qualities of the virtuous person. Right actions particularly for nurses, are those actions which proceed from a person acting from good motives (such as a sense of duty or kindness). Virtue ethics stress the importance of community values (Land and Pastura 2016).

In New Zealand, the principle-based approach has dominated healthcare especially in terms of concepts such as *confidentiality* and *impartiality.* For example, principle-based theorists assume that in making ethical choices, personal histories and family and community relationships are pushed into the background or altogether ignored (Lacovinao 2002). According to virtue-based theorists, they can neither forget who they are and where they come from nor ignore the special attachments and obligations they have to family and community. Nursing education in New Zealand has supported virtue-based ethics to an extent in terms of ensuring *cultural safety* competencies are met in order to become a registered nurse (Wepa 2015). An example of how cultural safety has influenced ethics education can be found in the following extract within the Code of Ethics for Nurses in New Zealand 'Nurses demonstrate ethical nursing practice when they advocate individually and collectively for the elimination of social inequities' (Nursing Council of New Zealand 2012). The attention paid to a person's culture within the Code provides an explicit understanding that nurses are culture bearers and as such bring their own biases and *taken-for-grantedness* to the nurse/patient relationship. Within the power dynamic of this relationship, nurses must carefully consider the impact of their own cultural history and how this might impact on the patient's cultural practices. Ultimately, attention to culture from the nurse *and* patient perspective provides the framework for ethical decisions to take place that are *regardful* of difference and not *regardless* of difference (Elaine and Irirhapeti 1996).

## 4 Inter-culturalism, Ethics and Research

In most countries there is a wide array of culturally diverse and complex social groups. Such a phenomenon is as considered necessary for humankind as biodiversity is for nature (United Nations Educational, Scientific and Cultural Organisation 2016). Yet such diversity sometimes leads to ethical concerns because certain groups of people may be especially vulnerable to the effects of poorly planned or inconsiderate interventions. This is because in the past such groups have often experienced the harmful effects of colonisation, indifference or ignorance. From a research perspective, within Australia and New Zealand Indigenous populations are governed by separate guidelines. The guidelines include The NHMRC Values and Ethics: Guidelines for Ethical Conduct in Aboriginal and Torres Strait Islander Health Research (National Health and Medical Research Council 2003) for Australia and the Health Research Council of New Zealand's Guidelines for Researchers on Health Research Involving Māori (Health Research Council 2010) and Guidelines on Pacific Health Research (Health Research Council 2014).

For Māori people, European conceptions of knowledge and of research have meant that while being considered *primitive*, Māori society has, nevertheless, provided fertile ground for research (Graham 1997). The question of *whose* knowledge was of little consequence as early ethnographers, educational researchers and occasional travellers described, explained and recorded their accounts of various aspects of Māori society. While this type of research was validated as scientific it did little to extend the knowledge of Māori people. Instead, it left a foundation of ideologically laden data about Māori society, which has distorted notions of what it means to be Māori: this is what is called the *deficit model* (Durie 2003).

Traditionally, Māori society valued knowledge highly, to such an extent that certain types of knowledge was entrusted to only a few members of the *whanau* or family. Knowledge was considered *tapu* or sacred and there were sanctions that ensured that it was protected, used appropriately and transmitted with accuracy. To make mistakes and to misuse it would take away *mana* (prestige) from the whole *whānau*, and would certainly reduce a student's chances of gaining more knowledge. Research practices played a small but important part of the colonisation of New Zealand First Peoples as it is concerned with defining knowledge. To be colonised is to be defined by someone else and to believe it even though you are confronted daily by evidence to the contrary (Freire 1972). In Māori communities today, there is a deep distrust and suspicion of research (Smith 2012). This suspicion is not just of non-Māori researchers, but of the whole philosophy of research and the different sets of beliefs which underlie the whole research process. Traditionally, robust research methodology was based on the skill of matching the problem with an appropriate set of investigative strategies. It was concerned with ensuring that information was accessed in such a way as to guarantee validity and reliability. In a post-colonial context, however, researchers must go further than simply recognising personal beliefs and assumptions and the effect they have when interacting with people. In a cross-cultural context, the questions that need to be asked are ones such as: Who has helped define the research problem? For whom is this study worthy and relevant? Who says so? Which cultural group will be the one to gain new knowledge from this study? To whom is the researcher accountable?

Moreover, we must also question the most fundamental belief of all: *that individual researchers have an inherent right to knowledge and truth.* With this dominant western value, it has been extremely difficult for Māori forms of knowledge and learning to be accepted as legitimate. This process implies a sharing of knowledge and a form of negotiation between those who do research and those who are being researched. Research in itself is a powerful intervention which has traditionally benefited only the researcher and the knowledge base of the dominant group in society. When conducting research either cross culturally or within a minority culture, it is critical that nurses recognise the power dynamic which is embedded in the relationship with their subjects.

Culturally safe research must inform the researched about themselves in a way that respects the participants' *mana* (dignity). This needs to be threaded through from conceptualisation of the research question, to its design, its delivery and its final analysis and presentation. Involving Māori people to do the data collection may well assist in developing rapport with the participants and gaining more accurate data. The research however must also assume that the solution to the problem lies within the research participants themselves as opposed to supporting the deficit theory that applies a reductionist lens to the health disparity between Māori and others. Nurses who intend to work either with Māori groups or other minority groups need to be well informed about the issues which are of concern to these groups. For example, it should not be the responsibility of the participants to educate the researcher about the socio-political context in which they live, nor is it their responsibility to justify their cultural world view or very existence.

In the same way that feminism has challenged society to include gender considerations in the just distribution of resources and opportunities, anti-racist, post-colonial and inter-cultural movements, within the late twentieth and early twenty-first centuries, have also prompted governments and global organisations to consider ethnic identity and the effects of colonialization on the health and well-being of different groups of peoples. Ethnicity is now considered a social determinant when accessing societal goods such as education, health, education and welfare (Walker 2006). From a social justice perspective, the recognition of ethnicity as an important feature of identity, aims to promote measures that reduce these inequalities of access. From a social justice perspective, the recognition of ethnicity as an important feature of identity, aims to promote measures that reduce these inequalities of access.

Following on this, the challenge ahead is to produce research which is meaningful for Māori people and which will ultimately liberate them from poor health, high educational failure, high incarceration rates, high unemployment rates for example.

Theoretical discussions about ‘emancipatory’, ‘post-structuralist’ or ‘praxis oriented’ research cannot begin to have meaning unless it can be shown to be real (Charmaz 2014). In New Zealand this is only just beginning to take place. However, as we move into the next millennium the urgency at least for Māori people to avert a continuing social crisis is critical. Confronting that crisis should be a priority for social science research in the twenty-first century.

## 5 The Personal is Political

Feminist theory initially concerned itself with women as an oppressed group. Black American theorist, Bell Hooks (Hooks 1994) unpacked the concept of feminism and argued that one could be an oppressor and oppressed at the same time. Such a challenge presented an opportunity for white women to be involved in anti-racism practices. White women, while being engaged in the conscientisation process about one hegemonic ideology (leading to female oppression), were uncritically reproducing other hegemonic ideology (leading to colonial racism).

The development of feminist consciousness raising began to consider gender and race at the personal and collective level. Henriques (1984) affirmed this new form of political awakening which was often described as *the personal is political*. Unlike traditional forms of resistance, feminism asserts that significant political change cannot be achieved without personal change.

Furthermore, Marshall (1993) argues that social change does not need to be large scale to be meaningful. In comparison to the focus on discourse in post-modern and critical theory, feminist theory keeps a focus on personal consciousness, ultimately leading to relationships that contribute to change on a collective level.

The personal and collective praxis developed during the women’s liberation movement provided a framework for similar social movements, including Indigenous movements, within New Zealand, Australia and Canada. Informed by the growth of the Black Power movement in the 1960s, the Kerner Commission (1968) found that structural and institutionalised racism were the catalyst for riots among African Americans. In 2020, the Black lives matter movement demonstrates entrenchment of racism that still remains 52 years later. The following range of concepts generate further discussion about the personal and the collective response to racism:

- Personal racism, where an individual’s negative stereotypes and attitudes towards other racial groups cause him or her to discriminate against those groups
- Institutionalised racism or structural racism, where the policies and practices of organisations deny members from an oppressed group access to resources and power
- Ethnocentrism or cultural racism, where the values, beliefs and ideas that are embedded in social representations endorse the superiority of one group over the other (Huygens 2007)

Within New Zealand, protests by Māori people over the detrimental effects of colonisation came to a climax in the late 1970s and early 1980s. High unemployment and marginalisation experienced by Māori people since the signing of the Treaty of Waitangi in 1840 were largely ignored up until this point. The Women's AntiRacism Group (1984) in collaboration with a Māori Advisory Unit (1985) identified racism within a major government department against Māori users of the service. Both groups' reviews prompted a Ministerial Advisory Committee on a Māori perspective for the Department of Social Welfare. The report was named *Puao-te-Atatu (Day break)* and provided a complete all-government approach to providing anti-racism education including teaching on the Treaty of Waitangi and the effect of colonisation on Māori. The role that non-Māori women played during this period has not been well documented, however, the result has been an enduring policy that ensures the public sector in New Zealand are provided with anti-racism training as part of the employment process.

There are several feminist theoretical positions, and according to which feminist analysis is used, different interpretations of women's oppression are identified. For example, the priorities of White feminists are different from those of Māori women who recognise and challenge dual oppressions (Irwin 1992). This means there is no single feminist analysis. Women's oppression is recognised in different contexts which indicate a variety of approaches to address oppression (Wearing 1986; Williams 1989; Hooks 1981).

## 6 Conclusion

In conclusion, there is much debate about the degree to which contemporary society is patriarchal compared to society in the past. Consideration of pre-colonisation and gender roles provides insights into factors that contributed to inequalities based on gender in New Zealand today. Feminism is not only interested in the ways in which men and women are treated differently in relation to their health within nursing, but also on differences between women. The revival of we-dentity and its parallels with a feminist world view that emphasise the collective well-being of people speaks volumes. If we are to fully comprehend inequities in health and healthcare provision, we need to include gender, ethnicity, class, disability, age and religion in future research and clinical practice. Nursing has at its core, a concern to provide humanitarian care for the sick and disabled. Ethical decision-making framed within an inter-cultural lens will be required more in the future as there is more of a focus on managed care, case management and briefer inpatient stays. Supplementing evidence-based practice with ethical-based care which considers all the complexities of the human experience, will contribute to eliminating inequities, so that First Peoples can enjoy long, healthy lives—as they deserve no less.

## References

Beauchamps, Thomas, and Childress James. 2001. *Principles of Biomedical Ethics*. 5th ed. Oxford: Oxford University Press.

Benner, Patricia E. 1984. *From novice to expert, excellence and power in clinical nursing practice*. Vol. 8, 95. Menlo Park: Addison-Wesley Publishing Company. https://doi.org/10.1002/nur.4770080119.

Benner, Patricia E., Ronda Hughes, and Molly Sutphen. 2008. Clinical reasoning, decision making, and action: Thinking critically and clinically. In *Patient Safety and Quality: An Evidence-Based Handbook for Nurses*, ed. R.G. Hughes, 6. Rockville: Agency for Healthcare Research and Quality (US).

Beresford, Mark J. 2010. Medical reductionism: Lessons from the great philosophers. *QJM* 103 (9): 721–724. https://doi.org/10.1093/qjmed/hcq057.

Browne, Ann, Celia Vercoe, Susy Wong, et al. 2012. *Closing the health equity gap: Evidence-based strategies for primary healthcare organizations*. Vol. 11, 59. International Journal for Equity in Health.

Burns, Nancy, and Susan K. Grove. 2009. *The Practice of Nursing Research: Appraisal, Synthesis and Generation of Evidence*. 6th ed. St. Louis: Saunders Elsevier.

Charmaz, Kathy. 2014. *Constructing Grounded Theory*. 2nd ed. London: Sage.

Davey, James, and Richard Dwyer. 1984. *Meeting Needs in the Community*. New Zealand Planning Council: Wellington.

De Souza, Ruth. 2015. Navigating the ethics in cultural safety. In *Cultural Safety in Aotearoa New Zealand*, ed. Dianne Wepa, 2nd ed., 111–123. Melbourne: Cambridge University Press.

Durie, Mason. 2003. *Ngā Kahui Pou: Launching Māori Futures*. Huia: Wellington.

———. 2007. Counselling Māori: Marae encounters as a basis for understanding and building relationships. *New Zealand Journal of Counselling* 27 (1): 1–8.

Edwards, Shane. 2009. *Titiro Whakamuri Ki a Marama Ai Te Wao Nei: Whakapapa Epistemologies and Maniapoto Māori Cultural Identities*. Unpublished Ph.D. Massey University, Palmerston North.

Freire, Paolo. 1972. *Pedagogy of the Oppressed*. New York: Herder and Herder.

Goodrich, Joanna, and Joceyln Cornwall. 2008. *Seeing the Person in the Patient: The Point of Care*. Review Paper. London: Kings Fund.

Graham, Smith. 1997. *The Development of Kaupapa Māori: Theory and Praxis*. Unpublished Ph.D. University of Auckland, Auckland.

Health Research Council (HRC) of New Zealand. 2010. *Guidelines for Researcher on Health Research involving Māori*.

——— (HRC) of New Zealand. 2014. *Guidelines on Pacific Health Research*.

Henriques, Julian. 1984. *Changing the Subject: Psychology, Social Regulation and Subjectivity*. London: Methuen.

Hooks, Bell. 1981. *Ain't I a Woman: Black Women and Feminism*. Boston: South End Press.

———. 1994. Feminist politicization. In *Toward a New Psychology of Gender: A Reader*, ed. M.M. Gergen and S. Davis, 533–539. New York: Routledge.

Huygens, Ingrid. 2007. *Processes of Pakeha Change in Response to the Treaty of Waitangi*. Published Ph.D. University of Waikato, Hamilton.

Irwin, Kathy. 1992. Towards theories of Māori feminism. In *Feminist Voices: Women's Studies Texts for Aotearoa/New Zealand*, ed. R. Du Plessis, P. Bunkle, K. Irwin, et al., 1–21. Oxford: Oxford University Press.

Kerner Commission. 1968. *Report of the National Advisory Commission on Civil Disorders*. New York: Bantam.

Kirmayer, Lynn. 2015. The health and wellbeing of indigenous youth. *Acta Paediatrica* 104 (1): 2–4. https://doi.org/10.1111/apa.12843.

Lacovinao, L. 2002. Ethical principles and information professionals: Theory. *Practice and Education: Australian Academic & Research Libraries.* 33 (2): 57–74. https://doi.org/10.1080/00048623.2002.10755183.

Land, M., and P. Pastura. 2016. The perspective of virtue ethics regarding the process of medical decision-making. *Revista Bioética* 24 (2): 243–249. https://doi.org/10.1590/1983-80422016242124.

Lowe, Joan, Huigang Liang, Cheryl Riggs, et al. 2012. Community partnership to affect substance abuse among Native American adolescents. *American Journal of Drug Alcohol Abuse* 38 (5): 450–455. https://doi.org/10.3109/00952990.2012.694534.

Māori Advisory Unit. 1985. *Māori Advisory Unit Report*. Auckland: Department of Social Welfare.

Marshall, Joan. 1993. Women managers: Travellers in a male world. In *Women's Studies: Essential Readings*, ed. S. Jackson. New York: New York University Press.

National Health and Medical Research Council (NHMRC). 2003. Values and Ethics—*Guidelines for Ethical conduct in Aboriginal and Torres Strait Islander Health Research*. Canberra: Commonwealth of Australia.

Nursing Council of New Zealand. 2012. Code of conduct for nurses. 9.

Papps, Elaine, and Irirhapeti Ramsden. 1996. Cultural safety in nursing education: the New Zealand experience. *International Journal for Quality in Health Care* 8 (5): 491–497.

Penetito, Wally. 2000. The social construction of Māori identity: The role of tastes and preferences. In *Human Development in Aotearoa: A Journey Through Life*, ed. L. Bird and W. Drewry. Sydney: McGraw-Hill.

Pihama, Leonie. 2001. *Tihei Mauri Ora: Honouring Our Voices: Mana Wahine as a Kaupapa Maori Theoretical Framework*. Unpublished Ph.D. University of Auckland, Auckland.

Racine, Louise. 2017. Theoretical nursing knowledge in the 21st century aporia. *The Nursing Journal* 8: 25–28. https://doi.org/10.18192/aporia.v9i1.3522.

Rogers, Carl. 1951. *Client-Centered Therapy: Its Current Practice, Implications and Theory*. London: Constable.

Smith, Linda. 2012. *Decolonising Methodologies: Research and Indigenous Peoples*. 2nd ed. Dunedin: Zed Books.

United Nations Educational, Scientific and Cultural Organisation (UNESCO). 2016. *Universal Declaration on Cultural Diversity*.

Waldram James, B., Herring D. Anne, and T. Kue Young, eds. 2006. *Aboriginal Health in Canada: Historical, Cultural and Epidemiological Perspectives*. 2nd ed. Toronto: University of Toronto Press. https://doi.org/10.3138/cbmh.25.2.543.

Walker, Ranginui. 2006. Influence of race, ethnicity and social determinants of health on diabetes outcomes. *Am J Med Sci* 351 (4): 366–373. https://doi.org/10.1016/j.amjms.2016.01.008.

Wearing, Brenda. 1986. Feminist theory and social work. In *Gender Reclaimed*, ed. H. Marchangt and B. Wearing. Sydney: Hale and Iremonger.

Wepa, Dianne, ed. 2015. *Cultural Safety in Aotearoa New Zealand*. 2nd ed. Melbourne: Cambridge University Press.

———. 2016. *Struggling to be Involved: A Grounded Theory of Māori Whānau Engagement with Healthcare*. Unpublished Ph.D. Auckland University of Technology, Auckland.

Williams, Fiona. 1989. *Social Policy: A Critical Introduction: Issues of Race, Gender and Class*. Cambridge: Oxford Polity Press.

Wilson, Denise. 2004. *Nga Kairaranga Oranga—the Weavers of Health and Wellbeing: A Grounded Theory*. Unpublished Ph.D. Massey University, Auckland.

Women's AntiRacism Group. 1984. *Institutional Racism in the Department of Social Welfare*. Auckland: Department of Social Welfare.

# An Interview with Joan Tronto on Care Ethics and Nursing Ethics

Joan C. Tronto

Joan Tronto, a renowned political theorist whose work on care ethics has argued for expanding our understanding of care, was interviewed by the coeditors of this volume. This interview has been edited.

In late 2019, early 2020. Tronto and her colleague, Berenice Fisher, offered this expansive notion of care:

> On the most general level, we suggest that caring be viewed as **a species activity that includes everything that we do to maintain, continue, and repair our 'world' so that we can live in it as well as possible.** That world includes our bodies, ourselves, and our environment, all of which we seek to interweave in a complex, life-sustaining web. (Fisher and Tronto 1990, p. 40)

From this general level, what actual care practices mean, and how care practices allow us to live in the world "as well as possible" still need to be explored. Yet, Tronto remains, 30 years later, committed to an expansive understanding of care. In this essay, we explore with Tronto what else such a broad understanding of care can contribute to nursing ethics.

QUESTION: Many leading theorists of care ethics are scholars of nursing ethics and vice versa. Nursing ethics and care ethics: why do you think there is such synergy between these two bodies of scholarship?

JT: It is true that care ethics has been vitally connected to concrete practices of care, and in my own thinking, nursing has been one of the core practices upon which I draw. My own experiences of nursing come not only from reading the scholarly literature on nursing and nursing ethics, but as well from my experience of a nearly fatal illness that required a long hospitalization in 1991. Decades later, I remember the care that I received with tremendous gratitude.

---

J. C. Tronto (✉)
Department of Political Science, University of Minnesota, New York, NY, USA
e-mail: jctronto@umn.edu

H. Kohlen, J. McCarthy (eds.), *Nursing Ethics: Feminist Perspectives*,
https://doi.org/10.1007/978-3-030-49104-8_6

Nurses are in a profession that is generally characterized by a gender difference: nursing is, in the contemporary world, overwhelmingly the work of women. In this regard, nurses share the gendered situation of being discounted because their work is seen as "women's work." Among the qualities of nursing, though, one that stands out is its holistic commitment to caring for patients. For nurses, people seeking medical care come with complex lives and for whom medical care has to be fitted to the entire person, not just the medical condition presented. In this way, nursing has as its core this same broad, diffuse concern with treating patients "as well as possible," whatever that means in individual cases. For nurses and nursing ethics, there are specific practices that must be followed but there are also myriad ways in which broader social and psychological and economic issues also arise. This broader frame for care helps me to think concretely about issues and about the kinds of crises that arise.

This capacity to have a broad and yet concrete practice makes nursing an extremely important way to understand caring.

Equally important for me, I think about nursing when I want to think about care because the situation of nurses helps us to keep power dynamics at the center of our understandings of care. Here's what I mean by the power position of the profession. Despite the emphasis on nurses as "less than" doctors, using metaphors such as that doctors are the architects, nurses the builders, etc., nurses are often possessed of more diffuse and important knowledge about patients that they garner from their senses and their skills. The role of the nurse was always broader than just "Let me do what the doctor says," but also was to be another set of eyes, ears, hands, to figure out what's actually going on. Yet, this understanding of nurses within an ongoing health care system also positions them vis-à-vis doctors and others in the health care system. While nurses are not as high in the hierarchy as doctors, they are also more highly valued in the health care system than other health care workers, or others who make the health care system function, such as aides, assistants, and for that matter, receptionists, cleaners, and others whose work is critical in organizing health care. Nurses are in a position to advocate for caring as a central form of human practice in part because of their elevated status. Their advocacy is less than entirely successful because they are not so powerful as others. For me, looking at this mediating position raises many productive questions about health care ethics.

QUESTION: What do you see as the main challenges for nurses from a care ethics perspective? What would you be investigating if you were to pursue nursing ethics?

JT: There are several questions that care ethics as a field of study is dealing with, and these questions are also critical for nursing ethics. Codes of conducts are meant to constitute a profession. And there are ethical codes to determine nursing ethics. I am not so interested in codes. I doubt that an ethics of care can be codified. Patricia Benner—who was very instrumental in my thinking about care early on—talks about the development of expertise as a nurse which comes from experience and which comes from just the quality of being around people and knowing something more about your illness, because you've been caring for them in a physical, close way.

Since I take a view that sees care as a *political* concern as well, it isn't surprising that I see these power dynamics of gendered professions, and the relative hierarchical standings of professions, as important questions. These issues are of course more serious in the United States, where health care is closely connected to economic concerns about costs.

But more precisely, I would be investigating how the kinds of larger issues of health care and cost containment affect the ethical possibilities of what nurses can accomplish. I am, generally, concerned with such issues as the tension between increasingly technical and technologically distant practices and the basic human needs of patients, such as the need to be touched and to be heard. Touch is absolutely such a critical part of what nurses know and almost nobody else does.

There is also, then, the organizational and political tension between professionalism for nurses and the place of nurses as advocates for everyone else in care settings. On the one hand, as nurses insist on their own roles as professionals, they risk participating in a kind of de-skilling for other kinds of care workers. On the other hand, nurses are well-situated to make claims on behalf of other care workers who are not so well regarded.

For me, the feminist nightmare back in the 1980s was that women would be able to become more upper class, marry upper class men, make themselves even richer, and leave behind everyone else. And that's what's happening. We can also see it happening in the area of nursing. Lower class, racialized, ethnic women and men have stepped in to complete the caring work that such professional nurses have no longer been inclined or able to do. It is a fine balance and a deep political question to take up.

The other huge question that I would pursue in nursing ethics is the issue of diversity. This is not only a question about the diversity among nurses themselves, but about whether and how nurses have to be the advocates for diverse patients in their care. People are different; can nurses be more appreciative of difference? How can they participate in health care organizations to make certain that differences of gender, sexuality, race, ethnicity, language, religion, are properly respected? In the United States, disparities in health care by race are well documented. How can nurses use their position to help to address these disparities? What would a truly diverse practice of nursing look like?

QUESTION: We are completing this interview as the Covid-19 pandemic rips through the world. What do you see as the unique challenges of this pandemic for nursing ethics?

JT: There are some ways in which the problems raised by the coronavirus pandemic are unique and there are other ways in which the problems sound familiar. Here in New York City, as thousands die and the governor keeps speaking about the needs for ventilator machines, nurses are holding protests asking for personal protective equipment (PPE). The authorities insist that there is no shortage, but on the ground, nurses are seeing a different reality; initially nurses were wearing trash bags. Why isn't their voice authoritative about their needs? Furthermore, in some places, when nurses complained about these shortages they were dismissed from their jobs for violating hospitals' rules about talking to the media. Nurses face these ongoing shortages of staff, hours, equipment in the United States.

What the coronavirus pandemic has made clear is that while some of the essential workers, such as nurses, are highly skilled, others provide care and yet receive little social or economic recognition for the care work they do. Once we start to look more closely, care work is vastly undervalued. Those deemed "essential workers"—sanitation workers, transit workers, grocery store workers, are now the most vaunted members of society. Nevertheless, such care work is devalued. It is also the case that gendered roles for men and women perpetuate the idea that care is "women's work," though men's organizations around the world are beginning to take up the challenge of seeing that men, too, do care and need to take caring more seriously.

Even though you would not necessarily know so by reading our leading political and social theories, care is central to all human life. Every human being is vulnerable. We will all eventually die and we are all susceptible to bad luck, disease, socially and politically induced harms, and other disasters than might befall us. We are all, every day, care receivers; we are in constant need of care to maintain our lives. Most of this care is either invisible because adults provide much care for themselves; and because much care is invisible because it is beneath our daily notice to see the extraordinary work that others are doing to smooth our ways through transit, stores, schools, cleaning up after us in our homes and offices, and so forth. If we are all care receivers, though, we are also all caregivers. From the youngest children who will imitate feeding their caregivers, to professionals like nurses, to home health workers, domestics, and others who clean up after us, to activities that meet our basic needs and those of our families, we all give care every day. We are all interdependent.

While nursing aims at producing a particular caring outcome, such as saving this patient's life, good care also produces another benefit: it produces a sense of safety, of being cared for, of being in a position to go forward and to return care to others. If greed creates a vicious circle as those who now have more want ever more, caring produces an opposite effect, a virtuous circle. Nancy Folbre, an economist, wisely called this "the invisible heart" that complements the economic self-interest of Adam Smith's "invisible hand."

The current crisis is a huge crisis in public health care. But it also allows us to take a pause and ask: what is it that we should really value? The struggles about reopening businesses are often framed as a question of "profits versus lives." A different way to put this question is to frame it as the philosopher Harry Frankfurt did when he insisted upon "the importance of what we care about." For much of the modern era, we have cared more about wealth and its production than about caring for people. Nurses have the opportunity to help turn this crisis into an opportunity to reorient social values toward all forms of care.

# Part II

# Nursing Ethics in Organisation, Clinical Practice, and Research through a Feminist Lens

# Organisation Ethics, Relational Leadership and Nursing

Louise Campbell

## 1 Introduction

Organisation ethics is a relatively new discipline which analyses the ethical behaviour of organisations, their motives, their actions and the effects of their actions (Spencer et al. 2000, p. 21). Traditionally, healthcare ethics as a discipline has focused on decision-making at the level of the individual encounter between patients, families and healthcare professionals. However, healthcare provision in the last 30 years has been transformed by advances in technology, demands for increased productivity, budgetary constraints, reductions in hospital inpatient capacity, service restructuring and changes in the way care is delivered (Suhonen et al. 2011, p. 285). Accompanying these changes is a growing realisation that individual clinical decisions are conditioned by the organisational context within which they take place. Organisation ethics as a discipline draws attention to the fact that aspects of organisational culture such as the behaviour and attitudes of employees, the values at play in the working environment and the existence of accepted 'ways of doing things' can significantly influence the quality of care received by patients (Kaufman and McGaughan 2013, p. 52). Interactions between the care team, patient and family occur against the backdrop of the myriad responsibilities the organisation has towards a wide range of stakeholders, including business administrators, regulatory authorities, governmental departments, insurance companies, employees and members of the public (Chen et al. 2007, S11). Contemporary healthcare is 'organisationally oriented'; it relies on multiple layers of managerial oversight to develop strategies for coordinating the use of expensive, institutionally-based technologies, to manage complex information systems, to

---

L. Campbell (✉)
Department of Anatomy, School of Medicine, National University of Ireland, Galway, Galway, Ireland
e-mail: Louise.campbell@nuigalway.ie

H. Kohlen, J. McCarthy (eds.), *Nursing Ethics: Feminist Perspectives*,
https://doi.org/10.1007/978-3-030-49104-8_7

carry out quality assessment and bring together different disciplines in the delivery of care to patients (Khushf 1999, p. 419). As a result of institutionalisation of healthcare provision, along with the profound economic and technological changes mentioned above, healthcare organisations have come to rely more heavily on ‘organisational guidance and control systems and structures’ than on the judgement and professionalism of individual clinicians (Renz and Eddy 1996, p. 293). Organisation ethics in healthcare therefore represents a shift in focus from individual decision-making to corporate decision-making, using concepts derived from the field of business ethics to examine the structures which govern how healthcare is delivered, purchased, administered and paid for (Childs 2000, p. 235).

Healthcare organisations are complex, dynamic entities which must establish a balance between competing priorities. Because health is a ‘primary good’, the mandate of organisations delivering healthcare is often viewed in terms of the ‘same range of moral responsibilities and obligations as have traditionally been implicit in the relationships between physicians and patients’ (Silverman 2000, p. 204). Healthcare organisations are expected to live up to these commitments even in the face of the substantial challenges posed by the corporatisation of healthcare and the pressures of the market economy (Silverman 2000, p. 204). While healthcare organisations are distinct from other kinds of market-driven organisations, they must nonetheless maintain financial stability and ensure their own economic survival in order to continue to discharge their public responsibilities. In an era of spiralling costs, this can create challenges: the provision of equitable, reasonably-priced core services to large populations of patients will ‘inevitably’ conflict with an ideal of ‘individualised healthcare which maximises patient choice’ (Shale 2012, p. 15). This single example of competing responsibilities—to optimise public resources *and* to promote patient choice—illustrates the complexity of the challenge for leaders of healthcare organisations faced with the task of resolving—or at least containing—the tension between competing values (Shale 2012, p. 15).

In addition to balancing their obligations towards patients with responsible financial stewardship, healthcare organisations must also demonstrate a concern for safety, efficiency and quality of care to their constituents and members of the public in general. Fallout from corporate scandals in the late twentieth and early twenty-first centuries—including Enron, Freddie Mac, Lehmann Brothers and more recently, Volkswagen—has led to demands for greater transparency and accountability in the management of all organisations. Businesses and corporations in both for-profit and not-for-profit sectors have responded to this demand by devising codes of ethics and creating visible compliance programmes designed to reassure regulators and members of the public that managers and employees are meeting certain standards of conduct. But effective governance of healthcare organisations requires going beyond mere adherence to the ethical ‘minimum’ represented by legal and regulatory requirements. Rather than emphasising what employees should *avoid* doing—the ‘compliance’ approach—leaders within healthcare organisations should focus on what employees *should* do in order to enable the organisation to discharge what is essentially a moral responsibility towards the community it serves (Silverman 2000, p. 203).

## 2 Ethical Climate

Because compliance programmes focus on meeting externally-imposed requirements, they fail to give due weight to the extent to which the internal dynamics of an organisation affect the ethical behaviour of the organisation and its members (Silverman 2000, p. 203). In order to create an ethical climate which 'discourages unethical behaviour and fosters ethical conduct', organisations need to go beyond mere legal compliance and address a broader range of issues, including criteria for decision-making within the organisation, the values of leaders, the effectiveness of processes for monitoring employees and the availability of mechanisms for providing guidance (Dallas 2004, p. 215). Ethical climate theory is a widely employed framework for analysing ethical behaviours and decision-making processes *within* organisations (Victor and Cullen 1988, p. 101). An ethical climate can be positive *or* negative and different organisations have distinct ethical climates, depending on a variety of factors, including the socio-cultural environment of the organisation, its history and its structure (Victor and Cullen 1988, p. 101). Generally speaking, an organisational work climate is a set of perceptions shared by agents within a system about the practices and procedures which characterise that system, including the way power is shared, the way decisions are made and the reward and control mechanisms employed by the organisation (Victor and Cullen 1988, p. 101). An organisation which ignores or rewards unethical behaviour, for example, can be said to have a negative ethical climate. Ethical climate influences how members of an organisation perceive organisational norms and conventions and this perception can have a significant influence on their actions and behaviour (Martin and Cullen 2006, p. 177). All organisational values involving judgements about 'right' and 'wrong' contribute to the development of ethical climate (Cullen et al. 1989, p. 51). These values underpin a set of shared perceptions relating to practices and behaviours which are viewed as acceptable or unacceptable by members of the organisation. As such, the value ascribed to ethical—or, for that matter, unethical—behaviour by members of the organisation will be shaped by perceptions which have developed in relation to the organisation's norms, processes and policies. Ethical climate has a far-reaching effect on an organisation, determining not only how members of an organisation respond to ethical dilemmas, but also which issues they deem to be ethically relevant in the first place and which criteria they use to understand and resolve these dilemmas (Cullen et al. 1989, p. 51). Predictably, perhaps, ethical climate is a determinant of employees' identification with and commitment to the organisation, their job satisfaction and their sense of psychological well-being, in addition to determining levels of dysfunctional behaviour within the organisation (Martin and Cullen 2006, p. 188). 'Lack of fit' between an individual and the ethical climate of the organisation by which she is employed may lead to dissatisfaction, stress or exit from the organisation (Victor and Cullen 1988, p. 119).

While businesses and other for-profit organisations are under increasing pressure to make their commitment to compliance programmes visible, publicly funded healthcare organisations are increasingly expected to publish explicit statements relating to their mission, values and goals. How well an organisation meets public expectations is often judged in terms of an alignment between the values which are publicly espoused by the organisation, the practices which constitute its day-to-day operation and the culture in which these practices are embedded. While values drive the actions of all organisations, in healthcare values ‘permeate every component of organisational activity’ (Pearson et al. 2003, p. 32). Because the values they espouse are often ‘aspirational’, it is expected that healthcare organisations will have a special preoccupation with organisational integrity (Boyle et al. 2001, p. 75).

## 3 Integrity and Values

Value conflict is inevitable in healthcare governance and a robust approach to organisation ethics would ‘openly acknowledge’ the ‘countervailing forces and expectations’ which confront those at the helm of healthcare organisations (Mantel 2015, pp. 662–663). In *No Margin: No Mission,* Pearson and colleagues define organisation ethics, not just in terms of the identification and resolution of conflicts which arise between the various values espoused by the organisation, but also in terms of the management of organisational performance to ensure that the organisation is able ‘to conduct itself with integrity in the full range of its activities’ (Pearson et al. 2003, p. 32). Organisations must ‘walk the talk’ (Pearson et al. 2003, p. 32), by avoiding what Stanley Joel Reiser terms ‘institutional dissonance’, a phrase used to describe a ‘contradiction between the behaviours organisations urge and the actions they take’ (Reiser 1996, p. 28). An organisation fails to conduct itself with integrity if it makes a public commitment to certain values—say, respect, compassion and accountability—but fails to operationalise these values in its relationships with key stakeholders. Like Pearson and colleagues, Silverman sees organisational integrity in terms of consonance between an organisation’s mission and values and patterns of decision-making at every level within the organisation. It is the ‘habitual decision’ to act in accordance with a publicly asserted set of values which allows healthcare organisations to manage the challenges posed by the monumental changes which have transformed healthcare in the twenty-first century (Silverman 2000, p. 204).

Organisational integrity can be achieved by developing a culture defined by a set of ‘fundamental value commitments’ which are accepted by members of the organisation and guide behaviour within the organisation (Silverman 2000, p. 204). Silverman argues that the ‘moral dimension’ of patient care must be seen as a reflection of organisational dynamics: ethical issues arising in the clinical setting are profoundly influenced by the culture, structures, relationships and processes which define the ethical climate of the organisation and as such resolving them is often beyond the control of individual agents. Whereas the organisation’s culture is determined by the values it promotes, the organisation’s ethical *climate* is a product of how well these values are ‘translated into action’ or integrated into the daily operations of the organisation at all levels. In an organisation concerned with integrity, its ethical climate must be proactively managed by senior administrators who have 'insight' into the culture of their organisation and whose commitment to organisational values must be explicit, visible and consistent (Silverman 2000, p. 213).

## 4 Leadership

Leadership is a central component in the development of ethical culture within an organisation and a concept which has received an enormous amount of scholarly attention over the course of the past 25 years as a critical factor in the success or failure of organisations. The role of leaders who are 'committed, credible and willing to take action [to promote the values they espouse]' (Silverman 2000, p. 212) is a recurring motif in discussions of ethical integrity in organisations. But leadership is a notoriously difficult concept to define and ethical leadership is only one of its manifestations. Now a century old, the concept of leadership is a 'many-headed hydra' traditionally defined in terms of 'some combination of power, authority and influence' (Pucic 2015, p. 656). It appears in multiple guises in the business and managerial science literature, evolving from a relatively straightforward conception of a unilateral relationship of influence between leaders and 'followers' to a more nuanced understanding of leadership in terms of a complex nexus of mutually influential relationships. Early research on leadership examined the individual leader—the norm being 'a male working in some large private-sector organisation in the US' (Avolio et al. 2009, p. 422)—and the specific personality traits which enabled that individual to influence others for the benefit of the organisation. Current discussions of leadership focus less on individual characteristics than on models of leadership which place as much emphasis on the role of peers, supervisors and organisational context as on the development of leadership competencies (Avolio et al. 2009, p. 422). Traditional theories of leadership generally construe leadership in 'transactional' terms as a set of exchanges between leaders and followers, defined primarily by the setting of goals and the provision of direction and support (Avolio et al. 2009, p. 428). Since the early 1990s, however, dissatisfaction with the transactional model of leadership has resulted in the emergence of a distinction between 'traditional' and 'new genre' theories of leadership, salient among which is the concept of 'transformational' leadership.

Central to the notion of transformational leadership is the leader's ability to 'raise followers' aspirations and activate their higher-order values (e.g. altruism)' by conveying visionary or inspirational messages and explicitly emphasising moral values (Avolio et al. 2009, p. 429). In very general terms, the 'transformative' leader communicates high expectations for the organisation, builds confidence, trust and respect among employees, acts according to high ethical standards and puts forward a clear vision for the organisation (Giddens 2018, p. 119). Leadership is seen as a meaning-making process and emotionally-appealing leadership behaviours are seen to confer upon the transformative leader the 'legitimate capacity to shape and interpret the experience of followers' (Hutchinson and Jackson 2013, p. 13). Leaders in this sense are role models who visibly promote values which 'foster commitment to organisational goals' (Hutchinson and Jackson 2013, p. 13). Emotional attachment to a leader allows followers to identify with the leader's mission or vision and to feel more positively about their own responsibilities; this in turn motivates them to exceed base—or 'transactional'—expectations in their performance (Avolio et al. 2009, p. 428).

## 5 Post-heroic Leadership: The Move to Relationality

The last two decades of the twentieth century were turbulent, characterised by globalisation, rapid demographic and economic change, and by seismic advances in technology, the nature and scale of which eroded traditional conceptions of power (Krantz 2000, p. 51). In the context of these momentous changes, hierarchical or 'top-down' models of leadership began to be seen as unsustainable, and organisations—particularly businesses seeking a competitive edge—shifted towards more participatory and relational leadership styles (Fondas 1997, p. 259). Workers at all levels were increasingly expected to 'take up their roles more authoritatively', while authority began to be seen 'in the outer boundaries as well as in the centre' (Krantz 2000, pp. 51–52). This expansion of authority from centre to periphery is central to the notion of what is now termed 'post-heroic' leadership. Twentieth-century analyses of leadership tended to perpetuate the myth of the 'heroic', charismatic or visionary leader whose possession of special qualities is reflected by his or her position at the apex of the organisational hierarchy. Commentators who advocate a repudiation of the 'hero myth' argue that it obscures the essentially collective or *relational* nature of leadership (Murrell 1997, pp. 35–36). Kenneth Murrell, for example, challenges both the assumption that organisations need to be hierarchically structured and the focus on the actions of the few, rather than on the shared responsibility of the 'many' (Murrell 1997, pp. 35–36; Turnbull James 2011).[1] Understood relationally, leadership is construed as a set of practices which are 'embedded within a network of interdependencies at different levels' (Fletcher 2003, p. 4). The notion of 'post-heroic' leadership which emerges from the work of Murrell and Fletcher signals a shift in emphasis from personal characteristics and individual accomplishment to collective achievement, collaboration and shared accountability. The post-heroic paradigm reconceptualises leadership as a social process and it is the interactions defining a given situation which determine how the roles of leader and follower are enacted. Followers 'play a significant role in influencing and creating leadership' (Fletcher 2003, p. 5) and influence is exerted bidirectionally rather than in a unidirectional or top–down manner. In other words, the distinction between leaders and followers becomes more fluid as the tasks and responsibilities of leadership are distributed 'up, down and across the hierarchy'

---

[1] For a similar perspective, compare Wicks, Andrew, Daniel R. Gilbert and R. Edward Freeman (1994). "A Feminist Reinterpretation of the Stakeholder Concept". *Business Ethics Quarterly* 4: 4, 475–97.

(Fletcher 2004, p. 650). 'Positional' leaders—visible figureheads at the top of organisations—are supported by 'a network of people engaging in leadership practices throughout the organisation (…) who may never acquire the label of leader' (Turnbull James 2011, p. 5). Relational leadership is enacted not only formally, but also informally, across organisational boundaries (Turnbull James 2011, p. 5) and recognised leaders must be open to being taught and led by others, regardless of their 'positional authority' (Fletcher 2004, p. 650). According to this view, leadership is a collective response to organisational change which necessitates the involvement of all members of the organisation in an ongoing process of 'finding organisational direction' (Painter-Morland 2011, p. 149). Sharing leadership requires understanding that the skills needed for leading and for following *jointly* constitute the full range of 'relational' competencies which are needed by everyone working in an organisational context (Fletcher 2004, pp. 648–649). Properly understood, relational leadership is defined by collectively determined outcomes, including mutual learning, collaboration, greater collective understanding and, ultimately, excellent work—all of which are seen as alternative routes to organisational success (Fletcher 2012, p. 90ff).

## 6 The 'Feminisation' of Leadership Discourse

These recent developments in leadership theory have not been immune from feminist scrutiny, however. In the 1990s, Nanette Fondas drew attention to a process of 'feminisation' in discussions of managerial work in the academic literature, namely, a shift in emphasis from characteristics culturally associated with masculinity to attributes generally understood as feminine (Fletcher 2003, p. 260).[2] Leadership traits perceived as 'masculine' included assertiveness, decisiveness, tough-mindedness, self-interest and an ability to abstract from personal or emotional considerations in accomplishing tasks. Traits associated with femininity included empathy, caring, nurturing, interpersonal sensitivity, attentiveness to others and responsiveness to their needs, helpfulness, a disposition towards promoting collective rather than individual interests and 'a preference for open, egalitarian and cooperative relationships, rather than hierarchical ones' (Fletcher 2003, p. 260). Fondas observed that organisations which replaced 'command and control' structures with a focus on shared responsibility, interconnectedness, cooperation and the empowerment of others were in effect endorsing a model of leadership which was more closely aligned with 'the type of power traditionally equated with femininity' (Fletcher 2003, pp. 266–267). Of note, the purpose of this analysis was not to identify behaviours which 'essentially' belong to men or women, but rather to draw

---

[2] Fondas restricts her discussion to members of the class of middle management, given that it is managers just below the 'elite' level who have the power to make and execute sweeping policy decisions, change organisational structures and influence strategy (Fondas 1997, p. 261). For the purposes of this discussion, Fondas' use of the concept 'management' will be understood as equivalent to a more general concept of leadership.

attention to the existence of distinct workplace 'cultures' by counterposing the 'female' culture of 'affiliation and collaboration' against the 'male' culture of competition and hierarchy. What was remarkable for Fondas was that this 'reversal of the subordination of femininity to masculinity' in management discourse was never explicitly named as such in the literature. It remained implicit, because to name it would undermine the system of gender relations—specifically, the elevation of masculine traits and the demotion of feminine traits—upon which organisation and management theory are built. Calling this a process of *feminisation* directly challenges the assumption that characteristics associated with masculinity are essential to organisational life—the norm, after all, is male—whereas traits associated with femininity are inessential or peripheral (Fletcher 2003, p. 273).

Similarly, Joyce Fletcher argues that the competencies and behaviours associated with post-heroic or relational leadership, although presented in the management literature in gender-neutral terms—explicitly associated with neither masculinity nor with femininity—are intimately bound up with gender. Fletcher maps the distinction between traditional (heroic)—and new (post-heroic) models of leadership onto a distinction between discrete domains of activity which she terms the sphere of 'work' and the sphere of 'domesticity' (Fletcher 2004, pp. 650–651). She argues that, in life, these socially-constructed spheres overlap, but at the level of theoretical analysis they are mutually exclusive, built upon idealised notions of masculinity and femininity and valued unequally. Each sphere has what Fletcher terms its own 'logic of effectiveness', that is, a set of beliefs about what constitutes success in that domain; in the sphere of work—culturally associated with an image of masculinity—the focus is on 'producing things', making decisions, achieving outcomes, whereas in the domestic sphere—the sphere of family life and relationships—the focus is on 'growing people', nurturing and supporting (Fletcher 2004, pp. 650–651). In the sphere of domesticity, the role of women has been to nurture and give without expectation of recognition or reciprocity, and these behaviours are not valued or visible in the same way as the activities traditionally carried out by men in the public domain. 'Work', in other words, has always taken priority over 'domesticity'. The concept of reciprocity is a fundamental component of what Fletcher terms relational leadership or relational intelligence. Building on the work of Jean Baker Miller, Fletcher argues that, while men are socialised to 'devalue and deny in themselves the relational skills needed to survive psychologically', women are given responsibility for meeting others' relational needs *without* drawing attention either to what they are doing or to the needs which they are meeting (Fletcher 2012, p. 91). That women do not, or should not, expect reciprocity—recognition of the value of what they do and an expectation of having their efforts reciprocated—stems from the power of this socially-constructed narrative, which defines what counts as competence and achievement in the workplace and renders relational competencies marginal (Fletcher 2010, p. 124).

For Fletcher, the myth of individual achievement involves a 'discursive exercise of power' which enables a small number of people to accomplish in a visible way by relying on the unacknowledged support of others who 'provide the collaborative subtext of life' and, crucially, do so invisibly (Fletcher 2004, p. 654; Fletcher 2012,

p. 92). The asymmetry of this exercise of power is inextricably bound up with gender. When men practice relational leadership, they are seen to be doing something novel and they may expect their efforts to be acknowledged and reciprocated, whereas the enactment of relational practice by women in business and organisational contexts 'disappears' into the roles which society has constructed for them and they are thereby denied the reciprocity to which their male counterparts feel entitled. Fletcher observes that, although the rhetoric about leadership has changed at the 'macro' level, the heroic model of leadership has retained traction at the level of everyday practice (Fletcher 2004, p. 652). The danger here is that, instead of being understood in terms of a new, relational approach to management, post-heroic leadership becomes confused with stereotyped activities which are expected of women as a matter of course, such as nurturing, deference, or 'selfless giving' (Fletcher 2010, p. 129; Fletcher 2012, p. 94).

> [W]omen often experience being expected to teach, enable and empower others without expecting anything in return, expected to work interdependently while others do not adopt a similar stance, expected to work mutually in nonmutual situations, and expected to practice less hierarchical forms of interacting even in traditionally hierarchical contexts. In other words, the conflation of relational practices with mothering may serve to 'disappear' the invitation to reciprocity embedded in the practice (Fletcher 2004, p. 655).

Heroic conceptions of leadership remain stubbornly 'resilient' because of the historical undervaluing of the type of work women do, and because post-heroic models of leadership violate entrenched cultural assumptions about the link between individualism, masculinity and organisational success (Fletcher 2004, p. 653). Putting into practice the relational intelligence now seen by many as critical to organisational success still runs the risk of being associated with 'feminine' characteristics which are seen to have no place in traditional management cultures: relinquishing control may be seen as powerlessness (Fletcher 2004, p. 653; Fletcher 2010, p. 126), acknowledging interdependence may be seen as indecisiveness, while helping others may be perceived as 'not achieving individually' (Fondas 1997, p. 271). For Fletcher, awareness of the gender dynamics underlying the practice of relational leadership—understanding that relational competencies are viewed differentially in men and women—is a prerequisite of better leadership (Fletcher 2010, p. 135).

Advocates of post-heroic leadership argue that it has the potential to transform organisations. Fletcher insists that realising this transformative potential requires explicitly acknowledging the challenges relational leadership poses to existing gender and power dynamics (Fletcher 2004, p. 657). Enacting post-heroic leadership cannot simply be a matter of building relational competencies into more traditional models of leadership, because this would involve assimilating these competencies into the dominant paradigm without attending to 'the changes to structures, systems and work practices that would be needed to make it work' (Fletcher 2004, p. 657). Relational practice—defined as the use of relational skills to achieve organisational goals (Fletcher 2010, p. 122)—requires intentionally and explicitly promoting the development of authentic relationships which facilitate learning and mutual growth as well as organisational effectiveness. Effective relational leadership—whether it is enacted by men or women—depends on what Fletcher terms 'conditions of mutuality and reciprocal influence' (Fletcher 2010, p. 129). 'Mutuality' in this context entails working collectively to create an environment in which individuals can learn, grow, achieve recognition and support one another while promoting the interests of the organisation. 'Reciprocity' requires listening, engaging and empowering others, acknowledging the contributions of colleagues, constructing meaning collaboratively and demonstrating a willingness to learn from and across different perspectives. 'Authenticity' requires addressing and resolving the 'tough issues' in a manner which acknowledges one's own needs and one's role in the organisation but 'give[s] primacy to the needs of the work' (Fletcher 2012, p. 99). Shying away from difficult decisions, constant deference to the needs of others or failing to demonstrate assertiveness where organisational priorities demand it are as constitutive of what Fletcher terms 'relational *malpractice*' (Fletcher 2010, p. 131) as the excesses of heroic leadership. Promoting relational practice or leadership requires that visible or 'positional' leaders intentionally create a work culture in which the quality of relationships is at the centre of any concept of organisational achievement and effectiveness (Fletcher 2004, p. 657). This means that relational skills and behaviours must be explicitly identified as such and—even more importantly—their value to the organisation must be made visible. This process has to be explicit because naming relational practice, for Fletcher, is the only antidote to its 'disappearance' (Fletcher 2010, p. 128).

## 7 Relational Leadership: Where Does It Lead for Nurses?

In recent years, the concept of leadership has attracted a considerable degree of attention in the literature on nursing management. Significantly, the strategic importance of leadership in nursing is increasingly being acknowledged by nursing associations across the world. Failures of nursing leadership have been linked to poorer clinical outcomes for patients and a decrease in the quality of the working environment for nurses themselves (Hutchinson and Jackson 2013, p. 11). The dawning recognition that a narrow focus on efficiency in healthcare has given rise to a culture of paralysing managerialism in nursing has led to calls for 'visionary' leadership to address the challenges of health system reform (Cummings et al. 2018, p. 20). A systematic review published by Cummings and colleagues in 2018 found a significant association between nursing leadership styles collectively described as 'relational focused' and a number of positive outcomes, including high reported levels of job satisfaction and empowerment, improved teamwork and productivity, greater satisfaction with the organisations within which the nurses worked, higher levels of retention and increased well-being among members of the workforce (Cummings et al. 2018, pp. 22, 44).[3] Recently, the model of transformational leadership, in

---

[3] It should be noted that this systematic review refers to a variety of leadership styles as 'relational focused', including not only transformational leadership, but also approaches to leadership which

particular, has been endorsed by the International Council of Nurses as a key component in 'strengthening health systems worldwide' (Ferguson 2015, p. 351).

Central to the concept of transformational leadership is the capacity of leaders to engage in 'exemplary behaviours' underpinned by visible and deep value commitments which allow them to motivate and empower followers and promote a sense of identification with the goals of the organisation (Hutchinson and Jackson 2013, pp. 12, 36; Doody and Doody 2012, p. 1212). Yet whether this complex, often elusive concept can be effectively integrated into nursing practice is far from obvious. Examining the applicability of the four commonly accepted components of transformational leadership to the nursing context—idealised influence, inspirational motivation, intellectual stimulation and individual consideration—Doody and Doody identify barriers to the implementation of the model at the coalface (Doody and Doody 2012, p. 1217). Barriers include communication and decision-making challenges arising from the existence of a number of distinct leadership roles at different levels within the nursing hierarchy, a system of promotion based on seniority and on candidates' ability to reflect existing organisational priorities rather than on a willingness to challenge the status quo, inadequate representation of frontline staff in organisational decision-making, insufficient opportunities for both formal and informal training and education and a consistent failure to support and empower staff (Doody and Doody 2012, pp. 1213–1217). Similarly, Cummings and colleagues point out that, despite an emerging association between effective leadership, optimal patient care and increased staff well-being, the current reality is that most healthcare leaders are primarily task-focused, meaning that they still engage in 'transactional' leadership practices, rewarding followers for their performance rather than appealing to a higher system of shared values (Cummings et al. 2018, p. 51). Concluding that the leadership skills of the majority of nursing leaders are 'formed on the basis of traditional hierarchical systems and practice wisdom', Doody and Doody argue that specific competencies must be learnt by nurse leaders if they are to empower others to seek and effect meaningful change (Doody and Doody 2012, pp. 1213, 1217).

Challenging the 'uncritical' adoption in the nursing literature of the model of transformational leadership, Hutchinson and Jackson argue that the focus on transformational leadership as the only alternative to the transactional model 'silences other possibilities for leadership' and excludes discussion of important considerations such as political context, power relationships within organisations, leader integrity and the harms associated with corrupt or negative leadership behaviours (Hutchinson and Jackson 2013, pp. 13–14). They observe that the overt emphasis on the role played by ethical values and integrity in the theoretical construction of transformational leadership does not preclude involvement by self-styled transformational leaders in self-interested or unethical behaviour (Hutchinson and Jackson 2013, p. 15). More importantly, they note that the tendency in the nursing literature

---

are described as 'inspirational', 'resonant', 'authentic', 'empowering' and 'charismatic' (among others). None of these are described in specific enough terms to permit an assessment of whether or not they align with the concept of relational leadership put forward by Fletcher.

to represent transformational leadership as ‘the prerogative of those in “distant” leadership positions (…), charged with shaping meaning, culture and behaviour within organisations’ fails to take into account the ways in which leadership can be ‘enabled’ in those who are not in designated leadership positions (Hutchinson and Jackson 2013, pp. 13–14). Clearly, this representation of followers as passive and the related lack of attention to the active role played by followers in the construction of leaders (Hutchinson and Jackson 2013, p. 18) carries overtones of the heroic model of leadership. Hutchinson and Jackson are correct to point out that the adoption of transformational leadership in the nursing literature retains an attachment to the vertical imposition of power associated with traditional conceptions of leadership. The claim that the model of transformational leadership is insufficiently attentive to the ways in which context influences leader behaviour and its perception (Hutchinson and Jackson 2013, p. 18) echoes Fletcher’s call for scrutiny of the concrete ways in which leadership is enacted at different levels in organisations and the conditions under which the authority of those in recognised leadership roles is enabled. Since ‘walking the talk’ requires—among other things—a willingness to interrogate these conditions and challenge structures which undermine reciprocal working relationships, transformational leadership may ultimately be unable to deliver on its transformative potential. For all these reasons, Fletcher’s conception of leadership as a set of relational competencies would seem to hold out more promise as a tool for transforming nursing practice.

## 8 Ethics and Relational Practice

Relational practice, although a relatively novel concept in the business and management literature, has been the bedrock of nursing care for many decades. Nursing is by definition a relational profession (Zou 2016, p. 1). Yet the concept of relationality is broad and the kind of relating which is central to the provision of care to patients is very different from the kinds of relationships which define optimal functioning in organisations and the business world. The most obvious difference is that nurses have a duty of care to their patients and the quality of the care they provide is in large part determined by the quality of their relationships with these patients, whereas no comparable duty exists in other types of organisations. Fundamentally, this is an ethical duty and nursing ethics can be defined in terms of ‘being in relationship to persons in care’ (Storch 2004, p. 7). Despite this difference, however, practising nurses and nurse managers may benefit from the study of relational models of leadership in organisations other than those which provide healthcare, such as businesses or governmental agencies. Fletcher and other advocates of relational leadership argue that, in order to flourish, organisations need to recalibrate their priorities in a manner which enhances the quality of relationships within the work environment. What is at issue here is the need to construe organisational or work environments holistically. The point of post-heroic or relational models of leadership is that *all* relationships within an organisation matter. So while the particular relationship between nurse and patient necessarily has a privileged status in the healthcare setting, it must be understood as resting on a nexus of other relationships, all of which need to be brought into clearer focus if the care provided to patients is to be optimised. The corollary of this is that the ways in which nurses, doctors, administrators, managers, health and social care professionals, care assistants, porters and executives relate to one another, and how each enacts relational competence in their interactions with others, are a critical factor in realising the primary goal of any healthcare organisation: the delivery of excellent, equitable and effective care to patients and their families. If collaboration is required in order to achieve this goal, relational intelligence is required at every level to enable the organisation to discharge its responsibilities effectively. This picture may seem naïve or unrealistic to health and social care professionals who grapple on a daily basis with the systemic challenges posed by contemporary healthcare provision. Cummings and colleagues are careful to point out that, despite evidence of the benefits associated with relationally focused leadership, this approach to leadership should not be employed 'at the expense of work to be done', arguing that leaders need to possess 'management, organisation and analytical skills' in addition to emotional intelligence (Cummings et al. 2018, p. 51). Clearly, management competencies are required by leaders, but leadership is not reducible to management and it must be acknowledged that it is possible to be 'over-managed and inadequately led' (Doody and Doody 2012, p. 2), to the detriment of both the individual and the organisation. Creating an environment in which relational competence is expected and valued requires an approach to leadership which is not only effective, but genuinely inclusive, flexible, innovative and responsive to the needs of everyone working in the organisation. While this may require a seismic cultural shift, and a new kind of communication across disciplines, it is not an impossibility.

## 9 Moral Distress and Relational Practice

Given its association with a decline in nurses' well-being, ability to provide optimal care and willingness to remain in the profession (Corley 2002, p. 639), moral distress is one issue which should challenge healthcare leaders to reassess their priorities.[4] Moral distress is an emotional response experienced by healthcare professionals who feel that their moral integrity is compromised by a clinical environment in which institutional constraints and other external factors limit their ability to enact their moral agency, sometimes to the point of compelling them to violate ethical norms (McCarthy and Monteverde 2018, p. 325). Environmental causes of moral distress include, but are not limited to, leadership deficits, poorly designed resource allocation strategies, excessive bureaucratisation of caring work, failure to heed the concerns of staff and dysfunctional working environments. In these kinds of organisational settings, moral agency—the ability to act in accordance with moral norms—can be viewed as held 'increasingly hostage to the exigencies of economic

---

[4] For reasons of space, a fuller account of the problem of moral distress in nursing cannot be provided here.

efficiencies, corporate management strategies and limited resources' (McCarthy and Monteverde 2018, p. 325).

One way of dealing with the problem of moral distress, as McCarthy and Monteverde suggest, is to acknowledge the effects of moral distress in policy documents and ethical frameworks and to promote moral resilience by supporting staff in negotiating situations which threaten their moral integrity. Another way of addressing moral distress might be to empower staff to challenge these constraints and their implications for practice from a relational perspective. Applying Fletcher's analysis to the healthcare context and focusing in particular on the challenges experienced by nurses, a relational approach to leadership would focus on the *relational impact* of the constraints in question on nurses' ability to collaborate, to communicate, to reciprocate and to be authentic in caring for patients. An environment which is consciously designed to promote a less hierarchical understanding of leadership would allow the voices of nurses to be heard and would acknowledge the centrality of their moral concerns. An environment which stifles the expression of these concerns encourages what Fletcher calls 'relational malpractice'—maladaptive patterns of unwarranted deference aimed at avoiding confrontation which undermines good work and is damaging both to the individual and the organisation (Fletcher 2012, p. 97). By contrast, genuine relational practice involves focusing on what is required in order to do 'excellent work' and on creating the conditions which make this possible. This entails facilitating a manner of working together such that it is the nature of the task—providing optimal care—rather than precedent, authority or personal or professional gain which dictates what expertise is required, which decisions have to be made and by whom.

## 10 Conclusion

In conclusion, it is clear that traditional definitions of leadership are no longer adequate in the face of the momentous changes confronting healthcare leaders and health and social care professionals. Healthcare organisations concerned with ethical integrity should respond to these challenges by developing organisation ethics programmes to address the ethical issues arising from the governance and management of these complex, dynamic organisations. Any such programme would '[focus] on the quality of the relational practices and interactions which define the organisation's culture, [draw] attention to its values, [invite] scrutiny of any perceived dissonance and [facilitate] moral repair' (Shale 2012). Creating space in the organisation's culture to enable discussion of relational leadership and what it might mean is a vital first step in this process. Cummings and colleagues argue that executives and senior administrators, including nursing administrators, should prioritise hiring 'leaders with relational skills' and should ensure that training is provided for existing leaders, even as they acknowledge that the lack of a clear conceptualisation of effective relational leadership complicates the process of screening for and assessing the relevant competencies (Cummings et al. 2018, p. 51). There will, however, be organisations in which the prevailing culture will undermine the development of relational leadership or will not allow it to be valued. Such organisations may have negative ethical climates, or they may simply be failing to function optimally because of poor leadership, institutional pressures or insufficient resources. In *Exit, Voice and Loyalty*, Alan Hirschmann argues that employees of declining or dysfunctional organisations have three choices: they may remain in the organisation and voice their concerns, in the hope that their criticism will be heeded and organisational performance will improve; they may stay in the organisation but remain silent out of loyalty to the organisation, or they may exit the organisation, thereby relinquishing the opportunity to advocate for change from within (Hirschman 1970).[5] From the perspective of a commitment to relational practice, 'voice' is the preferred option and 'loyalty' is the least defensible, although 'exit' may often be the only realistic alternative.

For their part, nurses must become aware of the need to develop their own relational competencies and promote relational intelligence in their interactions, not just with patients, but with colleagues across their organisations. Relational practice arguably has the potential to enhance care, increase nurses' satisfaction with their work and, possibly, reduce burnout and moral distress. Nurses can ensure that they are not drawn into patterns of relational malpractice by speaking truth to power and by identifying decisions which adversely affect the care of patients and compromise the quality of the working environment. They should be empowered to challenge policies and behaviours which undermine the organisation's values and give rise to institutional dissonance. None of this is easy, but it is part of what is entailed by a call for the recognition of reciprocity and mutuality as determinants of occupational flourishing. Ultimately, providing nursing care in complex healthcare environments challenges nurses to interrogate the leadership structures which affect them and to consider their own role in promoting, constructing, or acquiescing to these structures. Meeting the requirements of a relational approach to leadership may transform nurses' understanding of their own agency and revolutionise their experience of the work they do.

## References

Avolio, Bruce, Fred Walumba, and Todd J. Weber. 2009. Leadership: Current theories, research, and future directions. *Annual Review of Psychology* 60: 421–449.

Boyle, Philip J., Edwin R. DuBose, Stephen J. Ellingson, David E. Guinn, and David B. McCurdy. 2001. *Organisational Ethics in Health Care*. San Francisco: Jossey-Bass Publishing.

Chen, Donna T., Patricia H. Werhane, and Anne E. Mills. 2007. Role of organisation ethics in critical care medicine. *Critical Care Medicine* 35 (2(Suppl.)): S11–S17.

Childs, Brian H. 2000. From boardroom to bedside: A comprehensive organisational healthcare ethics. *HEC Forum* 12 (3): 235–249.

Corley, Mary C. 2002. Nurse moral distress: A proposed theory and research agenda. *Nursing Ethics* 9 (6): 636–650.

---

[5] I am grateful to Professor Marsha Barron for directing me to this book and for her very helpful comments on the conference presentation on which this chapter is based.

Cullen, John B., Bart Victor, and Carroll Stephens. 1989. An ethical weather report: Assessing the organization's ethical climate. *Organizational Dynamics* 18 (2): 50–62.

Cummings, Greta G., Kaitlyn Tatea, Sarah Leea, Carol A. Wongb, Tanya Paananena, Simone P.M. Micaronia, and Gargi E. Chatterjee. 2018. Leadership styles and outcome patterns for the nursing workforce and work environment: A systematic review. *International Journal of Nursing Studies* 85: 19–60.

Dallas, Lynn L. 2004. Corporate ethics in the health care marketplace. *Seattle Journal for Social Justice* 3 (1): 213–227.

Doody, Owen, and Caitriona Doody. 2012. Transformational leadership in nursing practice. *British Journal of Nursing* 21 (20): 1212–1218.

Ferguson, Stephanie L. 2015. Transformational nurse leaders key to strengthening health systems worldwide. *The Journal of Nursing Administration* 45 (7/8): 351–353.

Fletcher, Joyce K. (2003). *The Paradox of Post-heroic Leadership: Gender Matters*. Working Paper no. 17. Centre for Gender in Organisations. https://www.alnap.org/help-library/the-paradox-of-post-heroic-leadership-gender-matters.

———. 2004. The paradox of post-heroic leadership: An essay on gender, power and transformational change. *The Leadership Quarterly* 15: 647–661.

———. 2010. Leadership as relational practice. In *Extraordinary Leadership: Addressing the Gaps in Senior Executive Development*, ed. Kerry Bunker, Kathy Kram, and Douglas T. Hall, 121–135. San Francisco: Jossey Bass Publishing.

———. 2012. The relational practice of leadership. In *Addressing Relational Leadership Research: A Dialogue Among Perspectives*, ed. Mary Uhl-Bien and Sonia M. Ospina, 83–106. Charlotte: Information Age Publishing.

Fondas, Nanette. 1997. Feminization unveiled: Management qualities in contemporary writings. *Academy of Management Review* 22 (1): 257–282.

Giddens, Jean. 2018. Transformational leadership: What every nursing dean should know. *Journal of Professional Nursing* 34: 117–121.

Hirschman, Albert O. 1970. *Exit, Voice and Loyalty: Responses to Decline in Firms, Organisations and States*. Cambridge: Harvard University Press.

Hutchinson, Marie, and Debra Jackson. 2013. Transformational leadership in nursing: Towards a more critical interpretation. *Nursing Inquiry* 20 (1): 11–22.

Kaufman, Gerri, and Dorothy McGaughan. 2013. The effect of organisational culture on patient safety. *Nursing Standard* 27 (3): 50–56.

Khushf, George. 1999. The case for managed care: Reappraising medical and socio-political ideals. *Journal of Medicine and Philosophy* 24 (5): 415–433.

Krantz, James. 2000. Lessons from the field: An essay on the crisis of leadership in contemporary organisations. *The Journal of Applied Behavioural Science* 26 (1): 49–64.

Mantel, Jessica. 2015. Ethical integrity in health care organisations. *Journal of Law, Medicine and Ethics* 43 (3): 661–665.

Martin, Kelly D., and John B. Cullen. 2006. Continuities and extensions of ethical climate theory: A meta-analytic review. *Journal of Business Ethics* 69: 175–194.

McCarthy, Joan, and Settimio Monteverde. 2018. The standard account of moral distress and why we should keep it. *HEC Forum* 30: 319–328.

Murrell, Kenneth L. 1997. Emergent theories of leadership for the next century: Towards relational concepts. *Organization Development Journal* 15 (3): 35–42.

Painter-Morland, Mollie. 2011. Systematic leadership, gender, organisation. In *Leadership, Gender and Organisation*, ed. Patricia H. Werhane and Mollie Painter-Morland, 139–165. Dordrecht: Springer.

Pearson, Steven D., James S. Sabin, and Ezekiel J. Emanuel. 2003. *No Margin, No Mission: Healthcare Organisations and the Quest for Ethical Excellence*. Oxford: OUP.

Pucic, John. 2015. Do as I say (and do): Ethical leadership through the eyes of lower ranks. *Journal of Business Ethics* 129: 655–671, at 656.

Reiser, Stanley Joel. 1996. The ethical life of healthcare organisations. *Hastings Center Report* 24 (6): 28–35.

Renz, and Eddy. 1996. cited in Goodstein and Potter, 1999, "Beyond financial incentives: Organizational ethics and organizational integrity". *HEC Forum* 11 (4): 293–305.

Shale, Suzanne. 2012. *Moral Leadership in Medicine*. Cambridge: Cambridge University Press.

Silverman, Hugh J. 2000. Organisation ethics in healthcare organisations: Proactively managing the ethical climate to ensure ethical integrity. *HEC Forum* 12 (3): 202–215.

Spencer, Edward M., Anne E. Mills, Mary V. Rorty, and Patricia H. Werhane. 2000. *Organizational Ethics in Health Care*. Oxford: OUP.

Storch, Janet L. 2004. Nursing ethics: a developing moral terrain. In *Toward a Moral Horizon*, ed. Janet L. Storch, Patricia Rodney, and Rosalie Starzomski, 1. Toronto: Pearson.

Suhonen, Ritta, Minna Stolt, Heli Virtanen, and H. Helena Leino-Kilpi. 2011. Organisational ethics: A literature review. *Nursing Ethics* 18 (3): 285–303.

Turnbull James, Kim. (2011). *Leadership in Context: Lessons from New Leadership Theory and Current Leadership Development Practice*. The King's Fund. https://www.kingsfund.org.uk/sites/default/files/leadership-in-context-theory-current-leadership-development-practice-kim-turnbull-james-kings-fund-may-2011.pdf.

Victor, Bart I., and John B. Cullen. 1988. The organizational basis of ethical work climates. *The Administrative Science Quarterly* 33 (1): 101–125.

Zou, Ping. 2016. Relational practice in nursing: A case analysis. *Nursing and Health Care* 1 (1): 1–5.

# Hospital Ethics Committees and the Dismissal of Nursing Ethical Concerns: A Feminist Perspective

Helen Kohlen

## 1 Introduction

This chapter questions the usefulness of principle-based ethics when it comes to everyday ethical concerns, especially when attentiveness, competencies and responsibilities of care are at stake. Moreover, the chapter reveals that the question as to whose voices are most heard and valued in discussing issues of concern in patient care is dependent on the hierarchical setting and power relationships. I will show that nurses' relatively powerless position and the application of ethical principles for case consultation in Hospital Ethics Committees (HECs) can reduce ethical problems in such a way that issues of nursing care are marginalized, trivialized and even dismissed. Since many nurses have learned the language of principle-based ethics, they themselves contribute to the dismissal of caring concerns. I argue that a feminist ethics of care offers a language that can analyse everyday experiences of care in clinical practice by bringing in questions of attentiveness, competence, responsibility, responsiveness, as well as issues of power and conflicts.

In the first part of the chapter, I sketch the development of HECs and show how the four principles approach by Tom Beauchamp and James Childress (1983) has dominated the way in which ethical consultation takes place in HECs. In the second part, I present research about membership of, and nurses' voices in, HECs. Beyond the master story of principle-based ethics, care ethics developed in the 1980s. The third part outlines care-ethical approaches and the turn from a feminine ethics of care to a feminist one. I focus on those care ethicists who have gained insight into health care, institutional practices and nursing. The fourth part is based on my field studies in Germany. Two ethical case consultations in HECs illustrate how issues of

---

H. Kohlen (✉)
Lehrstuhl Care Policy und Ethik, Philosophisch-Theologische Hochschule Vallendar (PTHV), Vallendar, Germany
e-mail: hkohlen@pthv.de

H. Kohlen, J. McCarthy (eds.), *Nursing Ethics: Feminist Perspectives*,
https://doi.org/10.1007/978-3-030-49104-8_8

nursing care are dismissed and what a feminist voice of an ethics of care offers to make nurses' issues of care matter.

## 2 Hospital Ethics Committees

Over the past 30 years, worldwide healthcare institutions have used HECs to guide practitioners about ethical dilemmas in clinical practice. Many countries have encouraged or mandated hospitals to have a multi-professional membership in HECs to deal with everyday ethical questions. HECs are organizational forms of ethical consultation. The members meet at a certain time and place, generally once a month for about 2 h. Education, policy development and case review are their potential functions (Cranford and Doudera 1984). They need to define their own tasks carefully to use their limited time and energy (Ross 1986).

When HECs emerged in the 1970s, bioethicists were called upon to serve as expert consultants (Fox 1990). Based on the principlist approach of Beauchamp and Childress (1983), the principles of autonomy, beneficence, non-maleficence and justice became the guiding moral norms underpinning ethical consultation in clinical practice. Of course, applying one or more of the four principles to health care situations helps to highlight the ethical tensions and challenges that may arise. Nevertheless, the use of principles as a method runs the risk of denying the complexity of actually lived moral life.

David J. Rothman (2003) reveals in his historical analysis of how law and bioethics transformed medical decision-making that a principlist approach cannot replace the accumulated experiences of medical practice. He argues that the practical wisdom that the practitioner had accumulated over years of clinical experience has become less impressive and relevant than the wisdom that the philosopher or lawyer had accumulated through the study of first principles. He expresses his doubts about the establishment of HECs since its members might rather follow principles given by a bioethicist instead of supporting the wisdom based on experience in medical (and nursing) practice (p. 2).

The limits of a principlist approach in HECs became clear in a field study—in the United States—by Patricia Flynn (1991a). She found out that speakers in HECs were more concerned with ethical principles than with the individuality of the case, its context and steps of a process for decision-making. She critically reports about conversations in HECs:

> Someone would ask: 'What is the ethical principle?' and another person, often the ethicist, would say, as in a mantra, 'autonomy' or 'allocation of resources'. The incantations of justice, autonomy, beneficence, non-maleficence, veracity, and fidelity were heard throughout the committees. In one committee, the chair would press for two ethical principles that were in conflict, so that the response might be, for example: 'autonomy' and he would ask 'versus?' and someone would sing out 'justice'. (Flynn 1991a, p. 182)

She also remarks that committee members would sing the principle of autonomy like a refrain in a choir when it comes to decision-making (Flynn 1991b). Although her report might be an exaggeration of the rigour of using the principles, it certainly reveals the danger of reducing a complex case that deserves attention, space and time to ask questions beyond the sole application of principles. This finding is supported by my field study in Germany (Kohlen 2009). Since then, conversations might have changed in HECs, but there has not yet been any empirical research to shed light on current practices.

The feminist philosopher Margaret Urban Walker (1993) critically remarks in her essay on images of ethics consulting: 'Aren't abstract principles often given meaning under the impact of concrete cases, rather than cases being simply "decided" by the "application" of principles? And who or what decides what is a "case"—moral problem—in the first place …?' (p. 34)

Walker is convinced of the idea that 'a story, or better, history is the basic form of representation for moral problems' (Walker 1993, p. 35). Therefore, she suggests that it is necessary to know who the parties are, how they understand themselves and each other, what the terms of relationship are and what social or institutional frames shape or circumscribe their options (Walker 1993, p. 35). The presentation of a moral problem by telling a story involves paying attention to history, context and concreteness of the situation. The story might deal for example with the complex question: Who is doing what with whom for whom, under what circumstances, for what reasons, in which position of responsibility?

Walker argues: 'If moral accounts must make sense to those by whom, to whom, and about whom they are given, the integrity of these accounts is compromised when some parties (or members in HECs) to a moral situation are not heard or represented. If chances are missed for different perspectives that open critical opportunities, moral community is doubly ill served, alternative narratives go unexplored, and some members are in practice disqualified as agents of value' (Walker 1993, p. 37).

## 3 Membership and Nurses' Voices in HECs

### 3.1 Membership

From the start, Hospital Ethics Committees (HECs) have recognized the importance of including individuals from different clinical backgrounds and academic disciplines as members. Generally, physicians, nurses, social workers and chaplains participate in the meetings that usually take place once a month at a certain place and time. Different professions contribute to a variety of perspectives based on their academic disciplines with different knowledge and skills. They also speak in different languages with a plurality of values, norms and understandings of ethics. As a consequence, the interpretation of an ethical problem among team members can cause irritation and confusion. Thus, a process of clarification and mutual respect is needed. Interdisciplinarity entails a fair balance between scholarly approaches. Participation should be understood as a democratic process in which equality is put into practice (Kohlen 2017, 2018).

M. Jan Keffer (1997) argues that multidisciplinary committees, such as HECs, ‘should be formed by doctors and nurses in equal numbers to prevent one group from being dominated by the other; each professional should be heard by his or her peer because some details of valuable information can be easily identified by those in the profession’ (p. 694). However, the diverse positions of power and responsibility can prioritize one perspective and one voice over another. For example, a physician might be more influential in shaping the discussion with his or her ethical questions than the nurse who is working at the bedside. Although the nurse might know the patient better than the physician, his or her ethical questions might not have an equal part in the debate. When HECs were established all over the country in the United States, a sociological study on membership revealed:

> Membership indicates who can speak, whose opinions are counted, and whose are discounted. Membership may determine even which issues are seen as legitimate ethical concerns and which are not … So, to say that a hospital has an ethics committee tells us very little unless we know as well: who serves on the committee and under what authority. (Bosk and Frader 1998, p. 16)

Moreover, to say that a hospital has an HEC tells us nothing about which theories, models and concepts are used and which language dominates the discussion.

## 3.2 Nurses’ Voices

In the early 1990s, questions about the work of, and in, HECs were raised with regard to context, narrative and power relationships. Susan Rubin and Laurie Zoloth-Dorfman (1996) state:

> In a world of talk, where the hearers and tellers of narrative… and the ethics committees all serve as an answering chorus, we need to pay close attention not only to what is said, but to who talks, who listens, and how—we need to ‘see’ the ‘talk’, and the performance of the ‘talk’, as clearly as we study the substance of the argument. (Rubin and Zoloth-Dorfman 1996, p. 321)

Linguistic analysis of power relations has shown that the use of indirect communication is associated strongly with persons of lower power and authority (Rubin and Zoloth-Dorfman 1996). Indirect communication means that persons do not say directly what they have to say and address people in power, but rather talk to people in similar positions of power. Whose voices are most heard and valued in discussing issues of concern in patient care is dependent on the hierarchical setting: in a hospital, profession, rank and degree often determine the extent to which permission is given to speak freely and authoritatively (Rubin and Zoloth-Dorfman 1996). Rubin and Zoloth-Dorfman are not surprised by their findings since they assume that women generally tend to occupy less verbal space in conversations, and need greater and often specific encouragement to speak their opinions aloud (Rubin and Zoloth-Dorfman 1996).

With regard to nurses, researchers observed that many staff nurses are more likely to publicly hide their ethical concerns out of fear of reprisal. Gabriela Menezes Gonçales de Brito and Darci de Oliveira Santa Rosa (2019) studied nurses' performance in clinical ethics committees by reviewing articles published in national and international journals between 1994 and 2016. The analysis shows that not only competencies are necessary for participation, but also power relationships matter. They conclude that nurses' contribution is often not valued or recognized (de Brito Menezes Gonçalves and de Oliveira Santa Rosa 2019, p. 697).

Cheryl Holly (1986) also found that nurses are forced to function at conventional levels in the bureaucratic organization of the hospital. It was seen as a failure when they were not able to define concerns related to their practice in terms of rights and justice. Nurses who attempted to operate from a base of caring and responsibility were relegated to a conventional role. Betty Sichel (1992), who examines the predominant moral standards that are primarily used in ethics committees' meetings, wonders whether an ethics of justice and rights dominates deliberations in HECs. She states: 'the problem is how one justifies principles or general rules that would then be standards for making moral judgements' (Sichel 1992, p. 117). She argues that a model of rights and justice is not appropriate to describe ethical questions with regard to caring practices and argues for the application of an ethics of care. She explains: 'Women's moral language of response and caring starts from a very different perspective: Moral dilemmas are particular, unique situations in which all parties retain their individual identities, their life histories, emotions, feelings, and relationships' (Sichel 1992, p. 118). Sichel refers to Carol Gilligan (1982), who stresses the importance of communicative networks for the resolution of moral dilemmas. The decision of who is involved in making the decision, whether it is the entire familial network or only one person, is itself a critical component of a moral dilemma.

## 4 Beyond the Master Story of Principlism: Feminine Care Ethics and its Feminist Turn

### 4.1 Caring as a Different Voice and Attention to Particularities

Looking at the historical roots, nursing and medical ethos is an ethos of care. This ethos is based on the *conditio humana* with the aspect of interrelated human life preceding autonomous life. Especially children, sick and old people depend on care. What more recent care approaches have in common is that they assume fundamental humane integration. In these care ethics approaches, considerations are dealt with in a narrative way, taking into account relevant contextual as well as emotional aspects when it comes to decision-making (Kohlen 2016).

A major contemporary influence on a scholarly discussion of caring occurred with the 1982 publication of the developmental psychologist Carol Gilligan, 'In a Different Voice' (Gilligan 1982). Her empirical study revealed a contrast between the primary moral orientation of boys and girls. Gilligan puts forward the idea that females and males tend to employ different reasoning strategies and apply different moral concepts when formulating as well as resolving moral problems. According to her analysis, females compared to males are more likely to perceive moral dilemmas in terms of moral attachment in contrast to detachment. The female perspective she coins as the care perspective. Central concerns of a care perspective are to avoid hurting, deserting, alienating, isolating or abandoning persons and to engage in a way that strengthens, supports and protects attachment between persons. According to Gilligan, the different voice is the female voice that opens up the care perspective. In the moral world of girls and women 'an awareness of the connection between people gives rise to a recognition of responsibility for one another, a perception of the need for response' (Gilligan 1982, p. 30).

Gilligan argues that an ethics of care has been generally ignored in the past because girls and women have been excluded as subjects in the study of moral development. For example, accounts of moral maturation by Lawrence Kohlberg's work (1981) and Jean Piaget (1965) were based entirely on studies and observations of boys and men. These male-based theories of moral development were subsequently applied to girls and women. Though they acted differently to boys and men, the male-based theory that underpinned the study was not challenged and the study's conclusion was that girls and women were deficient in moral development.

Gilligan's investigation exclusively interviewed women. She found that, rather than talking about rights and rules, the participants used the language of relationships, connection and social context. Their moral reflections revealed the relevance of a contextual understanding and the need to look at concrete situations. She concluded that human beings live their life in a network of care and dependence and contrasted the voice of care with the voice of justice. The voice of care is seen as a moral orientation that pays attention to the particularities of individual situations and the meaning of relationships as an integral part of moral judgement.

In addition to Carol Gilligan, Nel Noddings (1984) has made decisive contributions to feminine ethics. While Gilligan stresses the different form of moral reasoning that caring engenders, Noddings focuses on caring as a practical activity, emphasizing the interaction that occurs between persons giving and receiving care. In her book 'Caring. A Feminine Approach to Ethics and Moral Education' (Noddings 1984), she argues that whilst philosophy generally acknowledges the difference between theory and practice, ethics is implicitly treated as if it is analogous with geometry: the focus is on theoretical foundations, principles and logical deductions. In her view ethics—philosophical reflection on morality—has concentrated on questions of moral foundation and judgement to a problematic degree. She criticizes the idea of moral judgements as being led by abstract principles. She argues that moral problems should be discussed in terms of concrete situations, that we should 'approach moral problems not as intellectual problems to be solved by abstract reasoning but as concrete human problems to be lived and to be solved in living' (Noddings 1984, p. 96). According to Noddings, when it comes to solving concrete human problems, caring approaches are helpful (Noddings 1984, p. 96).

For Noddings, placing an emphasis on care allows us to see the importance of being responsive to the needs of others. Moreover, the uniqueness of particular 'others' and the understanding of concrete situations are also rendered meaningful. For her, caring is not so much a matter of actions, special tasks or processes, but rather of being, a disposition, a virtue or a stance towards the other. For Noddings, caring is neither a principle nor a virtue in itself. Central to caring is that it is based on relationships, implying that moral decisions should not be separated—or abstracted—from relationships and their situational contexts.

The concept and practice of care have been widely studied in the area of nursing. Susan Reverby (1987a) finds caring to be a central ethic throughout nursing's history. Tracing the history of nursing to its domestic roots during the colonial era, when nursing took place within the family, Reverby argues that caring for the sick was originally a duty rather than a freely chosen vocation for women. Empirical studies reveal that care, or caring, are notions that have mostly been used to describe the work of nursing in relation to patients (Benner 1994; Chambliss 1996). Moreover, nursing scholars have identified care as a foundational concept and value for a nursing theory and nursing ethics (Leiniger 1991; Gadow 1985; Watson 2012; Benner and Wrubel 1989; Fry 1989; Bishop and Scudder 1990). For example, Sally Gadow (1985) Patricia Benner and Judith Wrubel (1989) argue for the primacy of caring in nursing on the grounds that skilful techniques and scientific knowledge do not suffice to establish ethical nursing in the absence of a basic level of caring and attachment. Benner and Wrubel's field studies aim to make nursing work as a practice of care visible. They are in line with care ethicists when they stress the necessity of making care visible and audible.

Since the publication of Gilligan's and Nodding's work, the proposal to develop a feminine ethics of care has met with a variety of concerns and objections. These also apply to caring approaches in nursing. One set of concerns is that a feminine ethics of care may undermine feminism. These concerns are partly based on the belief that the qualities in girls and women that feminine ethicists have studied have developed in the context of a sexist culture. In the context of a sexist culture, women's competency in caring for and serving others can be seen as the outcome of their subordinate status within modern societies (Sherwin 1992). Claudia Card (1990) insists on balancing caring with justice and other values since an excessive focus on caring at the expense of other values can blind us to the critical assessment of the object of caring. A second set of concerns about feminine ethics of care relates to the belief that caring for others can lead to neglect of the self. For example, the result might be burnout, a phenomenon that refers, for example, to caring situations of parents, nurses, family care-givers or other individuals who become extremely exhausted by physical and emotional demands associated with giving care. In a third group of objections, critics claimed that though a care perspective brings in women's voices, it could not be used for any critical institutional, social or political purposes (Noddings 1984; Chambliss 1996; Friedman 1993; Jaggar 1995). This group of objections acknowledges that an ethics of care may serve well within the limited sphere of personal ethics, but argues that attention to care is unhelpful outside of this sphere.

Hilde Lindemann Nelson (1996), in particular, has criticized using a feminine ethics of care in the field of nursing due to the danger of exploitation and loss of integrity. Alisa Carse and Lindeman (1996) emphasize that the danger of exploitation threatens care-givers and that limits should be set on the duty to care for others. Both ethicists, Lindemann Nelson and Carse (1996), conclude that not only the danger of exploitation of care-givers but also the danger of oppressing the recipient of care needs to be considered.

Since care work has mostly been done by women, they are the ones who mostly face exploitation and oppression. Noddings is convinced that 'if only women adopt an ethic of caring the present conditions of women's oppression are indeed likely to be maintained' (Noddings 1990, p. 171). She concludes that an ethical orientation that arises in female experience need not be confined to women. Thus, questions of justice matter; that is to say, the question of a fair distribution of care work needs to be addressed.

## 4.2 The Feminist and Political Turn in Care Ethics

The turn from feminine ethics to feminist ethics took place in the 1990s. Feminist ethics is different from feminine ethics. Feminine ethics consists of observations of how traditional approaches to ethics fail to fit the moral experiences and intuitions of women. It includes ideas of how ethics should be modified if it accounts for women's lived experiences including their experiences of care work. Feminist ethics broadens the feminine perspective. From a feminist perspective, women's lives and being 'ordered to care' (Reverby 1987b) have to be seen in the light of patriarchy, subordination and oppression. Feminist ethics stems from the explicitly political perspective of feminism, wherein the oppression of women is seen to be morally as well as politically unacceptable (Sherwin 1992). Sherwin argues that a recognition of women's actual experience and moral practices is not enough, but what is also necessary is a critique of specific practices that constitute their oppression. She explains: 'In my view, feminist ethics must recognize the moral perspective of women insofar as that includes the perspective described as an ethics of care, we should expand our moral agenda accordingly. Feminists have reason, however, to be cautious about the place of caring in their approach to ethics; it is necessary to be wary of the implications of gender traits within a sexist culture. Because gender differences are central to the structures that support dominance relations, it is likely that women's proficiency at caring is somehow related to women's subordinate status' (Sherwin 1992, pp. 49–50).

One of the most important voices when it comes to addressing the unequal distribution of care is that of Joan Tronto. In her book *Moral Boundaries* (Tronto 1994), she coins the term 'privileged irresponsibility' to capture injustice in care responsibilities and rights. For her, the uneven distribution of the benefits of care follows the pattern of power distribution in societies. Those who are well off define their needs and concerns as the most important ones, whereas the needs of those who are less well-off are ignored or devalued.

Women provide most of the caring activities in the home, community and institutions. Because of the impersonal goals of a bureaucratic system, care-givers in institutions are frequently thwarted in their efforts to provide good care. Moreover, their low status in the hierarchy intensifies this problem (Condon 1992). Berenice Fisher and Joan Tronto (1990) argue that where responsibility is great, but power is limited, women are the ones who are expected to compensate for deficiencies in the caring process. Fisher and Tronto (1990) have identified four dimensions of care, which are usually part of a caring process: (1) caring about, (2) caring for, (3) care giving and (4) care receiving. ‘Caring about’ involves becoming aware of and paying attention to the need for caring. ‘Caring for’ means assuming responsibility for the caring work that needs to be done. It also involves the ability to perceive one’s power to actually act. ‘Care giving’ is putting the actual care work into practice to meet the need. In most cases, the care-taker comes into direct contact with the care receiver. Here, nursing care as well as child care are mostly used as examples (Condon 1992). Finally, Tronto (1994) describes ‘care receiving’ as a fourth dimension: It is the evaluation of the response of those receiving the attention and care. For example, a nurse who does mouth care in the case of cancer care needs to pay attention to the response of the patient. She might face a patient at the very end of her life who is no longer able to do mouth care herself and is hardly able to speak. It is not only a question of how often this is (medically) necessary to maintain oral hygiene, but also of how to meet the patient’s particular needs including her preference of taste, e.g. for lemon or coffee. Without observation of the patient’s response to her care giving, she would not know whether caring needs have actually been met. Tronto remarks that the fourth dimension of care ‘can serve as an ideal to describe an integrated, well-accomplished, act of care. Disruptions in this process are useful to analyse’ (Tronto 1994, p. 109).

In accordance with the identified dimensions of care, Tronto (1994) describes ethical elements of care: (1) attentiveness, (2) responsibility, (3) competence and (4) responsiveness. The first ethical moment[1] of caring she calls attentiveness since care requires that a need is actually recognized and that this need should be cared about.

While ideally there is a smooth interconnection between these dimensions, in reality there are likely to be conflicts both between and within each of these dimensions (Tronto 1994). For example, a conflict occurs when care-givers find that their needs to care for themselves are in opposition to their responsibility of care for others or that they are responsible for taking care of a number of other patients or things whose needs collide with each other. Then the quality of care is put into question. As I will try to show in the following, good care is also at stake when patients’ needs are not interpreted adequately and are in conflict with institutional practices (see the chapter by Louise Campbell in this book).

Nurses may have their own ideas about patients’ needs; indeed, they may ‘care about’ patients’ needs more than the attending physician. Their job, however, does not often include correcting the physician’s judgement; it is the physician who ‘takes care of’ the patient, even if the care-giving nurse notices something that the doctor does not notice or consider significant. Often in bureaucracies those who determine how needs are met are far away from the actual care-giving and

---

[1] See interview with Joan Tronto in this book.

care-receiving, and they may well not provide very good care as a result. (Tronto 1994, p. 109)

Imagine a nurse who follows the written order of a physician that the patient who is diagnosed with dementia should be given sedatives whenever necessary, such as when they are in a state of anxiety. The nurse can get her work done on time since she need not be concerned with the reasons for the anxiety and look out for alternative caring solutions like taking a walk with the patient. The needs of patients who are suffering from dementia are often connected to their feelings. It takes time to attend to the needs adequately and sedatives are not generally the adequate answer for a state of anxiety. The situation of anxiety needs to be analysed and the nurse is challenged to react appropriately. Videos reveal how sensitive patients respond to the verbal as well as nonverbal acts of the nurse. Research shows that Marte Meo Counselling can serve as a facilitator for appropriate interactions. Marte Meo Counselling is an educational video-based counselling method that was developed to improve interactions (Alnes et al. 2011). Thinking with Tronto, providing good care involves caring about and caring for the patient attentively and responsibly in order to give competent care that is evaluated by the patient's response. Unfortunately, care is often not tailored according to patents' needs by following the logic of care, but rather according to the demands of the institution, organized along rational operations (Noddings 1984; Mol 2008).

For Tronto, caring well requires looking at any caring process, both in terms of the individual act of care necessary at a given moment and in terms of the entire caring process within specific contexts like institutional power relationships. This implies the use of different perspectives to make sure that care is not being distorted by power dynamics and imposed or ignored needs. Tronto argues that caring well 'requires a deep and thoughtful knowledge of the situation, and all of the actors' situations, needs and competencies' (Tronto 1994, p. 37).

Ten years after her work on moral boundaries, Tronto published her second book on care: Caring Democracy (Tronto 2013). Based on her understanding of care as a social practice that reveals an unequal distribution of care work and responsibilities, she focuses in this book on the relation between democracy and care. As a democratic ideal she explores a fifth dimension of care which she calls 'caring with'. She emphasizes that care as a democratic practice makes us see how different we are and what is required when citizens are 'caring with' each other in plurality. In a democracy it is the allocation of caring responsibilities that has to be taken seriously between citizens who act in solidarity. And she adds: 'all of those people engaged in them need to be part of the ongoing political discourse' (Tronto 2013).

## 5 How Can Feminist Approaches Enrich the Work of Hospital Ethics Committees?

In the following, I will present two case consultations taken from my field study in Germany (Kohlen 2009). Both case consultations reveal a dominance of principle-based ethics with a focus on autonomy and a marginalization of care. In my alternative analysis, I will draw upon research findings and feminist insights that are described in the sections above: especially, the invitation by Walker (1993) to pay attention to the history, context and concreteness of the situation and to see about complexity and alternative narratives; the findings by Bosk et al. (1998) as well as Rubin and Zoloth-Dorfman (1996) that positions of power and authority determine who gets to talk and whose voices are listened to; Condon's (1992) statement that care givers' low status in institutional hierarchies intensifies the problem of being thwarted in their efforts to provide good care due to the impersonal goals of a bureaucratic system; Tronto's (1994) four dimensions of a caring process that include the ethical elements of attentiveness, responsibility, competence and responsiveness as well as her recognition of the reality of conflicts.

### 5.1 'A Petit Ethical Problem': Using the Warmth of an Older Patient's Belly to Warm up a Blood Bottle

A retrospective case consultation at the beginning of a committee meeting.

A nurse had written to consult the committee about a situation that she had experienced two years previously but that she was still bothered about. The female minister took the nurse's paper to the committee meeting and read it aloud.

*An elderly female patient had been in need of a blood bottle. When the blood bottle had arrived from the lab, it had still been very cold, and the physician on shift asked the nurse to put the bottle on the belly of a patient who was sleeping, so that the blood bottle would warm up easily for the other patient who needed it. The nurse, who did know the patient, an elderly woman, who was sleeping, could not imagine doing it and refused. The patient had been sleeping and was not in an alert condition at all. The female physician then told her to ask another nurse to do it, someone who would be more professional than her.*

The discussion in the ethics committees developed as follows:

Female minister: 'That is really uncomfortable to have something cold on your belly!'

Physician A: 'This is absurd from a medical perspective. There are, of course, other technical aids that can help to warm up blood bottles.'

Nurse A: 'This nurse feels like an advocate for the patient, and wants to take care of her autonomy.'

Physician A: 'This is really a mini ethical problem!'

Physician B: 'I think the problem emerged from hierarchy!'

Minister A: 'I think they have some communication problems in the ward.'

Physician C: 'But this is really a petit ethical problem!'

The discussion ends after some minutes, declaring that this is really a minor problem. The minister explains that she will have to talk to the nurse who has revealed her concern.

The minister asks: 'What should I tell her?'

Physician A: 'You can tell her that she did not do anything wrong within the current knowledge of practice.'

Physician B: ‘And you can add that the problem had to do with hierarchy and failed communication.’

Physician C adds: ‘Well, the more I think about it, the more I feel misused by this nurse, because this is not an ethical problem at all!’

Nurse B: ‘You can tell her that she did not do anything wrong, and you can tell her about the possible hierarchy and communication problem behind it, but never tell her that this is at most a small ethical problem.’

The meeting abruptly ends, people rise from their places and leave the room. The minister keeps sitting there and takes some notes.

### 5.1.1 Analysis

The first reaction is given by the minister who states ‘that it is really uncomfortable to have something cold on your belly’. And this actually is in conflict with a practice of care that does not allow putting a person into an uncomfortable state in the interest of another.

The lady who is ill and sleeping cannot defend herself and therefore needs protection.

The physician explicitly speaks from a medical perspective that ‘this is absurd’ and that this is not the right way to warm up blood bottles, because there are technical aids. He clarifies that this is obviously not a medical dilemma in which physicians do not know how to make an adequate decision.

Nurse A shows empathy for the nurse who has revealed her concern. She identifies the role of the nurse who cared for the old lady as an ‘advocate for the patient’ who wanted to take care of her autonomy. Caring for her autonomy from the standpoint of the nurse could mean that the patient has to agree to everything that is done with her body. Since she is sleeping, she cannot express her will and therefore needs protection, given here by the nurse. It is the nurses’ task to attend to patients’ basic needs like having enough sleep. It is different from the task of the physician, who is interested in getting a warm blood bottle for a medical intervention. Nursing care for patients who are sleeping implies keeping her or him in a state as comfortable as possible while protecting them from disturbing noises, interventions that can be postponed like ‘taking blood pressure’, as well as disturbing and uncomfortable interventions like putting a cold blood bottle on their warm belly.

The nurse uses the principle of autonomy to justify her nursing care, but it is actually competent care to attend to and protect the patient’s sleep responsibly. The nurses’ professional role is to take care of the patient’s sleep. The nursing theorist Nancy Roper (1990) has developed a conceptual framework for nursing practice: ‘Activities of Daily Life’ (ADL). Relaxing and being able to sleep is one element of these daily activities nurses have to care for. This involves having an eye on the duration of sleep, times of sleep, day and night rhythm, sleeping quality, rituals of falling asleep, habits and aids to fall asleep. Knowing the patient involves knowing his or her sleeping habits and knowing what this special patient needs to get the kind and duration of sleep that helps her to recover and gives her comfort, especially if she is in pain or dying. The more dependent patients are due to their situation of illness or disease, the more comfort they need. For nurses, comfort implies a moral stance, clinical knowledge and the tangible, practical skills in which they have developed expertise (Kaufmann 2005).

When the physician defines the situation as 'a mini ethical problem' without giving any reason, no questions or controversial points are raised. Why this is only a small ethical problem, is left open. The physician does not feel a need for explanation and nobody else asks for it. Then the commentaries that lack explanation go on: Physician B declares it a problem that has to do with hierarchy and minister A remarks that the problem might be linked to 'some communication problems in the ward'. Since these are exclamations which follow after the non-rejected definition of a 'mini ethical problem', one could ask whether hierarchy and communication are categories that can be put under the umbrella of small ethical problems or whether they are indicators of difficult situations that cannot simply be framed as ethical. Framing them in the context of small ethical problems minimizes their potential for conflict and understanding the situation in its complexity which, of course, can not only harm patients, but also disrupt professional identities.

When physician C repeats the remark of physician A that this is a 'petit ethical problem' the conversation is concluded. There seems to be a hidden consensus about how much time should be spent on what kind of issues. That the discussion of the concern does not deserve much time could have been evoked by the minimization of the problem. The minister, realizing that the discussion is ending, asks the rather pragmatic question: 'What should I tell her?' and the first answer is given by physician A who started to comment on the concern. 'You can tell her that she did not do anything wrong…' he authorizes the minister to tell her. Does this mean that the nurse acted correctly according to a medical perspective? What is ultimately the criterion to distinguish between wrong and right in this situation? And, who has the power to define it?

Physician B adds that the nurse should be told that 'the problem had to do with hierarchy and failed communication'. What is the message of this piece of information? What can the nurse take out of this kind of analysis? This is difficult to tell because there is no explanation. Does it mean that the female physician who gave the order is not right, but cannot be questioned because she is in a stronger position of power than the nurse? Does it mean that hierarchy legitimizes inadequate orders and failed communication? Does it mean that where responsibility is great, but power is limited, nurses are the ones who are expected to compensate for deficiencies?

Physician C 'feels misused' by the concern of the nurse. This is a strong reproach. 'This is not an ethical problem at all!' is the explanation of his feeling. Does talk of problems which are not defined as ethical ones misuse disputants? Again, it is not clear what counts as a 'real ethical problem' in comparison to a 'petit' ethical problem or a different kind of problem, e.g. of competence and communication. Criteria are not given. What is the legitimization for minimizing the nursing concern at all?

It was the physicians who had the power to declare what counts as a 'real ethical problem' and what counts as a 'petit ethical problem'. Nobody in the group asked for an explanation of why the problem is declared to be a petit ethical problem.

Nobody talked about the physician who told the nurse to use the warmth of a patient's body to warm up a blood bottle. What is her part in the story? What can be said about her clinical expertise and responsibility? Did she behave in a competent manner? Did she possibly think that this might be a 'petit ethical problem' that counts less than the outcome, or having a warm blood bottle for another patient in need? Does she think that putting somebody in an uncomfortable situation is justifiable for the interests of another?

We do not know the whole story or history behind it, neither the context, nor the concreteness of the situation which might be helpful for retracing the behaviour of the physician and the nurse and relate to their feelings. The information given in the case consultation avoids complexity and only one perspective is given.

## 5.2 'She Wants to Go Home': An Older Woman Running Away from the Hospital

An ad hoc case consultation during a committee meeting.

A gerontologist (physician G) has interrupted the meeting for a case presentation.

Physician G reports:

*A female patient born 1928 had been treated at the Medical School. She had suffered from a decompensated heart insufficiency, and the General Practitioner had referred her to the hospital. It turned out that she had had a heart infarct. She was referred to the hospital for rehabilitation. Her physical capacity was limited, and she did not feel safe moving. Finally, dementia in the widest sense of the word was diagnosed. She was neither orientated in time nor in space. She kept talking about her wish to go home. Her brain waves showed an insufficient blood circulation. A form of vascular dementia was identified. It was realized that her home, was not only closed, but was sealed. Her neighbour had said that her flat had been absolutely run down. It had been a long time since she had allowed anybody to enter her flat. There had been the question of whether she would still be contractually capable. In the hospital, she was gradually arriving at a state of being able to go home. But she was not aware of her problems, she kept asking: When am I allowed to go home? Within the team it had been an unanswered question as to who would clarify things about her condition. Today, this morning, the ward informed me that she left the hospital on her own. Like every day she went to the kiosk, but then she did not return. She disappeared! (…) Looking out for her was in vain. What should I say? She is hard of hearing, suffers from diabetes, and has a walker. (…) I would like to ask the ethical question from my perspective at this point: How can patients with an advanced dementia get involved in the decision-making process?*

Chair A. (lawyer) 'Thank you for this report!'

She invites the committee participants to ask questions.

Social worker A: 'What forms of incapacitation are possible?'

Physician G: 'You know, the diagnosis is very complex! The medical school had treated her heart disease, but her dementia had not been diagnosed!'

Social worker A: ‘What about her relatives?’

Physician G: ‘Her relatives could not be found anywhere. There was no concrete address given by the patient.’

Social worker A: ‘And her general practitioner?’

Physician G looks astonished about this question.

Physician G: ‘We did not get into contact with him.’

Chair B (theologian) ‘What do you think is the real problem? What do you think it means that she constantly says, “I want to go home”? What is the symbolic meaning?’

Minister A: ‘She had probably been stressed in the Medical School Hospital.’

Minister B: ‘Yes, I think she could not cope with her situation there.’

Physician G: ‘We are talking about a quiet woman who only reacts if you ask her something. Other patients in her condition, can turn aggressive!’

Minister B: ‘Would it not have been necessary to engage a legal guardian earlier?’

Social worker A: ‘Are such patients not usually referred to short-term care?’

Nurse A: ‘What about nursing? What about nursing concepts for dementia?’

Physician G: ‘Nurses could not do much. They (dementia patients) can be so terribly dement that you cannot reach them any longer.’

Chair B: ‘The question of what she really wants is unclear. This is unsatisfactory.’

Physician G: ‘The stress of work has grown so much that we cannot save time for this kind of question!’

Chair A: ‘I think we have to thank you for bringing in this case! Thank you very much, Dr. Ammen!’

Physician G leaves the meeting and Chair A moves on to the next topic.

### 5.2.1 Analysis

Physician G presents the medical history of an old lady who had a heart infarct and is diagnosed with dementia. He says that she was neither orientated in time nor space. With regard to social aspects, he remarks that her neighbour had told about her unclean flat which she had not let anybody into for a long time. She kept talking about her wish to go home, but this remained an unanswered question within the team. Finally, she left the hospital without telling anybody. When social worker A asks about the presence of her relatives and a possible contact with her general practitioner, physician G explains that her relatives could not be found and that nobody had yet tried to get into contact with her family doctor is strange since physicians usually get in touch with family doctors to get to know more about patients, especially when no relatives are present.

When the chair B of the committee asks what the ‘real problem’ could be and what the meaning of her appeal ‘I want to go home’ might be, there is no idea given. Minister A explains that she had probably been stressed in the Medical School Hospital. The question arises as to whether she has in any way been taken seriously in her repeated wish to go home. When nurse B asks about the role of nursing and new ideas of how to deal with dementia patients, physician G answers quite harshly that nurses could ‘not do much’ because dementia patients ‘can be so extremely demented’ that they are unreachable. The answer shows that new ideas about how to deal with people with dementia are ignored. Nurse A seems to be informed about dementia care and asks adequately about the role of nurses. Since it is a professional task of nursing to take care of dementia patients, it is questionable why their caring responsibilities are left out of the discussion. Moreover, it could also be questioned whether physician G comes to present the problem about a patient who ran away, and not a nurse. It is not the nurse who presents the case, although, usually, it is she who has the responsibility to take care of dementia patients and try to build up a relationship. It is not the physician who takes care of a patient all day long, but the nurses. As his report shows, working on the right diagnosis is his competency and responsibility, but not identifying an adequate nursing care tool in the area of dementia which might best fit this individual patient. Nurses should have the competency to attend to patients with dementia and find out which tools can be helpful to give care. It is nurses’ responsibility to see about what to do and not to do, how the patient responds and in which way interaction succeeds. Why did the nurses who took care of the old lady not show up and raise their voices? What would have been their own narrative?

At the end of the conversation, chairperson B frankly and nervously remarks that ‘this is unsatisfactory’ since the question of what the old lady really wanted remained unclear. To put it more precisely, the question should be, why was it not taken seriously that the old lady wanted to go home? If it is not possible for her to go home, alternatives could have been considered such as thinking about a nursing home for persons with dementia to which she could have taken her own belongings.

Although there may have been a discussion about the relevance of paying attention to issues of dementia care as well as nurses’ competencies and responsibilities, the chair closes the case consultation and expresses her thankfulness that the physician brought a case to report.

## 6 Conclusion

The use of principles has become the master story of clinical ethics despite the critiques. Instead of running the risk of reducing or ignoring moral problems by the use of principles, Walker convincingly argues for paying attention to history, context and concreteness of the situation. Moreover, she addresses the importance of different perspectives on a moral problem, since these can open up critical opportunities. If chances of listening to different perspectives are ignored, actors in HECs are doubly ill-served. On the one hand, alternative narratives go unexplored and on the other hand, some members, for example nurses, are disqualified as agents of value. Nurses’ narratives and ethical concerns can also go unexplored or be dismissed due to their relatively weak position of power. Care ethical approaches can bring particularities to the forefront in clinical ethics and make history, context and concreteness of the situation matter. Especially Tronto’s care ethical approach offers a language that can analyse everyday experiences of care in clinical practice by bringing in questions of attentiveness, competence, responsibility and responsiveness. A feminist ethics of care has the potential not only to make caring issues matter, but to address hierarchies, power relationships and conflicts which influence whose voices count or do not count, and even what might have caused the ethical problem in the first place. As shown by the illustration of the two case consultations, the application of a feminist ethics can prevent the practice of caring from becoming marginalized and dismissed. The invitation to apply the insights of feminist ethics is certainly not restricted to HECs. HECs and ethical case consultation can serve as an example for other discursive spaces in health care settings. A feminist approach can shed light on the unspoken and unseen issues of concern which are often related to power and gender in any place where nurses talk and come together in a group with multi-professional membership.

## References

Alnes, Rigmor Einang, Marit Kirkevold, and Kirsti Skoydahl. 2011. Marte Meo counselling: a promising tool to support positive interactions between residents with dementia and nurses in nursing homes. *Journal of Research in Nursing* 16 (5): 415–433.

Beauchamp, Tom, and James F. Childress. 1983. *Principles of Biomedical Ethics*. 2nd ed. Oxford: University Press.

Benner, Patricia. 1994. The tradition and skill of interpretative phenomenology in studying health, illness, and care practices. In *Interpretative Phenomenology, Embodiment, Caring and Ethics in Health and Illness*, ed. Patricia Benner, 99–127. Thousand Oaks: Sage.

Benner, Patricia, and Judith Wrubel. 1989. *The Primacy of Caring. Stress and Coping in Health and Illness*. Menlo Park: Addison-Wesley.

Bishop, Anne, and John R. Scudder. 1990. *The Practical, Moral, and Personal Sense of Nursing. A Phenomenological Philosophy of Practice*. New York: State University of New York Press.

Bosk, Charles, and Joel Frader. 1998. Institutional ethics committees: Sociological oxymoron, empirical black box. In *Bioethics and Society. Constructing the Ethical Enterprise*, ed. Raymond DeVries and Janardan Subedi, 16. Upper Saddle River: Prentice Hall.

Card, Claudia. 1990. Carin and evil. *Hypathia.* 5 (1): 101–108.

Carse, Alisa L., and Hilde Lindeman Nelson. 1996. Rehabilitating Care. *Kennedy Institute of Ethics*. 6 (1): 19–35.

Chambliss, Daniel F. 1996. *Beyond Caring. Hospitals, Nurses, and the Social Organization of Ethics*. Chicago: University of Chicago Press.

Condon, Esther H. 1992. Nursing and the caring metaphor: Gender and political influences on an ethics of care. *Nursing Outlook.* 40 (1): 14–19.

Cranford, Ronald E., and A. Edward Doudera. 1984. The emergence of institutional ethics committees. *Law, Medicine and Ethics* 12 (1): 13–20.

de Brito Menezes Gonçalves, Gabriela, and Darci de Oliveira Santa Rosa. 2019. Nurses performance in clinical ethics committees and commissions: An integrative review. *Nursing Ethics* 26 (3): 688–699.

Fischer, Berenice, and Joan Tronto. 1990. Toward a feminist theory of care. In *Circles of Care: Work and Identity in Women's Life*, ed. Emily Abel and Margaret Nelson, 36–54. Albany: State University of New York Press.

Flynn, Patricia. 1991a. *Moral Ordering and the Social Construction of Bioethics*. Unpublished dissertation. University of California, San Francisco.

———. 1991b. The disciplinary emergence of bioethics and bioethics committees: Moral ordering and its legitimation. *Sociological Focus* 24 (2): 145–156.

Fox, C. Renee. 1990. The evolution of American bioethics: A sociological perspective. In *Social Science Perspectives on Medical Ethics*, ed. George Weisz, 201–217. Boston: Kluwer Academic.

Friedman, Marilyn. 1993. *What Are Friends For? Feminist Perspectives on Personal Relationships and Moral Theory*. Ithaca: Cornell University Press.

Fry, Sarah T. 1989. The role of caring in a theory of nursing ethics. *Hypathia.* 4 (2): 88–103.

Gadow, Sally. 1985. Nurse and patient: The caring relationship. In *Caring, Curing, Coping. Nurse, Physician, Patient, Relationships*, ed. Anne H. Bishop and John R. Scudder, 31–43. Tuscaloosa: University of Alabama Press.

Gilligan, Carol. 1982. *In a Different Voice: Psychological Theory and Women's Development*. Cambridge: Harvard University Press.

Holly, Cheryl Malahan. 1986. *Staff Nurses' Participation in Ethical Decision Making. A Descriptive Study of Selected Situational Variables*. Unpublished dissertation. Columbia.

Jaggar, Allison M. 1995. Caring as a feminist practice of moral reason. In *Justice and Care: Essential Readings in Feminist Philosophy*, ed. Virginia Held, 179–202. Boulder: Westview Press.

Kaufmann, Sharon. 2005. … *And a Time to Die. How American Hospitals Shape the End of Life*. New York: University of Chicago Press.

Keffer M. 1997. Why nursing ethics committees? *HEC Forum* 9 (1): 50–54.

Kohlberg, Lawrence. 1981. *The Philosophy of Moral Development: Moral Stages and the Idea of Justice*. San Franscisco: Harber & Row.

Kohlen, Helen. 2009. *Hospital Ethics Committees in the US and in Germany*. Frankfurt a. Main: Campus Verlag.

———. 2016. Plädoyer für eine widerständige Care-Praxis—Zur Entwicklung von Care-Ethiken im internationalen Vergleich und ihrem Status in der Pflege. In Kleibel, Veronika; Urban-Huser, Catherine (Hg.): Caring—Pflicht oder Kür? Gestaltungsräume für eine fürsorgliche Pflegepraxis. Wien: Fakultas. 15–27.

———. 2017. Caring about Care in the Hospital Arena and Nurses' voices in hospital ethics committees. Three decades of experiences. In *Care in Healthcare. Reflections on Theory and Practice*, ed. Franzsika Krause and Joachim Bold, 237–265. London: Palgrave Macmillan.

———. 2018. Evaluation for moving ethics in health care services towards democratic care. A three pillars model: Education, companionship and open space. In Visse, Merel/Abma. 143–155.

Leiniger, Madeleine. 1991. *Culture Care Diversity and Universality: A Theory of Nursing*. New York: National League for Nursing Press.

Lindeman Nelson, Hilde. 1996. Against caring. *Journal of Clinical Ethics* 3 (1): 8–20.

Mol, Annemarie. 2008. *The Logic of Care. Health and the Problem of Patient Choice*. New York: Routledge.

Noddings, Nel. 1984. *Caring: A Feminine Approach to Ethics and Morals*. Berkeley: University of California Press.

———. 1990. Ethics from the standpoint of women. In *Theoretical Perspectives on Sexual Difference*, ed. Deborah L. Rohode. New Haven: Yale University Press.

Piaget, Jean. 1965. *The Moral Judgement of the Child*. New York: Free Press.

Reverby, Susan. 1987a. A caring dilemma: Womanhood and nursing in historical perspective. *Nursing Research* 36 (1): 5–11.

———. 1987b. *Ordered to Care. The Dilemma of American Nursing, 1850–1945*. New York: Cambridge University.

Roper, Nancy. 1990. *The Elements of Nursing: A Model for Nursing*. London: Churchill Livingstone.

Ross, Judith W. 1986. Handbook for Hospital Ethics Committees. Practical suggestions for ethics committee members to plan, develop, and evaluate their roles and responsibilities. Chicago.

Rothman, David. 2003. *Strangers at the Bedside: A History of How Law and Bioethics Transformed Medical Decision Making*. New York: Basic Books.

Rubin, Susan, and Laurie Zoloth-Dorfman. 1996. She said/ he said: Ethics consultation and the gendered discourse. *The Journal of Clinical Ethics* 7 (4): 321–332.

Sherwin, Susan. 1992. *No longer patient. Feminist Ethics and health care*. Philadelphia: Temple University Press.

Sichel, Betty A. 1992. Ethics of caring and the institutional ethics committee. In *Feminist Perspectives in Medical Ethics*, ed. Helen Bequaert Holmes and Laura M. Purdy, 113–123. Bloomington: Indiana University Press.

Tronto, Joan. 1994. *Moral Boundaries. A Political Argument for an Ethics of Care*. London: Routledge.

Tronto, Joan C. 2013. *Caring Democracy: Markets, Equality, and Justice*. New York: New York University Press.

Walker, Margaret Urban. 1993. Keeping moral space open. Images of ethics consulting. *Hastings Center Report* 23 (2): 33–40.

Watson, Jean. 2012. *Nursing: Human Science and Human Care. A Theory of Nursing*. 2nd ed. London: Jons and Bartlett.

# Feminist Reflections on Home, Digital Health Technologies, and Ethics

Elizabeth Peter

## 1 Introduction

The provision of care in the home has a long-standing history in nursing, but in recent years societal trends and technological change, including digital health technologies, have brought new ethical challenges. Home care services have the potential to disrupt practices in the home and raise ethical issues because homes are places that are laden with cultural norms and social meanings including associations with love, security, and privacy. Nevertheless, the flipside of these ideals, which includes isolation, abuse, and surveillance, also exist in part, because they are not adequately challenged and are made possible by women's domestic roles. In this chapter, I examine the ethical implications of providing and receiving home services focusing on the use of digital health technologies in the home and their potential implications for the moral practices of the home to highlight a number of ethical considerations related to the provision and receipt of home care services. In particular, I focus on medicalization and surveillance, privacy, autonomy, and family caregiving relationships. Along with feminist ethics, this analysis is informed by feminist relational geography, given that spatial factors are central to the ethics of home care. How these two related perspectives are aligned and how the foregrounding of space and place in geography can enhance the use of feminist ethics will be explained below.

---

E. Peter (✉)
Lawrence S. Bloomberg Faculty of Nursing and Joint Centre for Bioethics,
University of Toronto, Toronto, ON, Canada
e-mail: elizabeth.peter@utoronto.ca

H. Kohlen, J. McCarthy (eds.), *Nursing Ethics: Feminist Perspectives*,
https://doi.org/10.1007/978-3-030-49104-8_9

## 2 The Compatibility of Feminist Ethics and Feminist Relational Geography

Beyond their attention to the lives of women and less powerful groups in society, feminist ethics and feminist relational geography share a number of characteristics, including their emphasis on a relational ontology, power and politics in everyday care work, and context. Like feminist ethics, central to geographical thought is the understanding that social relations influence the development of identities, experiences, and agency. The notion of space "denotes a dimension in which phenomena are distributed. Conventionally it has been viewed as orthodox geometric space, quantifiable in terms of Euclidean distance" (Curtis and Jones 1998, p. 645). Yet, space can also "be seen as both the medium and outcome of social relations. Space therefore has social significance and is socially constructed" (Curtis and Jones 1998, p. 645). Thus, geographers recognize how spaces are created through social interactions and are viewed to be ever-changing, creating "social space" which describes how spaces are experienced and navigated (Andrews et al. 2013; Hall 2018).

The importance of power and politics in everyday life, particularly with respect to care work, is also understood to be central by both areas of thought. Massey (1991) speaks of social spaces being made by the "geographical stretching-out of social spaces" (p. 24) which refers to the production of the inequities of spaces that are a consequence of changing socio-material aspects of our everyday world, such as technology, transportation, and modes of communication (Hall 2018; Massey 1991). For example, because of neoliberal policies and changes in technology, the boundary that ostensibly separates the home, thought to be a private space, and the state and the market, thought to be a public space, becomes blurry when paid homecare workers provide care (England 2010). These changes impact everyday life in the home, particularly the lives of women who perform the most paid and unpaid homecare work. Dyck (2005) describes women's unaccounted for care work in the home as "place-making" (p. 236) which is the result of neoliberal policies. These seemingly routine and mundane care practices are of interest for geographers (Hall 2018) as they are for feminist ethicists. Geographers, however, foreground place. As Hall (2020) states: "Care also has a *place*, both in society at large, and in everyday routines, relationships and practices, commonly associated within the personal space of home" (p. 3).

Both feminist ethicists and feminist geographers emphasize context, but often describe it somewhat differently. Relational moral theories, such as feminist ethics, conceptualize context, and situatedness in predominantly social terms, with the material relations often ignored unlike what is typical in geography (Whatmore 1997). Yet, the possibility to introduce place coherently into feminist ethics exists if we consider that persons' particularity and location offer the potential to include place because persons can be thought of as located both in sociopolitical and material terms (Peter 2002). Ultimately, while these two areas of scholarship tend not to be brought together frequently, they share many elements and can be combined to address issues in moral life, especially in areas where place is paramount, such as those surrounding home care.

## 3 Feminist Ethical and Geographical Insights Regarding the Home

Home is commonly understood to be the site in which we live, yet it is much more than this. “Home is also an idea and an imaginary that is imbued with feelings” (Blunt and Dowling 2006, p. 2). These feelings are inherently spatial and can range from feelings and cultural meanings of love and belonging to fear and alienation (Blunt and Dowling 2006). From a feminist ethics perspective, these ideas, meanings, and feelings reflect deeply held values and practices that are rooted in home life and are intertwined with those of society more generally. The morality of home as an idea or imaginary, like morality more generally, can best be revealed by recognizing the practices of responsibility associated with home because these responsibilities illustrate our identities, values, and accountabilities. These are inextricably connected with our social roles and practices making morality a dimension of everyday social life (Walker 1998). Similarly, making home is also a practice. Blunt and Dowling (2006) state, “relational geographies of home require attention to what we term home-making practices. Home does not simply exist, but is made. Home is a process of creating and understanding forms of dwelling and belonging. This process has both material and imaginative elements” (p. 23). Relational geography also recognizes that places, like the home, are not fixed, but develop through their relationships with other spaces and places that exist on multiple scales (Skinner et al. 2015).

Feminists underscore that power relations are omnipresent in the home, creating identities and hierarchies. Practices of the home, manifested through both caring and domestic work, are gendered and often are attributed to the so-called private as opposed to the public world. Yet, these worlds are mutually constructed. While traditionally, men have viewed the home as a haven from public life, the home for many women is a workplace, illustrating how norms and ideas are infused across places (Blunt and Dowling 2006). In a similar vein, Walker (1998) calls us to critically reflect on these forms of moral–social arrangements and their practices to ensure that they are coherent to those who engage in them and that they are not coercive or marginalizing.

## 4 Digital Health Technologies

Digital health technologies have become increasingly prevalent in society, including those that are in the homes of those receiving healthcare services. These technologies can involve telehealth to offer consultations, education, and support remotely; digitized devices for medication delivery and the enhancement or regulation of bodily functions, for instance, cardiac monitors and insulin pumps; health informatics, for example, electronic health records; wearable technologies for monitoring blood sugar, heart rate, and emergencies; blogs and social media sites for patients; and digital health promotion for the dissemination of health education (Lupton 2014). These innovations, while often developed as solutions to health-related problems, have wide-ranging ethical and social implications that require reflection.

Any attempt to generalize regarding the impact of these technologies, however, is difficult because of the degree of variability in the nature and purpose of these technologies and the variability among the people who rely on them. Moreover, new technologies are continually emerging along with research studying their impact, further adding to the challenge of making any definitive statements. Moreover, homes, unlike institutions, are diverse and spatially dispersed, resulting in the experiences of users of technology being similarly diverse (Andrews 2003). As such, a feminist particularist approach, which examines the unique strengths, vulnerabilities, and preferences of people along with their contexts, is ideal in this regard because it permits an examination of each person's individual needs and situation.

It is also important to consider vast differences that exist in terms of accessibility to these digital health technologies. Differential access to these has been referred to as the "digital divide," which has been defined as "the gap between individuals, households, businesses and geographic areas at different socio-economic levels with regard both to their opportunities to access information and communication technologies (ICTs) and to their use of the Internet for a wide variety of activities" (OECD 2001, p. 5). This gap is the result of many factors related to equity, including lower levels of education, health and digital literacy, and income (Lupton 2014). Even in high-income countries, there are geographical differences in the availability of technologies depending on the quality of data infrastructure between urban and rural areas with less availability in rural communities despite their need being the greatest (Salemink et al. 2017). This gap is of most concern when certain health services and information are only offered digitally. Nevertheless, fears of oversimplification and generalization aside, I raise some possible ethical implications here that require a nuanced interpretation when examining particular situations.

## 5 Medicalization and Surveillance

Feminist ethicists not only have a long history of questioning the medicalization of childbirth, they have also been concerned with the excessive medicalization of aging and other human experiences. Over 25 years ago, Liaschenko (1994) expressed concern regarding the rise of technology in the home that could bring the "gaze of medicine", or medicalization, with its emphasis on the biomedical view of disease, into the landscape of the home, potentially impacting home practices that foster and maintain human agency. Liaschenko (1994) argued for the "gaze of nursing,", which embraces both the "gaze of medicine," if that is in keeping with patients' values, along with a perspective that supports the view of patients as persons who live particular lives in particular places. She, like Conrad (2005), was concerned that technology has the potential to further encroach on the everyday lives of people allowing normal human experiences such as aging and death to be understood through a medical lens and to fall under the control of health care professionals. It is important to recognize, however, that how individual patients experience the constant surveillance of wearable technologies, whether it be self-surveillance or that of the surveillance by health professionals, is for some reassuring and for others a source of anxiety (Lupton 2014). Moreover, while technologies can enhance quality and quantity of life for some, these technologies can encroach on what has, at least previously been believed to be, the private domain of the home (Poland et al. 2005).

The use of digital health technologies also raises questions about the meaning of embodiment and the relation between humans and the ever-changing nature of technology and the normalization of the creation of what have been called cyborgs, or beings with both biological and technical components. As prosthetics, these devices can enhance bodily capacities by providing data that can be used to inform people of their limitations and strengths. They also allow people to work on themselves and to present a particular identity (Lupton 2014), such as person who derives a positive sense of self by achieving a high number of daily steps. While on an individual level this might improve quality of life, it is important that the social implications are taken into account, because as Poland et al. (2005) have argued, health technology has the potential to have profound effects on the self, identity, and personhood. For example, Boström et al. (2013) studied the perceptions of older adults who wore monitoring technology and had sensors in their home to maintain their independence. The main theme of their research was “maintaining a sense of self” that represented older adults’ need to maintain their identities and control over their lives, given the loss of privacy they experienced. Yet, overall, they believed they could accept the surveillance if they could maintain their autonomy and sense of security.

## 6 Privacy

Surveillance also has ramifications for privacy. Privacy is a complex and deeply problematized concept in feminist ethics which DeCew (2018) argues can be best understood as a cluster concept which embraces interests in: “(1) control over information about oneself, (2) control over access to oneself, both physical and mental, and (3) control over one’s ability to make important decisions about family and lifestyle in order to be self-expressive and to develop varied relationships” (p. 2). In this way, the concept does not only pertain to informational and physical privacy but also can contest the traditional dichotomy of the public and private spheres, which protects the private sphere from state interventions and scrutiny (Allen 2011). This problematization is necessary because privacy is not always ideal because it can foster unchosen seclusion and the hidden domination and abuse of women and others. Yet, it is also important to ensure that the state does not interfere with the most personal aspects of life in unwanted ways (DeCew 2018). Consequently, cyberfeminists, who have an interest in examining and theorizing the internet, digital technologies, and cyberspace, argue that the impact of adopting digital technologies must not be taken up uncritically at both the level of individuals and also at the level of culture (Consalvo 2002). On the one hand, they argue that these technologies give people the opportunity not to be isolated in their homes and to be politically empowered, yet on the other, the anonymity can lead to a lack of accountability and potential safety (Allen 2011).

With respect to informational and physical privacy, concerns have been expressed regarding the unauthorized sharing of data, the intrusiveness of the equipment, and the disruption of daily routines by technology. Yet, home care recipients have expressed that these issues are of less consequence to them than having to move out of their homes. With respect to older adults living in the community, some have concluded that the ethics of the use of assistive technology requires that a balance be struck between the violation of privacy and the protection of people in their homes (Zwijsen et al. 2011). From a feminist perspective, the balance can only be struck by assessing each person in their unique situation and assisting them to understand the implications of their choices. These conclusions also require that long-term care environments are not so unappealing that people have no other real choice than to remain in the home, even if they find that the experience of receiving care in the home is unacceptably intrusive.

## 7 Autonomy

Conventionally, little attention in ethical theory has been given to the significance of place to the self. Instead, ethics has tended to equate the self with the mind—a thinking thing that is immaterial, nonspatial, and separate from the body (Waymack 2001) with notable exceptions arising from phenomenology and feminist philosophy. In a similar way, in bioethics, conceptualizations of autonomy have not fully considered the implications of an emplaced self which is not surprising because the roots of bioethics are in mainstream ethical theory and because bioethics has tended not to concentrate on ethical issues that arise in homes. Hospitals, unlike homes, tend to be more generic in nature, allowing their spatial features to become invisible to professionals who occupy them regularly (Peter 2002). Feminist ethics along with insights from feminist geography, however, make it possible to understand the emplaced nature of autonomy because they recognize that people are not only socio-politically situated, they are materially situated which is an important consideration with respect to home care. Without this sense of autonomy as being emplaced, how different settings, like the home, situate autonomy can be overlooked (Andrews and Peter 2006). As Malpas (2003) states, “Since all human life, and with it human illness and suffering, is essentially lived in place, so any attempt to engage with human life that ignores its placed character will inevitably fail, to some degree or another, in that engagement” (p. 2347). The saying “he is the king of the castle” typifies the imaginary and cultural values of the home that express autonomy and agency, along with gender, which can become altered when digital health technology enters the home because of the requirements of patients to conform to the demands of healthcare professionals who have decided to use these technologies (Lupton 2014).

In many instances, however, the restriction of autonomy may be a matter of degree because the technology may free people from not needing to attend medical appointments, to be in hospital, or to have healthcare workers coming into the home.

For example, it is important to take into account that despite the popularity of so-called patient-centered care, the experience of receiving care in an institution, such as a hospital or nursing home, can restrict autonomy even more than receiving home care services because of the regimentation and spatial limitations often inherent in them. As opposed to the idealized practices of home, in which the identities of people are built and preserved and the unique needs of people are respected when providing care, institutions can be regimented reflecting an ethos of efficiency. As a consequence, caregiving including meal provision, bathing, medication provision, and even recreational activities can be highly scheduled and regimented (Andrews and Peter 2006), which limits the everyday autonomy of care recipients. This phenomenon has been called the "task and time" (p. 332) approach that has been described as depersonalized and mechanistic (Kitson et al. 2014).

Even if home care provision avoids such mechanistic efficiencies, however, the entry of care workers into the home can be experienced as an intrusion, interfering with the freedoms and everyday routines and choices of the home's occupants. They also often experience an erosion of their autonomy because they can become passive objects of care without the necessary voice to direct their everyday lives as others care for them (Jacobs 2018). Autonomy understood relationally emphasizes that the "exercise of personal autonomy is enabled or constrained by social relationships and by social norms, structures and institutions" (Mackenzie 2019, p. 4) which reflects the many possible scales of analysis needed to understand autonomy. How autonomy is exercised is a reflection, not only of micro influences but also of social policy as it impacts the nature and amount of support that is provided by the state, which may or may not include the availability of digital health technologies. It is important to recognize that autonomy can also be enhanced by the provision of services that allows for choice and control and by the nature of relationships among care recipients and caregivers (Bjornsdottir 2017; Öresland et al. 2009). For example, Jacobs' (2018) research, which incorporated a feminist ethics lens, found that home care nurses could promote autonomy by adapting to patients' unique needs, values, and preferences; by activating their strengths, and by collaborating with them and their informal caregivers. While care can result in dependence and restricted autonomy of patients, it is a needed prerequisite for the enhancement of their autonomy because the relational support makes autonomy possible (Jacobs 2018). To what extent this can be meaningfully supplied in a virtual fashion through technology is necessary to explore.

## 8 Family Caregiving Relationships

Family caregiving in the home is virtually synonymous with practices in the home, such as the domestic and caring work which maintains not only the physical well-being of its occupants but also fosters their identity, belonging, and privacy (Blunt and Dowling 2006; Hall 2020). In recent years, this caregiving has greatly expanded as the responsibility for the provision of many healthcare services has shifted from the state to the home, especially in countries such as Canada, New Zealand, the

United Kingdom, and the United States (Milligan 2009). While, traditionally, women have held a disproportionate degree of responsibility for the everyday caring for family members, including for those who are sick and dying, they, along with men and even children, have become progressively more responsible for providing care that heretofore would have been provided in hospitals and other institutions by paid, professional nurses. This privatized caring is supported by a neoliberal ethos, which rests on the assumption that families are and should be available to provide care without sufficient attention to their ability and willingness to do so, and it is reflected in the social policies of many countries (Milligan 2009; Peter and Liaschenko 2014; Peter et al. 2007; Tronto 2006).

This shift in social policy has had a profound impact on home-life disrupting home routines and practices as those practices of formal health care are overlaid onto those of the home. Family caregivers and their care recipients must adapt to changed places with not only the invasion of the often ever-present medical equipment, but also with the presence of formal homecare providers who, on one hand, make necessary care possible, but on the other, can be unwelcome (Angus et al. 2005; Seto-Nielsen et al. 2013). The nature of this transformed family caregiving can be extraordinary, encompassing a full range of care, such as support with activities of daily living, emotional care, technical nursing care, and service coordination and supervision, often with minimal available public support and training. As a consequence, many caregivers experience reduced quality of life, distress, physical burdens, and needs that are not met by healthcare systems (Dionne-Odom et al. 2017; Martín Martína et al. 2016). Furthermore, there can be significant out-of-pocket costs and lifelong income losses for informal caregivers (Canadian Cancer Network 2017).

The moral responsibilities of nurses in the home are also not always straightforward as social policy directing home care services has increasingly shifted the moral responsibility for care from the state to the family, thereby altering the kinds of relationships nurses have with patients and families. Ward-Griffin and McKeever (2000) and Milligan (2009) have provided typologies of relationships that assist in conceptualizing the evolving and sometimes conflicting types of relationships. The first type the “nurse-helper” has become least common, although it is the type of relationship most commonly idealized in nursing. Its sustained face-to-face nature allows nurses to preserve the identities of people who are vulnerable, which, in turn, allows nurses to maintain their own sense of identity and value (Peter et al. 2018). It is the type of relationship in which nurses provide and coordinate most of the care with the family playing a supportive role, but this relationship, as a consequence of social policies that have limited the amount of nursing care provided, has become increasingly uncommon (Ward-Griffin and McKeever 2000). Given that nurses often view this kind of relationship and the kind of care that flows from it as reflecting their moral identities and responsibilities, it is not surprising that they experience moral distress when they cannot provide this type of care in their practice (Brazil et al. 2010; Peter and Liaschenko 2013).

The second type of relationship is one in which family caregivers are viewed as a resource—they are coworkers alongside nurses, or, they are workers who are managed by nurses. These caregivers often acquire a high level of skill and knowledge as they assume responsibilities that would normally be in the domain of professionals even though many feel unqualified and fearful and would prefer assistance from nurses (Milligan 2009; Ward-Griffin and McKeever 2000). Despite their skill and knowledge, unlike professional caregivers, family caregivers do not have the power and privilege of nurses who are socially recognized for their expertise and exercise significant power in healthcare systems. When they are not provided the supports of professional networks and associations, they can be left feeling relatively isolated and powerless (Pauley et al. 2018). Unsurprisingly, the second type of relationship frequently evolves into the third type in which the family member also becomes a patient as their own health deteriorates as a result of substantial caregiving and preexisting health conditions. As the needs of the caregiver become more evident, they may come to conflict with those of the patient and complicate who is the focus of care in the relationship, i.e., the patient or the caregiver (Milligan 2009; Ward-Griffin and McKeever 2000).

The current evidence we have of the distress of patients and family members can inform what Walker (1998) calls an "empirically saturated reflective analysis" (p. 11) to evaluate whether the moral understandings embedded in home care arrangements are intelligent, coherent, and morally habitable to those involved in them. Morally habitable environments are those that are characterized by mutual recognition and cooperation as opposed to suffering and the uneven distribution of responsibilities (Walker 1998). The experiences of those involved in home care make it evident that the current moral–social arrangement of the delivery of home care services is not creating morally habitable environments, in this case homes, because this arrangement is not supporting sustainable moral practices for many. While families and friends may want to care, without outside support, they often cannot do so without falling ill themselves or becoming exceedingly distressed. They, like all people, are interdependent and require support to continue to provide care.

Digital health technologies have been found, however, to bring improvements to some of these problems. In their review of the literature examining the role of digital technologies to enable aging in place, Kim et al. (2017) found a number of benefits that are relevant to the well-being of both home care participants and their caregivers. While there are a number of definitions of aging in place, they use one that focuses on the ability of older adults to live in the community and their own home while maintaining their quality of life. This technology has made possible the early detection and management of health problems, the self-management of hypertension and diabetes, and safety monitoring (Kim et al. 2017). It also has decreased the social isolation of older adults and has provided a way for caregivers to receive additional support from health care professionals and watch over their loved ones remotely. While these relationships are not as ideal as face-to-face encounters because older adults fear losing the physical contact of others (Sundgren et al. 2020), technology can make possible what might not otherwise be possible at all. Some have spoken about the unprecedented compression of time and space as the "death of distance" in the capacity of telemedicine and the internet to breakdown both social and physical barriers (Andrews et al. 2013) and enhance the abilities of families and friends to extend their relational capacities to hold and maintain the identities of older adults in the community (Parks 2015).

## 9 Conclusion

While digital health technologies in the home may hold much promise in improving the quality of life, enhanced autonomy, and decreased social isolation for many, continued ethical scrutiny is needed particularly with respect to concerns regarding privacy and surveillance. It is also important to consider the broader societal changes these technologies may bring, including an emphasis on self-care and self-monitoring that neglects the impact of the social determinants of health, the potential impact on the evolution of the institution of the family and practices of the home, and the effect on our identities as humans as we become increasingly wed to technology. Further research and scholarship and a heightened awareness of these issues and the possible solutions these technologies can bring will help bring about informed use of these technologies. Feminist ethics coupled with relational geography can permit this type of ongoing and rich ethical analysis of home care issues, given their capacity to address an array of concerns combined with their recognition of the significance of place.

## References

Allen, Anita. 2011. *Unpopular Privacy: What Must We Hide?* New York: Oxford University Press.

Andrews, Gavin J. 2003. Locating a geography of nursing: space, place and the progress of geographical thought. *Nursing Philosophy* 4 (3): 231–248. https://doi.org/10.1046/j.1466-769X.2003.00140.x.

Andrews, Gavin J., and Elizabeth Peter. 2006. Moral geographies of restraint in nursing homes. *Worldviews on Evidence-Based Nursing* 3 (1): 2–7. https://doi.org/10.1111/j.1741-6787.2006.00044.x.

Andrews, Gavin J., Joshua Evans, and Janine L. Wiles. 2013. Re-spacing and re-placing gerontology: Relationality and affect. *Ageing and Society* 33 (8): 1339–1373. https://doi.org/10.1017/s0144686x12000621.

Angus, Jan, Pia Kontos, Isabel Dyck, Patricia McKeever, and Blake Poland. 2005. The personal significance of home: Habitus and the experience of receiving long-term home care. *Sociology of Health & Illness* 27 (2): 161–187. https://doi.org/10.1111/j.1467-9566.2005.00438.x.

Bjornsdottir, Kristin. 2017. I try to make a net around each patient': Home care nursing as relational practice. *Scandinavian Journal of Caring Sciences* 32: 177–185. https://doi.org/10.1177/0969733008100081.

Blunt, Alison, and Robyn Dowling. 2006. *Home*. New York: Routledge.

Boström, Martina, Sofia Kjellström, and Anita Björklund. 2013. Older persons have ambivalent feelings about the use of monitoring technologies. *Technology & Disability* 25 (2): 117–125. https://doi.org/10.3233/TAD-130376.

Brazil, Kevin, Sharon Kassalainen, Jenny Ploeg, and Denise Marshall. 2010. Moral distress experienced by health care professionals who provide home-based palliative care. *Social Science and Medicine* 71 (9): 1687–1691. https://doi.org/10.1016/j.socscimed.2010.07.032.

Canadian Cancer Network, Canadian Home Care Association, & Carers Canada (CCN, CHCA, & Carers Canada). 2017. Advancing collective priorities: A Canadian carer strategy. http://www.cdnhomecare.ca/media.php?mid=4918.

Conrad, Peter. 2005. The shifting engines of medicalization. *Journal of Health and Social Behavior* 46 (1): 3–14. http://www.jstor.org.myaccess.library.utoronto.ca/stable/4147650.

Consalvo, Mia. 2002. Cyberfeminism. In *Encyclopedia of New Media*, ed. Steve Jones, 109–110. Thousand Oaks: Sage.

Curtis, Sarah, and Ian Rees Jones. 1998. Is there a place for geography in the analysis of health inequality? *Sociology of Health and Illness* 20 (5): 645–672. https://doi.org/10.1111/1467-9566.00123.

DeCew, Judith. 2018. Privacy, In (Ed.) Edward N. ZaltaThe Stanford Encyclopedia of Philosophy. (Spring Edition). https://plato.stanford.edu/archives/spr2018/entries/privacy/>.

Dionne-Odom, Nicholas, Stephanie A. Hooker, David Bekelman, Deborah Ejem, Gwen McGhan, Lisa Kitko, Anna Strömberg, Rachel Wells, Meka Astin, Zehra Gok Metin, Gisella Mancarella, Salpy V. Pamboukian, Lorraine Evangelista, Harleah G. Buck, Marie A. Bakitas, and on behalf of the IMPACT-HF National Workgroup. 2017. Family caregiving for persons with heart failure at the intersection of heart failure and palliative care: A state-of-the-science review. *Heart Failure Review* 22: 543–557. https://doi.org/10.1007/s10741-017-9597-4.

Dyck, Isabel. 2005. Feminist geography, the 'everyday', and local-global relations: Hidden spaces of place-making. *The Canadian Geographer* 49: 233–245.

England, Kim. 2010. Home, work and the shifting geographies of care. *Ethics, Place & Environment* 13 (2): 131–150. https://doi.org/10.1080/13668791003778826.

Hall, Sarah Marie. 2018. Everyday austerity: Towards relational geographies of family, friendship and intimacy. *Progress in Human Geography* 43 (2): 030913251879628. https://doi.org/10.1177/0309132518796280.

———. 2020. The personal is political: Feminist geographies of/in austerity. *Geoforum* 110: 242–251. https://doi.org/10.1016/j.geoforum.2018.04.010.

Jacobs, Gaby. 2018. Patient autonomy in home care: Nurses' relational practices of responsibility. *Nursing Ethics* 26 (6): 1638–1653. https://doi.org/10.1177/0969733018772070.

Kim, Kwang-il, Shreya Gollamudi, and Steven Steinhubl. 2017. Digital technology to enable aging in place. *Experimental Gerontology* 88: 25–31. https://doi.org/10.1016/j.exger.2016.11.013.

Kitson, Alison L., Åsa Muntlin Athlin, and Tiffany Conroy. 2014. Anything but basic: Nursing's challenge in meeting patients' fundamental care needs. *Journal of Nursing Scholarship* 46 (5): 331–339. https://doi.org/10.1111/jnu.12081.

Liaschenko, Joan. 1994. The moral geography of home care. *Advances in Nursing Science* 17: 16–25.

Lupton, Deborah. 2014. Critical perspectives on digital health technologies. *Sociology Compass* 8 (12): 1344–1359. https://doi.org/10.1111/soc4.12226.

Mackenzie, Catriona. 2019. Feminist innovation in philosophy: Relational autonomy and social justice. *Women's Studies International Forum* 72: 144–151. https://doi.org/10.1016/j.wsif.2018.05.003.

Malpas, Jeff. 2003. Bio-medical topoi—The dominance of space, the recalcitrance of place, and the making of persons. *Social Science & Medicine* 56 (2003): 2343–2351. https://doi.org/10.1016/S0277-9536(02)00233-2.

Martín Martína, Jesus, Maddi Olano-Lizarragaa, and Maria Saracíbar-Razquin. 2016. The experience of family caregivers caring for a terminal patient at home: A research review. *International Journal of Nursing Studies* 64: 1–12. https://doi.org/10.1016/j.ijnurstu.2016.09.010.

Massey, Doreen. 1991. A global sense of place. *Marxism Today*: 24–29.

Milligan, Christine. 2009. *There's No Place Like Home: Place and Care in an Ageing Society*. Farnham: Ashgate.

OECD. 2001. *Understanding the Digital Divide*. http://www.oecd.org/sti/1888451.pdf.

Öresland, Stina, Sylvia Määttä, Astrid Norberg, and Kim Lützén. 2009. Patients as 'safeguard' and nurses as 'substitute' in home health care. *Nursing Ethics* 16 (2): 219–230. https://doi.org/10.1177/0969733008100081.

Parks, Jennifer A. 2015. Home-based care, technology, and the maintenance of selves. *HEC Forum* 27 (2): 127–141. https://doi.org/10.1007/s10730-015-9278-4.

Pauley, Tim, Byung Wook Chang, Anne Wojtak, Gayle Seddon, and John Hirdes. 2018. Predictors of caregiver distress in the community setting using the home care version of the resident assessment instrument. *Professional Case Management* 23 (2): 60–69. https://doi.org/10.1097/NCM.0000000000000245.

Peter, Elizabeth. 2002. The history of nursing in the home: Revealing the significance of place in the expression of moral agency. *Nursing Inquiry* 9 (2): 65–72. https://doi.org/10.1046/j.1440-1800.2002.00138.x.

Peter, Elizabeth, and J. Joan Liaschenko. 2013. Moral distress re-examined: A feminist interpretation of nurses' identities, relationships and responsibilities. *Journal of Bioethical Inquiry* 10 (3): 337–345. https://doi.org/10.1007/s11673-013-9456-5.

Peter, Elizabeth, and Joan Liaschenko. 2014. Care and society/public policy. In *Bioethics*, ed. Bruce Jennings, vol. 2, 4th ed., 504–512. Farmington Hills: Macmillan Reference USA.

Peter, Elizabeth, Karen Spalding, Nuala Kenny, Patricia Conrad, Patricia McKeever, and Amy Macfarlane. 2007. Neither seen nor heard: Children and home care policy in Canada. *Social Science & Medicine* 64: 1624–1635. https://doi.org/10.1016/j.socscimed.2006.12.002.

Peter, Elizabeth, Anne Simmonds, and Joan Liaschenko. 2018. Nurses' narratives of moral identity: Making a difference and reciprocal holding. *Nursing Ethics* 25 (3): 324–334. https://doi.org/10.1177/0969733016648206.

Poland, Blake, Pascale Lehoux, Dave Holmes, and Gavin Andrews. 2005. How place matters: Unpacking technology and power in health and social care. *Health and Social Care in the Community* 13 (2): 170–180. https://doi.org/10.1111/j.1365-2524.2005.00545.x.

Salemink, Koen, Dirk Strijker, and Gary Bosworth. 2017. Rural development in the digital age: A systematic literature review on unequal ICT availability, adoption, and use in rural areas. *Journal of Rural Studies* 54: 360–371. https://doi.org/10.1016/j.jrurstud.2015.09.001.

Seto-Nielsen, Lisa, Jan Angus, Denise Gastaldo, Doris Howell, and Amna Husain. 2013. Maintaining distance from a necessary intrusion: A postcolonial perspective on dying at home for Chinese immigrants in Toronto, Canada. *European Journal of Oncology Nursing* 17 (5): 649–656. https://doi.org/10.1016/j.ejon.2013.06.006.

Skinner, Mark W., Denise Cloutier, and Gavin J. Andrews. 2015. Geographies of ageing: Progress and possibilities after two decades of change. *Progress in Human Geography* 39 (6): 776–799. https://doi.org/10.1177/0309132514558444.

Sundgren, Suki, Minna Stolt, and Riitta Suhonen. 2020. Ethical issues related to the use of gerontechnology in older people care: A scoping review. *Nursing Ethics* 27 (1): 88–103. https://doi.org/10.1177/0969733019845132.

Tronto, Joan. 2006. Vicious circles of privatized caring. In *Socializing Care: Feminist Ethics and Public Issues*, ed. Maurice Hamington and Dorothy C. Miller, 3–36. Lanham: Rowan & Littlefield.

Walker, Margaret Urban. 1998. *Moral Understandings: A Feminist Study in Ethics*. New York: Routledge.

Ward-Griffin, Catherine, and P. Patricia McKeever. 2000. Relationships between nurses and family caregivers: Partners in care? *Advances in Nursing Science* 22 (3): 89–103.

Waymack, Mark. 2001. The ethical importance of home. In *Ethics in Community-Based Elder Care*, ed. Martha B. Holstein and Phyllis B. Mitzen, 51–75. New York: Springer.

Whatmore, Sarah. 1997. Dissecting the autonomous self: Hybrid cartographies for a relational ethic. *Environment and Planning D: Society and Space* 15: 37–53.

Zwijsen, Sandra A., Alistair R. Niemeijer, and Cees M.P.M. Hertogh. 2011. Ethics of using assistive technology in the care for community-dwelling elderly people: An overview of the literature. *Aging & Mental Health* 15 (4): 419–427. https://doi.org/10.1080/13607863.2010.543662.

# Conscience, Conscientious Objection and Commitment: Midwives, Nurses, and Abortion Care

Joan McCarthy and Sheelagh McGuinness

## 1 Introduction

Over the past six decades, many countries around the world have considered, debated, and disagreed about the moral nature of abortion. The laws of many Western countries are the result of a sort of political compromise that tries to meet at least some of the deeply felt concerns of those who disagree about the rights and wrongs of abortion. In recognition of the complex moral terrain surrounding abortion, most of the countries which have legalized abortion have also made some accommodations for healthcare practitioners who refuse to provide termination of pregnancy services for religious or other reasons (Center for Reproductive Rights 2018). Their refusal is usually grounded in an appeal to "conscience." As such, a key feature of the compromise or settlement which constitutes abortion laws is often protection of "conscientious objection" (Montgomery 2015). In this chapter, we consider the nature and value of these protections and, in doing so, wish to recognize some of the dangers that can accompany treating abortion and conscience as issues of compromise. A further aim is to highlight the dominant emphasis on conscience as a mechanism to protect refusal, as opposed to provision, of abortion care.

---

J. McCarthy (✉)
School of Nursing and Midwifery, University College Cork, Cork, Ireland
e-mail: j.mccarthy@ucc.ie

S. McGuinness
Centre for Health, Law, and Society, University of Bristol Law School, Bristol, UK
e-mail: sheelagh.mcguinness@bristol.ac.uk

H. Kohlen, J. McCarthy (eds.), *Nursing Ethics: Feminist Perspectives*,
https://doi.org/10.1007/978-3-030-49104-8_10

## 2 Background

Until recently, Ireland has had one of the most restrictive pieces of legislation on abortion in the world (Taylor et al. 2020; McCarthy et al. 2018). In 1983, Article 40.3.3 of the Irish Constitution, known as the Eighth Amendment, conferred on the "unborn" an equal right to life to that of the pregnant woman: "The state acknowledges the right to life of the unborn and, with due regard to the equal right to life of the mother, guarantees in its laws to respect, and, as far as practicable, by its laws to defend and vindicate that right." (Article 40.3.3) However, in a referendum on 25 May 2018, the Irish electorate voted by a two-thirds majority to remove the Eighth Amendment from the Constitution, and the Health (Regulation of Termination of Pregnancy) Act 2018, which came into force on January 1, 2019, was a milestone in access to abortion care in Ireland. The 2018 Act allows pregnant women to access abortion care in the Republic of Ireland in four situations: on request, up to 12 weeks of gestation; where there is a risk to the life, or of serious harm to the health of the pregnant woman and the fetus has not reached viability; where there is an immediate risk to the life or of serious harm to the health of the pregnant woman; where the fetus has a condition such that it is likely to die before or within 28 days of birth. As Mary Donnelly and Claire Murray point out, clinicians play a gatekeeper role in each of these situations "deciding when and whether the statutory criteria for access to care have been met" (Donnelly and Murray 2020, p. 128).

Overall, the legislation heralds a shift in clinical practice among healthcare practitioners working in hospitals and community settings in Ireland who look after women's sexual and reproductive health needs. There is little empirical evidence as to the standpoint(s) of midwives and nurses in Ireland in relation to the morality of abortion and the provision of abortion care. In advance of the referendum to remove the Eighth Amendment, a few individuals and small groups of nurses and midwives contributed to both sides of the debate. Mary Kelly Fitzgibbon, a nurse, midwife, and a lecturer in Tralee Institute of Technology, for example, representing the group, "Nurses and Midwives for Life," claimed that nurses and midwives were concerned that the proposed legislation permitting abortion could mean that nurses would have to give up their jobs on conscience grounds: "We are concerned about freedom of conscience […] It's quite clear in the general scheme of the legislation that we would be required to facilitate [abortion] [by passing the care to someone]. So that would mean that we would be co-operating in the act of abortion" (McGarry 2018). On the other hand, the group, "Midwives for Choice," cofounded in January 2016 by independent midwife, Philomena Canning, agitated for abortion rights and greater respect in all aspects of maternity care (O'Connor 2019). In the days immediately preceding the referendum, Mary Brosnan, Director of Midwifery and Nursing at the National Maternity Hospital and adjunct associate professor at the School of Nursing and Midwifery and Health Sciences at UCD, made the following public statement:

> Women who decide they cannot proceed with a pregnancy for whatever personal reason need support from us, not judgment. We need to trust women to make their own decisions, in line with their own values, hopes, and circumstances. The Constitution should have no role in this matter. We cannot continue to be hypocritical and ignore the clear and present

> reality of the existence of abortion in our society. I can't keep turning a blind eye to this very human experience. (Brosnan 2018)

After the referendum, 367 nurses and midwives signed a letter to Minister for Health, Simon Harris, in order to register their conscientious objection to abortion.

> 'For us, as nurses and midwives, participation in termination of pregnancy … is morally objectionable and conflicts with our conscientious commitment to life,' added Ms Fitzgibbon. She said that participation includes 'supervision, delegation, planning or supporting of staff involved in termination of pregnancy.' (Bray 2018)

Drawing anecdotally on the basis of one of the author's (McCarthy's) facilitation of several meetings with midwifery groups in anticipation of the January 1, 2019 deadline when abortion care was to be included as part of healthcare provision in the maternity services, it was clear that many midwives expressed relief that abortion was finally available and they were able to provide women with important and necessary care. However, for some, the idea that they might be expected or required to assist and/or support the carrying out of terminations was unexpected and unsettling, and they experienced mixed, or in some cases, extremely negative feelings. These discussions prompted us to reflect on the topic of conscience in relation to the obligations of midwives, nurses, and other healthcare practitioners to provide services that are legally permissible and within the scope of their professional competence.

## 3 A Standard Account of Conscience

### 3.1 Conscience

"Conscience" is a complex concept that has a range of theological and secular delineations (Smith 2020). Common to all is the view that it is an inward-looking faculty or process by which we can discern moral principles or truths and that it acts as a moral and emotional compass that guides and motivates human action and maintains a sense of moral integrity (Giubilini 2016). Sources of moral knowledge that inform conscience vary. For example, in the Christian tradition, God is the source of moral standards of right and wrong and conscience is viewed as a means of accessing these standards:

> Within Christianity, Judaism and Islam, the conscience may be understood as enabling moral agents to know whether an act conforms to the divine law, that is, to God's standard of right and wrong […] In each of the Abrahamic religions, right and wrong are divinely established categories, which the conscience enables a person to discern. (Lawrence and Curlin 2007, pp. 10–11)

Nonreligious persons also have moral commitments and consciences (Brock 2008) and a secular perspective might hold education, family, or culture, as the source of moral beliefs and values. From a secular perspective, conscience might be viewed as the combined force of reason, emotion, and intention that prompts an individual to act with moral integrity:

> [Conscience] arises from a fundamental commitment or intention to be moral. It unifies the cognitive, conative and emotional aspects of the moral life by a commitment to integrity and moral wholeness. It is a commitment to uphold one's deepest self-identifying moral beliefs; a commitment to discern the moral features of particular cases as best one can, and to reason morally to the best of one's ability; a commitment to emotional balance in one's moral decision-making [...] (Sulmasy 2008, p. 138)

## 3.2 Freedom of Conscience

The notion of "freedom of conscience"—the freedom to act or refrain from acting according to one's conscience—can also be interpreted in different ways. For some, e.g., the Catholic Church, genuine freedom of conscience rests in the assumption that moral values are instilled by God into humans' hearts, and that humans exercise their freedom when they commit themselves to God's laws: "human freedom finds its authentic and complete fulfillment precisely in the acceptance of that law" (John Paul 1993, par. 35). An alternative view would see the exercise of freedom of conscience in the commitment of individuals to the moral standards and the moral life that they hold to be authentic and good: "In appealing to conscience I indicate that I am trying to preserve a sense of myself, my wholeness and integrity" (Childress 1979, p. 327).

While both of these views—religious and secular—differ in their understanding of the meaning of freedom of conscience, that freedom is at risk from both perspectives if a state or society acts to prevent an individual from acting according to their conscience. This raises the question of the extent to which an individual might have a legal *right* of freedom of conscience (Leigh 2019).

## 3.3 Right of Freedom of Conscience

The right of freedom of conscience is usually encapsulated within broader rights. Article 18 of the United Nations (UN) Universal Declaration of Human Rights 1948 states that: "Everyone has the right to freedom of thought, conscience and religion". In order to ensure that everyone can exercise their freedom of conscience to the greatest extent possible, the UN Declaration also places a limit on the scope of this freedom:

> In the exercise of [individual] rights and freedoms, everyone shall be subject only to such limitations as are determined by law solely for the purpose of securing due recognition and respect for the rights and freedoms of others and of meeting the just requirements of morality, public order and the general welfare in a democratic society. (Article 29)

Similarly, Article 9 of the European Convention on Human Rights states:

> Everyone has the right to freedom of thought, conscience and religion; this right includes freedom to change his religion or belief and freedom, either alone or in community with others and in public or private, to manifest his religion or belief, in worship, teaching, practice and observance. (Article 9)

Again, this right is qualified and is "subject only to such limitations as are prescribed by law and are necessary in a democratic society in the interests of public safety, for the protection of public order, health or morals, or for the protection of the rights and freedoms of others" (Article 9). In sum, in order to ensure the greatest extent of freedom possible for individuals to act according to their conscience, some limits are placed in circumstances where their exercise of conscience might negatively impinge on the rights and freedoms of others. Such an approach allows for the possibility of a plurality of moral and religious views that ought to be respected and protected.

Determining the extent to which conscience should be protected, however, is contested. This is especially evident when the right of freedom of conscience is appealed to in order to justify a person's refusal to participate in certain activities or to provide certain goods or services and that refusal impacts on the rights of others. Generally, such a refusal, or "conscientious objection," has been perceived to have most legitimacy when it is personal, or inward looking:

> a matter of following the dictates of one's own reasoning rather than the dictates of others in the discharge of one's moral obligations, and thus a matter of taking a stand against what one has been called upon to do by exempting oneself from its demands. *Not me, or at least not in my name, goes the cry*. (Macklem 2006, p. 69)

On this account, those who express a conscientious objection should not be seen as making an assessment of how others should act:

> [T]he practice generally known as conscientious objection is one in which the objector refuses to comply with an obligation on the ground that it would be wrong for him to do so. The objector does not claim that the obligation is illegitimate and that others should not comply with it either. (Macklem 2006, p. 69)

However, as we will examine further, this boundary is harder to fix when someone is making a claim of conscientious objection in an employment or service provision context. Often these sorts of claims of conscience can have the effect, even if not intended by the proclaimer, of casting judgment on the acceptability and morality of third party behavior or practices (NeJaime and Siegel 2015). For some, this has important consequences for the extent to which such refusals should be protected or facilitated (Macklem 2006).

## 3.4 Conscientious Objection in Healthcare

Notions of conscience and freedom of conscience have traditionally found expression in healthcare provision in debates about whether or not healthcare practitioners should be allowed to refuse, or conscientiously object, to provide treatment or care that is in accord with the law and with professional standards but that contravenes the dictates of their personal conscience (Wicclair 2011). Positively, making room for nurses, midwives, and doctors to refrain from acting in ways that are contrary to their deeply held beliefs and values recognizes their moral agency and the often profoundly moral nature of their work. In addition, research suggests that the impact of the loss of moral integrity—often described as moral distress—that is associated with ignoring or contravening the dictates of conscience can have profound effects on the personal and professional lives of healthcare practitioners as well as negatively impacting on the quality of patient care they provide (Ulrich and Grady 2018). A counter to this, however, is the concern that as professionals, the personal morality of nurses, midwives, and doctors should not be allowed to trump their professional, legal, and societal obligations to provide needed health services, to promote patient health and well-being, and prevent harm (Savulescu 2006). Moreover, the professional standards of healthcare practitioners generally require them to respect the autonomy and dignity of patients, to treat them equally, and to foster relationships of trust and respect with patients and colleagues alike. In this chapter, we do not focus on the mechanisms of protecting conscientious objection, i.e., whether specific statutory clauses are necessary. Instead, our focus is on the prior question of whether, if at all, conscience should be accommodated in healthcare. As will be clear, both authors think recognition of conscientious beliefs is important, however, caution is needed when expressions of conscience have the potential to harm third parties, e.g., women in need of abortion, particularly if those third parties are already in a vulnerable position.

Given the grave implications for both healthcare practitioners and patients of either ignoring, or recognizing, the conscience claims of healthcare practitioners, many countries require that conscientious objections are grounded in beliefs that meet widely accepted epistemological and normative standards in order to be afforded protection (McLeod 2008; Liberman 2017). So, for example, a healthcare practitioner who refuses to provide pain medication to a patient who needs and wants it on the grounds that their suffering is deserved, is not protected under any regulation providing for conscientious objection because there is a general consensus that the refusal of pain medication to a suffering patient runs contrary to a long enduring goal of medicine and a widely accepted social norm (McLeod 2008). Equally, a healthcare practitioner who refuses to treat someone on the basis of their sincerely held racist views about "racial purity" is universally condemned. Such views are repudiated as unacceptable in any walk of life (McLeod 2008). In these cases, were the notion of conscientious objection appealed to, it would simply be as a cloak for unethical beliefs and harmful clinical practice.

The refusal on the part of some healthcare practitioners to provide abortion care to women who need or want it, however, is generally viewed—rightly or wrongly—to be of a different sort to the refusals of the healthcare practitioners just mentioned (Giubilini 2014).

Abortion exists as a social fact (Greenwood and Young 1973). By this we mean that abortion has existed for as long as women with the capacity to be pregnant have not wanted to be. However, abortion is also perceived to be a kind of intractable moral issue about which reasonable and sincere people disagree. Many countries where abortion is legal, including Ireland, allow healthcare practitioners to exempt themselves from providing it in certain circumstances (World Health Organization 2018).

In Great Britain, Section 4 of the Abortion Act 1967 sets the boundaries for protection of conscientious objection in the context of abortion provision. The meaning and scope of this provision were adjudicated in a decision handed down by the Supreme Court in the case of *Greater Glasgow Health Board v Doogan and another* [2014] UKSC 68. In this case, two Scottish midwives challenged the boundaries their employing Health Trust placed on the use of Section 4 in their roles as "labour ward coordinators." This role combined aspects of clinical practice with administrative responsibilities for the day-to-day running of the ward. The midwives had long refused any direct clinical involvement in provision of abortion care and this was accepted by the Trust in accordance with Section 4. However, the midwives wished further to refuse to be involved with the "delegation, supervision, and support" of patients and nurses who received, and provided, abortion care. The Trust rejected the argument that the extended categories of activity were protected by Section 4 stating that these activities were not proximate enough to constitute "participation" in abortion. The Supreme Court ultimately agreed that "delegation, supervision, and support" were not proximate enough to the termination procedure to constitute "participation."

The Scottish case illustrates the complexity of assessing the scope of protections afforded by statutory clauses (Neal 2015). It also highlights the difficulties of delineating different aspects of a given individual's professional role which may encompass many parts. There are those who argue that requiring health professionals to provide even these ancillary activities as well as referral would make them complicit in what they believe to be a grave moral wrong (Bayles 1979; Oderberg 2018). However, a key concern in this case, and clearly an important feature for the Supreme Court Justices, was the extent to which widespread conscientious objection could be used to undermine the ability of the health service to provide necessary abortion care.

In Ireland, the Health (Regulation of Termination of Pregnancy) Act 2018 legalizes abortion in certain circumstances while also setting out the grounds on which a midwife, nurse, or doctor, can conscientiously object. Section 22(1) states:

> Subject to *subsections* (2) and (3), nothing in this Act shall be construed as obliging any medical practitioner, nurse or midwife to carry out, or to participate in carrying out, a termination of pregnancy in accordance with *Section 9*, *11* or *12* to which he or she has a conscientious objection.

In keeping with many clauses of this type, the ability to refuse to provide care does not apply in cases of emergency where there is an immediate risk to the life, or of serious harm to the health, of the pregnant woman (Section 22(2)). In addition, refusals of care are mitigated as follows in Section 22(3):

> A person who has a conscientious objection referred to in *subsection* (1) shall, as soon as may be, make such arrangements for the transfer of care of the pregnant woman concerned as may be necessary to enable the woman to avail of the termination of pregnancy concerned.

In normal circumstances then, a midwife, or other healthcare practitioner, who views abortion as a grave moral wrong may work in accordance with the dictates of her conscience. However, she must transfer the care of her patient to others who are willing to provide such services. Here the legislation strikes a balance between protecting the conscience of the healthcare practitioner while also ensuring a woman's right to access care. By linking the ability to conscientiously object to the specific activities outlined in the Act, the legislation further implies that the grounds on which a healthcare practitioner can conscientiously object are limited to direct involvement in abortion. Healthcare practitioners are not obliged to "carry out, or to participate in carrying out, a termination of pregnancy" except in cases of emergency but it is not explicit as to what to "carry out" or to "participate in carrying out" might mean. However, should the question be tested in court, it is likely that the *Greater Glasgow Health Board v Doogan and another* [2014] case would inform any Irish judicial decisions and that participation in a termination of pregnancy would not be interpreted as including ancillary duties such as taking telephone bookings from the Fetal Medicine Unit to arrange appointments for medical termination of pregnancy or supervision or rostering.

The scope and limits of any right of conscientious objection have also been interpreted in a series of cases that have come before the European Court of Human Rights including cases which involve refusals to provide lawful abortion care (in particular Pichon and Sajous v. France [2001] ECHR 898; R.R. v. Poland [2011] ECHR 828; P. and S. v. Poland [2012] ECHR 1853). It is clear from these cases that any "right" to refuse to provide certain sorts of care must be carefully weighed against the right of a woman to access necessary healthcare in a timely manner. In short, refusals of care should not be used as a mechanism for refusing access to abortion.

The following section takes a distinctly feminist turn which critiques the very meaning of conscience and its relationship to moral integrity. It also argues that the narrow focus on the consciences of those who refuse to provide termination of pregnancy services ignores and diminishes the consciences of those who provide such services at great personal and professional risk to themselves.

## 4 A Feminist Account of Conscience

### 4.1 A Relational View of Conscience

A relational view of conscience understands it as a moral process that is wholly embedded in the social world of the individual (Baylis 2015). Following on authors such as Catriona Mackenzie, Natalie Stoljar (Mackenzie and Stoljar 2000), and Susan Sherwin (Sherwin 1998), the Canadian philosopher, Carolyn McLeod, argues that moral agency is something that is engendered and fostered among human relationships in a sociopolitical context (McLeod 2012). Offering a feminist relational critique of the standard account of conscience, McLeod suggests that the dominant understanding of what it means to have a conscience "is to be compelled to act in accordance with one's own moral values for the sake of one's 'moral integrity'" (McLeod 2012, p. 161). Delineating moral integrity as inner or psychological unity, McLeod claims that the dominant view of conscience considers conscience valuable because it promotes or fosters such unity and that the latter contributes to living a good life. Furthermore, on the dominant view, the loss of integrity, or the violation of deep moral commitments, is perceived to have a serious impact on an individual and their identity—it is associated with feelings of guilt, shame, sense of self-betrayal, self-alienation, etc., which conscience can help to remedy. While McLeod acknowledges that this view of conscience "makes sense of many of our intuitions about the nature and value of conscience" (McLeod 2012, p. 164), her critique of the dominant view centers on her rejection of the notion that moral integrity or unity is core to living a good life and that inner conflict should always, or even mostly, be reduced, integrated, or avoided.

Drawing on a relational account of moral agency which views it as embedded in social relationships that both enable and constrain it, McLeod is particularly concerned with the impact of oppressive social relations on the exercise of moral agency and the link between conscience and inner unity. She points out that these relations influence what it is that people value and, therefore, what grounds their moral integrity. They also impact on how much power people have to determine the meaning of their actions and how these contribute or not to maintaining their inner unity. McLeod gives the example of a nurse, who, she suggests, is suffering from psychological oppression:

> Overall, [Betty] has low self-worth because she has internalized views about nurses being "intelligent machines" that exist "for the purpose of carrying out [doctor's] orders" and about women being second-class citizens. Nurse Betty could be optimally unified around her low self-worth, in which case as many of her actions and thoughts as possible would be consistent with it. Her sense that she matters less than other people would infect as much of her as possible, precisely because she is optimally unified around this diminished perception of herself. I assume that such unity is not good for her—it does not contribute to her having a good life—and neither is it something that she morally ought to encourage. Instead, she would have a better life and a better character if she were to oppose any internal pressure she feels (that is, from her conscience) to be optimally unified in this way. (McLeod 2012, p. 166)

So the loss of self-respect is the price that Betty would have to pay in these circumstances in order to achieve a very high level of inner unity—her actions would be consistent with the role of subservient nurse that she identifies with but her very subservience would undermine her self-esteem. The implication of this relational view is that, without social and political support, say from her colleagues and nursing union, any actions that would resist her subservient role might cast her as a trouble maker and would, therefore, make her professional life difficult to endure. In short, Betty may well have to choose between inner peace and unity on the one hand, and self-respect but self-alienation on the other. Alternatively, she might adjust her expectations and endure a little more personal and professional turmoil but also achieve a little more self-esteem. In any of these scenarios, the actions of her nursing colleagues and the other professionals around her will play a critical role in the outcome.

This relational account of conscience requires that Betty scrutinizes the demands of her conscience as well as the level of unity she thinks she needs in order to function as an authentic moral agent in the situation that she finds herself in. As McLeod remarks, "The kinds of social relations in which people are embedded help to shape how valuable their inner unity is. Inner unity and its value are relationally constituted" (McLeod 2012, p. 167). Her argument is that conscience is valuable, not just because it prompts us to take our moral values seriously, but also because it involves making moral judgments about what our conscience cares about. On her view, the function of conscience is better understood as encouraging "morally responsible agency" (rather than moral unity as such)—conscience should prompt us to rethink our values especially if they are derived from social relations that are oppressive to ourselves and others. Social relations, relations of oppression and privilege, may both damage and enlighten us, and for many, the "inner voice" may be sexist, racist, classist, etc.:

> [T]he value of conscience lies in its ability to encourage us not simply to do what we think we morally ought to do but also to revise these thoughts when necessary and to reconstitute itself in the process so that it becomes the voice of what we genuinely (that is, authentically) value. This view about conscience is feminist and relational because it rests on a theory of selves as beings who are fully embedded within relationships, some of which are oppressive. (McLeod 2012, p. 174)

Applied to clinical practice, this relational account of conscience has a number of implications. It places an onus on healthcare practitioners to critically reflect on the values that they have internalized from simply growing up in a society that is likely to be oppressive in different ways. The mental work of a "dynamic conscience" (McLeod 2012, p. 176) means that should the healthcare practitioner have an objection to providing a service, they should be prepared to justify their refusal with reasons other than "I simply believe that this is the case" (McLeod 2012, p. 176). Moreover, recognizing that every debate about abortion has taken place in societies that have, historically at least, ignored, downplayed or dismissed the reproductive lives and work of women and girls and viewed them as second-class, irrational and irresponsible creatures who are incapable of their own moral agency, should give them pause. Lori Kantymir puts it this way: "The fact that it is most often women who are refused medical goods and services should at least make us ask, are there discriminatory beliefs about women at work in refusals?" (Kantymir 2014, p. 257)

Chris MacDonald has advocated moving away from approaches to conscience that emphasize "individual" decision-making; "a more satisfying perspective on healthcare ethics must shift attention to the social relations and institutions that distribute power" (MacDonald 2002, p. 282). We need to be sensitive to the gendered impacts of protections of conscience in the context of abortion care, such protections place the burden of protecting a practitioner's conscience on the woman seeking care. While the conscientious objector might respond that it is the abortion service that they are refusing to provide, not women as a class, that they are refusing to treat, Kantymir's point is that abortion is a basic healthcare need for those with the capacity to be pregnant. As such, longstanding sexist oppressive views about women may be at play in refusals related to reproductive health (Cook 2018). There is a further danger that conscience can be used as a means of perpetuating the stigmatization of those seeking abortion and those who wish to provide it. As Charles Ngwena cautions: “The health care sector mirrors society in its propensity to violate women’s reproductive rights through systemically embedded laws, policies, practices and values that draw from harmful stereotypes” (Ngwena 2016). A relational view of conscience emphasizes the importance of taking this possibility seriously.

### 4.2 Conscientious Commitment

There is an emerging literature that aims to reorient the debate on what it means to be a conscientious healthcare professional by focusing not just on those who wish to refuse to provide certain sorts of care but also those who are committed to providing care often at great personal cost (Joffe 1996; Buchbinder et al. 2016). Bernard Dickens, a prominent advocate of this approach, has argued that “[c]onscientiously committed practitioners often need courage to act against prevailing legal, religious, and even medical orthodoxy, following the honourable medical ethic of placing patients’ interests above their own” (Dickens, p. 1241). On this view, providers of abortion care are compelled by the dictates of their conscience just as conscientious objectors are. As Lisa Harris argues, equating conscience solely with the non-provision of abortion contributes to the stigmatization of abortion providers:

> If physicians who offer abortion care don’t have a legitimate claim to act in “good conscience”, like their counterparts who oppose abortion, the implication is that they act in “bad conscience” or lack conscience altogether. This understanding reinforces images of abortion providers as morally bankrupt. (Harris 2012, p. 982)

For Dickens and Harris, the conscientious health professional isn’t one who refuses to provide care but rather one who prioritizes the interests of their patients over their own personal interests, and if necessary the law (Dickens 2014; Harris 2019). Dickens associates conscientious commitment with the early advocates for women’s health who defied laws and religious authority and endured hostility, loss of employment, and imprisonment to publish or distribute literature on birth control because of their support for women’s health, well-being, and autonomy (Dickens 2008).

An examination of the early days of the implementation of Ireland’s new abortion service also evidences pioneers of conscientious commitment. In their analysis of the Health (Regulation of Termination of Pregnancy) Act 2018 in Ireland, Donnelly and Murray call for greater attention to the ethical and clinical context of the conscientious provision of abortion care (Donnelly and Murray 2020). They warn that those who conscientiously provide abortion care in Ireland face a number of obstacles. When responding to questions in the Dáil (government) chamber 6 months after the legislation was introduced, the Minister for Health, Simon Harris, acknowledged that only 10 out of a possible 19 maternity hospitals/units were providing termination of pregnancy services (Minister for Health, Simon Harris 2019).

In her strong critique of the lack of support for the rollout of the abortion services, obstetrician and maternal-fetal medicine specialist, Keelin O'Donoghue, identified a number of reasons for this: lack of leadership, poor resourcing, limited education, and failure to recognize the complex clinical and cultural changes required (O'Donoghue 2019).

The 2018 Act also continues to criminalize abortion care that is provided by healthcare practitioners outside of the circumstances specified in it with a sanction of a prison sentence of up to 14 years. For Donnelly and Murray, this criminalization perpetuates the stigmatization of abortion care and distinguishes abortion care from other forms of healthcare:

> [T]he retention of the criminal sanction sets abortion care apart from other forms of healthcare and suggests that health professionals providing abortion care are in some way inherently less conscientious than other professionals and that the usual regulatory mechanisms of (general) criminal and civil sanctions and professional/fitness to practice oversight are insufficient for these professionals. (Donnelly and Murray, p. 130)

The role of criminal law in regulating abortion is widely condemned. The criminal law framework has the consequence of framing abortion as an area of "moral doubt" and acts as a barrier to care. Regulating abortion through the criminal law frames abortion as an area of moral controversy or concern rather than emphasizing the health and human rights dimensions of care. Further to this, it has long been recognized that criminal sanctions can have a "chilling effect" on medical practice, something that has been emphasized about provision of abortion care in Ireland by the European Court of Human Rights (A, B, C v. Ireland [2010] ECHR 2032). Decriminalization of abortion has been emphasized as key to promoting and protecting optimal clinical practice and vindicating the rights of women in need of abortion care (Sheldon and Wellings 2020).

In addition to stigmatization through social practice and logistical infrastructure, there are other features of the legislation itself that pose problems for the conscientious healthcare practitioner. This is not unique to the Irish legal framework. A review of global abortion laws evidences the ways in which they undermine and subvert clinically optimal care. Examples of problematic features include "waiting periods," overly burdensome consent rules, and restrictions on who can carry out an abortion and where (Culwell and Hurwitz 2013). Arguably, this is the consequence of laws and regulations that center on the morality of abortion, seeking to balance divergent views, rather than promoting human rights and clinically optimal medical practice (Zampas and Gher 2008). As such laws can be a powerful tool for obstructing and stigmatizing conscientious healthcare practitioners (McGuinness and Montgomery 2020). From a social justice perspective, Donnelly and Murray also highlight the problems of the three-day waiting period following a request for a termination. It is widely acknowledged that women unequally experience restrictions to abortion care and the impacts of such restrictions can be exacerbated by sociocultural barriers and obstacles (Sedgh et al. 2016). The three-day wait could lead to conscience quandaries for healthcare practitioners who are caring for women and girls who are disproportionately impacted on by the delay; those subjected to domestic violence, or homeless, or seeking asylum and living in direct provision accommodation.

### 4.3 Managing Conscience in Practice

In this section, we advocate for the management and accommodation of conscience at an institutional level. This is not to say that we don't think individual healthcare practitioners have an important role to play in how conscience operates within healthcare institutions. However, it is our belief, in keeping with the relational view of conscience, that healthcare organizations have a responsibility to ensure that the voices of practitioners who are in marginalized social groups or who hold minority views are supported in articulating them. Equally, there is an onus on those in positions of authority to be sensitive to their relative position of power and privilege. At the very least, hospital managers, lead clinicians, directors of nursing and midwifery should not use their positions in the hospital hierarchy to monopolize conversations about conscience which might intimidate those around them into silence or acquiescence because they feel stigmatized or professionally vulnerable if they hold views that are contrary to theirs.

This is important in the Irish context since the rollout of termination of pregnancy services began in January 2019. While most abortion care is being successfully provided by general practitioners in the community, it would seem that a number of those who are in positions of authority in some Irish hospitals have thwarted the introduction of termination of pregnancy services by refusing to participate in ancillary tasks related to termination of pregnancy and by refusing to transfer patients to other non-objecting colleagues. Dickens and Cook argue that the conscientious commitment of healthcare practitioners is needed because conservative legislatures and providers' religiously based conscientious claims deny abortion services to women who need or want them (Dickens and Cook 2011). In her critique of the roll out of services O'Donoghue also points to conscientious objection as a key contributor to the difficulties that she and providers like her experienced:

> In some hospitals, staff committed to providing care can feel isolated and undermined. […] Doctors like me are being judged by other staff for our views and practice. This is creating conflict in what is an already stressful environment. Some specialists will not agree to any role in the provision of this service, either for pregnant women or caring for babies with fatal foetal abnormalities born alive after a late termination. […] There are also many so-called "convenient objectors", especially where hospital management does not clearly support providers. (O'Donoghue 2019)

Douglas NeJaime and Reva Siegel have highlighted a concern that often conscience objection gets deployed in ways which are directed toward the prevention of abortion rather than protecting the moral integrity of healthcare practitioners. When this happens conscientious protections serve “larger law reform goals in ‘culture war’ conflicts” which serve to perpetuate disagreement over the legitimacy of a particular health care service (NeJaime and Siegel 2015, p. 2543). Dickens describes practices such as these as deviating from the intended social good that protecting the consciences of healthcare practitioners was meant to achieve:

> The shield tolerant societies allowed to protect religious conscience is abused by religiously-influenced agencies that beat it into a sword to compel patients, particularly women, to comply with religious values they do not share. (Dickens 2006, p. 513)

The realities, practicalities, and human relationships at the center of clinical practice add another layer of complexity to abortion care. The expression of hostility experienced by conscientious providers like O’Donoghue confirms the relational view that social context, relationships, and power are central to the way in which healthcare practitioners understand the dictates of conscience as well as their ability to exercise their moral agency responsibly. Many of the “convenient objectors” O’Donoghue describes may be motivated by such relational concerns as these.

Describing abortion provision as requiring a spectrum of different kinds of care, obstetrician, Mary Higgins, rejects the idea that clinicians can be easily divided into two groups—“those who will provide such care, and those who most definitely will not” (Higgins 2018). Instead, she suggests that there will be clinicians “who will provide, may provide, sometimes provide, won’t provide, will never provide and will actively stop others from doing so” (Higgins 2018). Suggesting that the successful implementation of abortion services nationally in Ireland will require that a range of clinicians share the tasks involved, Higgins provides a list of the different indications for abortion that clinicians will be more or less comfortable with: emergency situations such as an overwhelming infection where the majority of clinicians will act to save a woman’s life; where the fetus has a condition that is incompatible with life; where the woman is under 12 weeks pregnant.

In addition, she suggests that clinicians will also be more or less comfortable with the different kinds of tasks involved in the spectrum of abortion care: initial appointment; hospital admittance; prescription; administration of medications; administration of anesthesia prior to surgical abortion care; performance of surgery; aftercare; appropriate contraception information. Higgins notes that the sharing of these tasks would ensure that abortion care could be provided but that “open, respectful, thoughtful discussions of what individuals will provide in the spectrum of care” are required. Alternatively:

> [i]f clinicians are asked whether they will provide abortion services in totality, the temptation may be to say no, meaning they will become objectors for convenience. In reality, the situation is much more nuanced. We must accept this and adapt accordingly. (Higgins 2018)

While the focus of Higgins' list is on the contribution that doctors make to abortion care, a similar list might also be compiled for the work of midwives and nurses. Globally, their scope of practice, role, and expertise in relation to abortion provision varies greatly but, increasingly, midwives and nurses provide a wide range of essential abortion services (Fullerton et al. 2018; Kishen and Stedman 2010; Mainey et al. 2020). Moreover, the World Health Organization (WHO) has included trained midwives and nurses as possible key providers of first and second trimester abortions in community, primary, and tertiary care (World Health Organisation 2012). In any case, the expanding roles of midwives and nurses in community and hospital settings and their practice, usually as members of teams, combined with advances in the way in which pregnancies can be terminated—medical induction of labor or surgical dilation and evacuation—mean that the tasks that they might consider to be directly or indirectly related to termination of pregnancy have grown more complex. At the very least, in countries like Ireland where their role is fairly circumscribed, these tasks might include: booking appointments; pelvic examination to diagnose and date a pregnancy; performing ultrasounds to determine gestational age; inserting a cannula in order to allow administration of medicine; preparing a woman for a surgical abortion; provision of antibiotics; pain management. In addition, midwives and nurses might also offer holistic, person-centered features of abortion care such as counseling and emotional support; education about sex, pregnancy, and appropriate family planning; screening for domestic violence; culturally sensitive care; advocacy; and aftercare support (Mainey et al. 2020).

In addition to identifying the range of tasks and psycho-social supports that midwives and nurses might undertake in relation to abortion care, it is also important to determine the motivations and deliberative processes that inform their decision-making. In their 2018 systematic review of the reasons that have been reported in the argument based literature on the issue of conscientious objection to abortion, Valerie Fleming et al. point out that "midwives and nurses remain invisible, either hidden in the more generic 'health' or even 'medical' professionals, in the debates over conscientious objection" (Fleming et al. 2018). Our own preliminary search of the empirical literature addressing nursing and midwifery conscience concerns also yielded few results though there has been a growing research interest on this topic in recent years (Fleming and Robb 2019; Kane 2009; McLemore and Levi 2011; McLemore et al. 2015; Mizuno et al. 2013; Oppong-Darko et al. 2017; Toro-Flores et al. 2019).

The findings of a 2015 study by Valerie McLemore et al., which interviewed 25 nurses from a range of settings that provided different kinds of abortion care, used the phrase "tacking back and forth" to describe how the study respondents wrestled with their own attitudes, beliefs, and feelings and their professional obligations as nurses in real time and with actual specific patients (McLemore et al. 2015, p. 224). According to the authors, the respondents reported on "the tension of holding two contradictory positions simultaneously" (p. 224) and concluded that diverse factors influenced their level of participation in abortion care including the shared nature of the work, the role, and views of others especially the perceived or real hostility of medical and nursing colleagues, the reasons for the abortion and its perceived legitimacy as a medically indicated or elective procedure, and whether or not they had the actual technical skills necessary to offer assistance.

Drawing on 50 interviews with the staff of a labor and delivery unit offering abortion care (including nurses but also maternal-fetal medicine specialists, obstetrics and gynecology residents, and anesthesiologists), Danielle Czarnecki et al. reported in 2019 that participation was defined in different ways and that it was influenced by many factors beyond personal beliefs about the morality of abortion. Pointing out that “hospital-based abortions may unfold over days and involve multiple tasks and forms of care,” the authors emphasized that their starting point was not to assume that “a fully formed ‘conscience’ determines participation decisions” (Czarnecki et al. 2019, p. 182). Instead, they concluded that their own life experiences including personal experiences and struggles with unintended pregnancy, abortion, miscarriage, infertility, or disability played a role in the approaches of the study respondents to providing or not providing abortion care. The experience of working in a hospital that provided abortion care also shaped their attitudes as did wider community, professional, and organizational factors. Like McLemore et al.’s study, the respondents also differentiated between morally acceptable and unacceptable reasons for termination decisions. The authors noted that the respondents did not refer to the term “conscience” itself when they talked or thought about their work. Rather, they referred to beliefs, values, morality, and, more broadly, their obligations as a “good person” and “good caregiver.” Emphasizing the “everyday experiences of healthcare workers,” the authors highlighted the need to develop a more complex understanding of the elements of participation and the deliberative processes that influenced participation which could change over time and as a result of personal and professional experiences (Czarnecki et al. 2019, p. 186).

We agree with Czarnecki et al.’s conclusion that their work lends empirical support to McLeod’s feminist critique of the standard account of conscience that we explained and discussed in the previous section. The standard view sees the main function of conscience as a means of unifying moral beliefs and actions while their research highlights the complex, deliberative, contradictory, and transformative nature of the moral labor of healthcare practitioners in providing morally contested care. We also suggest that it adds texture to McLeod’s description of the individual with a “dynamic conscience,” who is attentive to the social embeddedness of their moral beliefs and values and open to their reconsideration and revision in light of practice, experience, and reflection. Providing a ray of hope in the seemingly never-ending and intractable debates on abortion access and provision, the authors underline a lesson from their study that is worth repeating here:

> There is an important lesson in the voices of our study participants—that people in contested arenas have enormous capacity to engage in nuanced, complex thinking and to find solutions that meet their own needs both for moral coherence and compassionate care of others. Lived experience appears to offer an antidote to dualistic or polarized thinking. For our respondents, providing care, compassion, and empathy was a shared moral imperative, even in the face of profound personal disagreement about the morality of abortion. Their ability to find ways to collaborate in the interest of this shared commitment to care for women is remarkable […] (Czarnecki et al. 2019, p. 188)

## 5 Conclusion

Conscience and freedom of conscience are complex and contested concepts and whether there is a free-standing right to conscientiously object to provision of certain sorts of services, such as abortion care, is subject to debate and controversy. A feminist perspective on conscience deepens our understanding of this difficult moral terrain by drawing attention to the way in which conscience and its deliberative processes are socially embedded in structures and contexts that are oppressive to some while they privilege others.

A relational account of conscience presents personal, practical, and political challenges to midwives, nurses, and other healthcare practitioners in relation to the provision of abortion services. On the one hand, they may struggle to act in ways that are consistent with the dictates of their conscience in order to maintain their moral integrity. On the other hand, they may also struggle with the awareness that their conscience may be informed by oppressive values that they had considered settled. In rethinking and revising these values and beliefs, they may experience a sense of ambivalence and confusion as they try to adjust their moral compass. Central to all of these deliberations is the context, and the power relations within which health professionals take a stance, e.g., their role in the team, the moral climate of their organization, the recognition of their moral standing, and authority.

Moreover, the relational account of conscience views conscience as a dynamic process that motivates healthcare practitioners to act as morally responsible agents. They make moral judgments about what their conscience cares about; are willing to rethink and revise any values that they hold which may be oppressive to themselves or others; are prepared to justify their actions or inactions; are conscious of their own relative power and privilege in the exercise of conscience—using it as a shield to honor their own authentic values and not a sword to coerce others to act as they would.

A feminist perspective on conscience also deploys the term, conscientious commitment, to signal that conscience is not simply the purview of those who refuse to provide termination of pregnancy services—it also applies to those who do. These include the first pioneers who defied religious and legal authorities and risked unemployment and imprisonment to support women's reproductive rights as well as the conscientious providers of today who, at the very minimum, risk being stigmatized or isolated because of their commitment to providing abortion care in the absence of support from their hospital management or peers.

Finally, it is important to recognize that ethical stances are taken in specific real-world contexts and the shared range of tasks and psycho-social supports involved in the delivery of any kind of clinical treatment may work to reduce what seem like intractable conflicts in the case of abortion care. Recognizing the diversity of views that healthcare practitioners may have in relation to these tasks and supports is an important first step. Intentionally creating a moral space which recognizes the moral work that informs abortion care, acknowledges the impact of time, experience, social and institutional context, and encourages conscientious reflection and respectful communication, is a necessary second. These practical steps make sense from a feminist perspective because they help to avoid the kind of polarizing position-taking that undermines trust, increases hostility, and, ultimately, leads to the abandonment of the women and girls who need and want abortion care.

**Acknowledgments** We would like to thank our midwifery colleagues, Mary Brosnan and Ríóna Cotter, in the Ethics and Law in Pregnancy Group, Faculty of Law, University College Cork (https://www.ucc.ie/en/elpin/aboutelpin/) for their insightful feedback on the penultimate draft.

## References

Article 9 European Convention on Human Rights. 1950. echr.coe.int/Convention.ENG.pdf. Accessed 3 Feb 2020.

Article 18 The UN Universal Declaration of Human Rights. 1948. https://www.un.org/en/universal-declaration-human-rights/index.html. Accessed 3 Feb 2020.

Article 29 The UN Universal Declaration of Human Rights. 1948. https://www.un.org/en/universal-declaration-human-rights/index.html. Accessed 3 Feb 2020.

Article 40.3.3 Eighth Amendment of the Constitution Act 1983. http://www.irishstatutebook.ie/eli/1983/ca/8/enacted/en/html. Accessed 4 Feb 2020.

Bayles, Michael D. 1979. A problem of clean hands: Refusal to provide professional services. *Social Theory and Practice* 5 (2): 165–181.

Baylis, Françoise. 2015. A relational view of conscience and physician conscientious action. *International Journal of Feminist Approaches to Bioethics* 8 (1): 18–36.

Bray, Jennifer. 2018. Abortion legislation: Nurses petition Harris on opt out, Irish Times, 27 November.

Brock, Dan W. 2008. Conscientious refusal by physicians and pharmacists: Who is obligated to do what, and why? *Theoretical Medicine and Bioethics* 29: 187–200.

Brosnan, Mary. 2018. I have been a midwife for 30 years and am voting yes. The Eighth Amendment does not change the reality of Irish abortion, merely where and how it happens. Irish Times, 21 May.

Buchbinder, Mara, Dragana Lassiter, Rebecca Mercier, Amy Bryant, and Anne Drapkin Lyerly. 2016. Reframing conscientious care: Providing abortion care when law and conscience collide. *The Hastings Center Report* 46 (2): 22–30.

Center for Reproductive Rights. 2018. Addressing Medical Professionals Refusals to Provide Abortion Care on Grounds of Conscience or Religion: European Human Rights Jurisprudence on State Obligations to Guarantee Women's Access to Legal Reproductive Health Care. https://reproductiverights.org/sites/default/files/documents/GLP_Refusals_FS_Web.pdf. Accessed 10 May 2020.

Childress, James F. 1979. Appeals to conscience. *Ethics* 89 (4): 315–355.

Cook, Rebecca. 2018. Sir Nigel Rodley's insights on the feminist transformation of the right of conscience. *Human Rights Quarterly* 40: 255–259.

Culwell, Kelly R., and Manuelle Hurwitz. 2013. Addressing barriers to safe abortion. *International Journal of Gynaecology and Obstetrics* 121 (Suppl 1): S16–S19.

Czarnecki, Danielle, Renee R. Anspach, Raymond G. De Vries, Mercedez D. Dunn, Katrina Hauschildt, and Lisa H. Harris. 2019. Conscience reconsidered: The moral work of navigating participation in abortion care on labor and delivery. *Social Science & Medicine* 232: 181–189.

Dickens, Bernard M. 2006. Ethical misconduct by abuse of conscientious objection laws. *Medicine and Law* 25: 513–522.

Dickens, Bernard. 2008. Conscientious commitment. *The Lancet* 371 (9620): 1240–1241.

Dickens, Bernard M. 2014. The right to conscience. In *Abortion Law in Transnational Perspective: Cases and Controversies*, eds. Rebecca Cook, Joanna N. Erdman, and Bernard Dickens. Philadelphia: University of Pennsylvania Press.

Dickens, Bernard M., and Rebecca J. Cook. 2011. Conscientious commitment. *International Journal of Gynecology and Obstetrics* 113: 163–166.

Donnelly, Mary, and Claire Murray. 2020. Abortion care in Ireland: Developing legal and ethical frameworks for conscientious provision. *International Journal of Gynecology & Obstetrics* 148: 127–132.

Douglas, NeJaime, and Reva Siegel. 2015. Conscience wars: Complicity-based conscience claims in religion and politics. *Yale Law Journal* 124: 2516–2591.

Fleming, Valerie, and Yvonne Robb. 2019. Potential conflicts in midwifery practice regarding conscientious objection to abortions in Scotland. *Nursing Ethics* 26 (2): 564–575.

Fleming, Valerie, Lucy Frith, Ans Luyben, and Beate Ramsaye. 2018. Conscientious objection to participation in abortion by midwives and nurses: A systematic review of reasons. *BMC Medical Ethics* 19 (31): 12. 575.

Fullerton, Judith, Michelle M. Butler, Cheryl Aman, Tobi Reid, and Melanie Dowler. 2018. Abortion-related care and the role of the midwife: A global perspective. *International Journal of Women's Health* 10: 751–762.

Giubilini, Alberto. 2014. The paradox of conscientious objection and the anemic concept of conscience: Downplaying the role of moral integrity in health care. *Kennedy Institute of Ethics Journal* 24 (2): 159–185.

———. 2016. Conscience. The Stanford Encyclopedia of Philosophy (Winter 2016 Edition), Zalta, Edward N. (ed.). https://plato.stanford.edu/archives/win2016/entries/conscience/.

Greenwood, Victoria, and Jock Young. 1973. *Abortion in Demand.* London: Pluto Press.

Harris, Lisa H. 2012. Recognizing conscience in abortion provision. *New England Journal of Medicine* 367: 981–983.

Harris, Lisa. 2019. The moral agency of abortion providers: Conscientious provision, dangertalk and the lived experience of doing stigmatized work. In *Ethical Issues in Women's Healthcare: Practice and Policy*, eds. Lori d'Agincourt-Canning and Carolyn Ells. Oxford: Oxford University Press.

Health (Regulation of Termination of Pregnancy) Act 2018. Irish Statute Book. http://www.irishstatutebook.ie/eli/2018/act/31/enacted/en/html. Accessed 4 Feb 2020.

Higgins, Mary. 2018. Conscientious objection should not become conscientious obstruction, Business Post, 30 December.

Joffe, Carol. 1996. *Doctors of Conscience: The Struggle to Provide Abortion Before and After Roe V. Wade*. Boston: Beacon Press.

John Paul II. 1993. Veritatis Splendor. Vatican City: Libreria Editrice Vaticana. Official English translation at http://w2.vatican.va/content/john-paul-ii/en/encyclicals/documents/hf_jp-ii_enc_06081993_veritatis-splendor.html. Accessed 4 Feb 2020.

Kane, Roslyn. 2009. Conscientious objection to termination and pregnancy: The competing rights of patients and nurses. *Journal of Nursing Management* 17: 907–912.

Kantymir, Lori. 2014. Review, conscientious objection in health care: An ethical analysis by Mark Wicclair. *IJFAB: International Journal of Feminist Approaches to Bioethics* 7 (2): 253–261.

Kishen, Meera, and Yvonne Stedman. 2010. The role of advanced nurse practitioners in the availability of abortion services. *Best Practice & Research: Clinical Obstetrics & Gynaecology* 24 (5): 569–578.

Lawrence, Ryan, E., and Farr A. Curlin. 2007. Clash of definitions: Controversies about conscience in medicine. *The American Journal of Bioethics* 7 (12): 10–14.

Leigh, Ian. 2019. Chapter 6: The courts and conscience claims. In *Religious Beliefs and Conscientious Exemptions in a Liberal State*, ed. J. Adenitire. Oxford: Hart Publishing.

Liberman, Alida. 2017. Wrongness, responsibility, and conscientious refusals in healthcare. *Bioethics* 31 (7): 495–504.

MacDonald, Chris. 2002. Relational professional autonomy. *Cambridge Quarterly of Health Care Ethics* 11 (3): 282 –289.

Mackenzie, Catriona, and Natalie Stoljar. 2000. *Relational Autonomy*. Oxford: Oxford University Press.

Macklem, Timothy. 2006. *Independence of Mind*. Oxford: Oxford University Press.

Mainey, Lydia, Catherine O'Mullan, Kerry Reid-Searl, Annabel Taylor, and Kathleen Baird. 2020. The role of nurses and midwives in the provision of abortion care: A scoping review. *Journal of Clinical Nursing* 29: 1513–1526.

McCarthy, Joan, Katherine O'Donnell, Louise Campbell, and Dolores Dooley. 2018. Ethical arguments for access to abortion services in the Republic of Ireland: Recent developments in the public discourse. *Journal of Medical Ethics* 44: 513–517.

McGarry, Patsy. 2018. Intentionally ending the life of an innocent baby does not treat any illness. Irish Times, 4 May.

McGuinness, Sheelagh, and Jonathan Montgomery. 2020. Legal determinants of health: Regulating abortion care. *Public Health Ethics.* (Forthcoming).

McLemore, Monica, and Amy Levi. 2011. Nurses and care of women seeking abortions, 1971 to 2011. *Journal of Obstetric, Gynecologic, & Neonatal Nursing* 40: 672–677.

McLemore, Monica R., Susan Kools, and Amy J. Levi. 2015. Calculus formation: Nurses' decision-making in abortion-related care 2015. *Research in Nursing & Health* 38 (3): 222–231.

McLeod, Carol. 2008. Referral in the wake of conscientious objection to abortion. *Hypatia* 23 (4): 30–47.

McLeod, Carol. 2012 Taking a feminist relational perspective on conscience. In: *Being Relational*, Downie, Jocelyn, and Jennifer J. Llewellyn (eds) Toronto: UBC Press; pp. 161–181.

Minister for Health, Simon Harris. Abortion Services Provision, Dáil Éireann Debate, 2 July 2019. https://www.oireachtas.ie/ga/debates/question/2019-07-02/89/. Accessed 28 Jan 2020.

Mizuno, Maki, Emiko Kinefuchi, Rumiko Kimur, and Akiko Tsuda. 2013. Professional quality of life of Japanese nurses/midwives providing abortion/childbirth care. *Nursing Ethics* 20: 539–550.

Montgomery, Jonathan. 2015. Conscientious objection: Personal and professional ethics in the public square. *Medical Law Review* 23 (2): 200–220.

Neal, Mary. 2015. When conscience isn't clear: Greater Glasgow Health Board v Doogan and Another (2014) UKSC 68. *Medical Law Review* 23 (4): 668–682.

Ngwena, Charles. 2016. Taking women's rights seriously: Using human rights to require state implementation of domestic abortion laws in African countries with reference to Uganda. *Journal of African Law* 60 (1): 110–140.

O'Connor, Marie. 2019. Obituary of Philomena Canning, September 1959–March 2019. *AIMS Journal* 31 (1): 43–45.

O'Donoghue, Keelin. 2019. Doctors left high and dry after repeal of eighth amendment, The Business Post, 7 July.

Oderberg, David S. 2018. Declaration in support of conscientious objection in healthcare. https://research.reading.ac.uk/conscientious-objection-in-health-care-declaration/declaration/. Accessed 4 Feb 2020.

Oppong-Darko, Prince, Kwame Amponsa-Achiano, and Elisabeth Darj. 2017. I am ready and willing to provide the service … though my religion frowns on abortion, Ghanaian midwives' mixed attitudes to abortion services: a qualitative study. *International Journal of Environmental Research and Public Health* 14 (12): 1501–1512.

Savulescu, Julian. 2006. Conscientious objection in medicine. *BMJ* 332: 294–297.

Sedgh, Gilda, et al. 2016. Abortion incidence between 1990 and 2014: Global, regional, and subregional levels and trends. *The Lancet* 388 (10041): 258–267.

Sheldon, Sally, and Kaye Wellings, eds. 2020. *Decriminalizing Abortion in the UK: What Would It Mean?* Bristol: Policy Press.

Sherwin, Susan. 1998. A relational approach to autonomy in health care. In *The Politics of Women's Health: Exploring Agency and Autonomy*, ed. S. Sherwin and The Feminist Health Care Ethics Research Network. Philadelphia: Temple University Press; pp. 19–47.

Smith, Stephen. 2020. The responsibilities of conscience in healthcare decisions: Moving towards a collaborative framework. *Cambridge Law Journal* 79 (1): 120–147.

Sulmasy, David. 2008. What is conscience and why is respect for it so important? *Theoretical Medicine and Bioethics* 29: 135–149.

Taylor, Maeve, Alison Spillane, and Sir Sabaratnam Arulkumaran. 2020. The Irish journey: Removing the shackles of abortion restrictions in Ireland, best practice & research. *Clinical Obstetrics & Gynaecology* 62: 36–48.

Toro-Flores, Rafael, Pilar Bravo-Agüi, María Victoria Catalán-Gómez, Marisa González-Hernando, María Jesús Guijarro-Cenisergue, Margarita Moreno-Vázquez, Isabel Roch-Hamelin, and Tamara Raquel Velasco-Sanz. 2019. Opinions of nurses regarding conscientious objection. *Nursing Ethics* 26 (4): 1027–1038.

Ulrich, Connie M., and Christine Grady, eds. 2018. *Moral Distress in the Health Professions*. Berlin: Springer International Publishing.

Wicclair, Mark. 2011. *Conscientious Objection in Health Care: An Ethical Analysis*. Cambridge: Cambridge University Press.

World Health Organisation. 2012. *Safe Abortion: Technical and Policy Guidance for Health Systems*. 2nd ed. Geneva: WHO. http://apps.who.int/iris/bitstream/10665/70914/1/9789241548434_eng.pdf?ua. Accessed 31 Jan 2019.

World Health Organization. 2018. Global abortion policies database 2018. https://abortion-policies.srhr.org. Accessed 22 Mar 2020.

Zampas, Christina, and Jaime M. Gher. 2008. Abortion as a human right—international and regional standards. *Human Rights Law Review* 8 (2): 249–294.

# Feminist Ethics in Nursing Research

Heike Felzmann

## 1 Introduction

Evidence from nursing research is underpinning professional decision-making in nursing. Increasing numbers of nursing researchers investigate a wide range of aspects of nursing practice and their impact on stakeholders. Addressing research ethical concerns is an important element of preparing for the conduct of research, and research ethics committee approval is frequently required for any research activity in nursing. As this chapter is going to argue, focusing simply on the requirements for research ethics approval by research ethics committees alone may not do justice to the ethical challenges arising in a research project. Instead, considering research ethics from the point of view of feminist ethics can add substantively to the understanding of ethical concerns in research, not just in nursing, but also more generally, not least through more in-depth consideration of what Judith Preissle (2007) describes as a "concern with relationship, particularity, constraint and inclusion" (p. 519).

Feminist ethics provides important conceptual resources for understanding research ethical concerns in nursing. Rather than endorsing a specific feminist approach, the potential significance of various prominent concepts from feminist ethics will be explored for the context of research ethics and a feminist interpretation of core concepts and concerns of research ethics will be provided. The chapter begins by considering the professional and organisational aspect of research ethics, with a view to how considerations of power need to be taken into account when understanding the development and current forms of research ethics review. Then the question of the vulnerability of research participants will be discussed, drawing on feminist reflections on vulnerability, arguing for a more differentiated

---

H. Felzmann (✉)
School of History and Philosophy, National University of Ireland, Galway, Galway, Ireland
e-mail: heike.felzmann@nuigalway.ie

H. Kohlen, J. McCarthy (eds.), *Nursing Ethics: Feminist Perspectives*,
https://doi.org/10.1007/978-3-030-49104-8_11

understanding of participant vulnerability that takes into account individual participant characteristics and contextual factors. This is followed by a reflection on research participants' agency, and it will be argued that informed consent and confidentiality are important, but also significantly limited expressions of agency in traditional research ethics; the potential of participatory research to address concerns around participants' agency will be explored. Care ethical considerations will then be used to understand the ethical concerns underpinning the management of risks and benefits in research, as well as the duties of researchers following the completion of the research. And finally, the researcher-participant relationship will be interpreted through the lens of relational ethics and trustworthiness. This includes consideration of conflict of interest and dual roles in research but will also address the embeddedness of the research activities in the relationship between researcher and participants. This chapter aims to show that feminist ethics provides concepts that elucidate the ethical responsibilities of researchers in a more comprehensive way that shows the limitations of mere adherence to research ethical requirements as set by research ethics committees.

## 2 Power in the Ethical Review of Research

The concept of power helps elucidate ethical underpinnings but also the ethical limitations of contemporary ethics review. Research ethics was initially conceived as corrective to unchecked professional power but wields its own institutional power as a "bureaucracy of virtue" (Bosk 2007). Traditionally, ensuring ethical practice in research was considered the sole responsibility of the (then primarily male) professionals who were involved in the conduct of research. However, it became clear that professionals did not always conduct research in the best interest of their participants and at times abused their professional power. According to Lukes (2005), power can be conceptualised as capacity or as domination, as mutualistic or adversarial, and as collaborative or conflictual. However, in the traditional research setting, where the participant is seen as a passive recipient of the research interventions, the power of professionals can be conceptualised with Lukes and Boser (2007) as dominance in a dyadic relationship that allows them to influence other people's actions. The most prominent cases of research misconduct in professional healthcare relationships involved populations who were socially marginalised, disabled, or in positions of dependency, such as poor African Americans suffering from syphilis in the Tuskegee experiments (Reverby 2009), or children with cognitive disabilities at risk of infection with hepatitis in the Willowbrook experiments (Rothman 1982; Krugman 1986).

Professional guidance documents were developed in response to such abuses of research participants. A first international statement on research ethics, specifically in response to the atrocities of the Nazi medical experiments, was proposed in 1949 with the Nuremberg code (The Nuremberg Code 1949). The Nuremberg Code outlined important conditions for ethical research and established the principle of informed consent as an essential requirement. In 1964, the first edition of the

Helsinki declaration was issued by the World Medical Association (World Medical Association (WMA) 2018) outlining detailed ethical principles for medical research as binding in an international context. The Belmont Report (The National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research 1979) in the United States in 1979 was partly a response to concerns arising from the abuses in the Tuskegee and Willowbrook experiments, outlining core principles of research ethics that were later echoed in Beauchamp and Childress' work (Beauchamp and Childress 2012). Other large international organisations followed with their own ethics codes, including the Council for International Organisations of Medical Sciences (CIOMS) (2016) guidelines for international research. Professional organisations in the healthcare professions also implement standards of ethical practice for their members that include the ethical conduct of research.

Research ethics codes and research ethics committees can be understood as an institutional response to a problem of the abuse of professional power. Research ethics committees (RECs) or institutional review boards (IRBs) are formal structures that review research proposals before research activities are initiated. RECs are multidisciplinary bodies that bring together a mix of professionals and laypersons with different experiences and levels of seniority to provide ethical peer review. The inclusion of a substantial number of lay members, that is, non-scientists and non-affiliated members, is often considered particularly important, due to the hope that their presence might allow addressing biases and blind spots and help break open entrenched institutional power structures (Jones et al. 2008; Solomon 2016).

Their implementation meant that the trust in the judgment of individual professionals was replaced with reliance on scrutiny by an external review body that brought together a multitude of perspectives and was independent of the research to be reviewed. RECs were first implemented in clinical contexts to review the risks and benefits of potentially harmful clinical interventions and to ensure that research participants were adequately informed about what their research participation entailed. Over time, health research employing social science methodologies, as is common in nursing research, also became subject to research ethics review.

The emergence of formalised review structures has received criticism with regard to its institutional power. It gives power to new actors and evolving bureaucracies that define what counts as a legitimate conceptualisation of knowledge, ethical issues and appropriate solutions, leading to the potential silencing, marginalisation or delegitimisation of incompatible approaches (Ackerly and True 2008). For example, application forms for RECs often require the description of research activities in a format that is designed to capture information on randomised controlled trials rather than on qualitative participatory research, where research activities are less predictable and where risks are less quantifiable. Lukes states that "an IRB will typically operate from a "power as dominance" perspective" (Lukes 2005, p. 1063). Accordingly, the power wielded by research ethics bureaucracies has been criticised as "ethical imperialism" (Schrag 2010) or even as "systemic bullying" of researchers (Carr 2015). As feminist theory has argued, the dynamics of power and pervasive asymmetrical power relationships in professional and institutional settings are a feminist issue, not just because personal power is wielded by predominantly male professionals, but also because bureaucracy can be understood “as a structural expression of male dominance” (Ashcraft 2001, p. 1301) which embodies and perpetuates underlying ideologies, “revealing persistent patterns of dominance and subordinance … that parallel power relations between men and women” (Ferguson 1984, p. x). As Lukes argues, in research ethics there is a complex intersecting bureaucratic structure of power as dominance: “the IRB has ‘power over’ the researcher, the power to withhold approval of research projects…” (Lukes 2005, p. 1063); also regulations exert power over the ethics committee, and the researcher holds power over participants.

The institutional positioning of RECs makes their decisions difficult to challenge by individual researchers, even though ethics committees themselves do not see it that way (Klitzman 2011). Especially in the social sciences, many have decried the implementation of mandatory REC review as a regulatory overreach that imposes undue limits and burdens on researchers that are disproportionate to the risk to research participants (Schrag 2010; Dingwall 2008; Dyer and Demeritt 2009; Haggerty 2004; Schrag 2009, 2011). It has been suggested that RECs judge diverse research by means of a certain general understanding of what constitutes knowledge and good research, described by Boser as “postpositivist epistemological assumptions of a distanced objectivist research stance” (Boser 2007, p. 1060). Traditional research ethics often relies on an understanding of knowledge that is divorced from concerns about its application. RECs typically rely on a set of fixed rules and requirements, embodying “the principled orientation to research ethics” (Preissle 2007, p. 519). Application forms used by committees are often modelled on what is taken as the paradigmatic case of clinical trial research in medicine that may not match the qualitative approaches of social science research in health, especially not participatory research (Wilson et al. 2018). Feminist theory has highlighted the risks of relying on generalised knowledge and the importance of doing justice to the particular and unpredictable. As Alderson and Morrow state, following the postmodernist Baumann: “We may be blindly obedient to rules instead of also carefully feeling a way forwards through unpredictable, ambiguous, negotiated interactions” (Alderson and Morrow 2006, p. 413).

Nursing research, unlike medical research, has avoided prominent research ethics scandals. However, that does not mean nurses have been ethically faultless regarding their role in research in the past; nurses were, for example, actively involved in research activities in Tuskegee and Willowbrook. It is essential that nurses be aware of their position of professional power vis-à-vis many participants as representatives of the healthcare service and reflect on their contribution to sustaining such power differentials, for example by making efforts to share decision-making power (Henderson 2003). Nurses have the responsibility to conduct their own research ethically but also to avoid potential complicity with ethically problematic research carried out under the guidance of other professions, even though potentially problematic interprofessional power dynamics might be in play in such situations. Regarding the confrontation with the institutional power of research ethics committees, nursing research generally falls under the remit of healthcare RECs but often employs qualitative social science investigative methodologies which often do not conform to the model of clinical trial research on which healthcare REC submission forms tend to be modelled. Accordingly, their engagement with research ethics committees may at times reflect some of the conflicts that other social science researchers have noted (Schrag 2010) with regard to the imposition of requirements that may not adequately reflect the practical characteristics of the research conducted in nursing.

## 3 The Vulnerability of Research Participants

Vulnerability is an important research ethical concern, comparable to its role in the delivery of healthcare. Nurses are sensitised through their training to paying attention to the vulnerability in their healthcare practice, not least through their professional obligations of care and advocacy (Gaylord and Grace 1995; MacDonald 2007; Hanks 2008). Vulnerability in research ethics is linked less prominently to advocacy for participants' rights—although some research approaches, such as participatory research make that link—and more to the protection of research participants. Most research ethics committees require the assessment of the vulnerability of research participants. The demands generally increase substantially if participants are considered to be members of a vulnerable group, such as children, pregnant women, persons with mental illness, persons who are socially marginalised, prisoners or persons in dependent relationships. Often RECs see their role as preventing participants from entering problematic research settings in the first place, or otherwise focusing on increasing participants' awareness of their rights.

Despite being such a central concept in research ethics, vulnerability as a concept has only received more careful ethical attention in recent years, especially in feminist literature. Levine et al. (2004) problematises the limitations of the concept of vulnerability and the associated risk of stereotyping of participants when applying vulnerability as a blanket concept to persons based on their membership of a particular group. Hurst analyses vulnerability in terms of "an increased likelihood of incurring additional or greater wrong" (Hurst 2008, p. 194). Luna (2009, 2019) differentiates this position further and argues for understanding vulnerability in terms of "layers, not labels", where multiple layers of vulnerability might combine and compound each other, or where particular strengths in one layer may help mitigate the vulnerability in another layer. She gives the example of vulnerability associated with being a woman, which may be compounded or mitigated to some extent by the rights and protections available to women in different societies, for example with regard to reproductive rights, but also with different levels of privilege associated with certain social positioning. Luna points out that the blanket use of vulnerability taxonomies can lead, paradoxically, to disempowering participants whose resilience may be underestimated. Working adequately with the notion of vulnerability, according to Luna, would involve identifying which layers of vulnerability might apply in a particular case and what factors might trigger a vulnerability. Luna also highlights what is sometimes called "pathogenic vulnerability" (Luna 2019), insofar as layers do not simply add up in a straightforward way, but certain conditions that trigger vulnerability in one situation might exacerbate others and then cascade through the layers. An example that Luna gives is of an older person's loneliness that might lead to a variety of further cascading harms, such as psychological harm, lack of appetite and activity, resulting in greater general frailty. Applying the concept of vulnerability in research ethics from a feminist point of view, therefore, means paying attention to how the particular context, content and methodology of the research and the specific characteristics of research participants might interact and whether there might be any cascading negative effects resulting from the research.

Applying Luna's concept of layers of vulnerability also means to balance potential harms of inclusion versus exclusion carefully. In the field of clinical trials, it is acknowledged that the exclusion of children from participation in research for the purpose of protection from research risks is itself associated with significant subsequent risks: without systematic large-scale trials, healthcare interventions that may be deemed necessary for children's healthcare remain insufficiently evidence-based. Researchers in paediatric research have long been concerned about the complexity of requirements for trials with children and the "draconian oversight" by research ethics committees (Joseph et al. 2016) which may make their inclusion more difficult to achieve. Similarly, clinical research involving pregnant women has been virtually non-existent, due to substantial vulnerability concerns, despite the need, argued for by feminist authors, to provide evidence-based healthcare for many pre-existing conditions in pregnant women (Baylis and Kaposy 2010; Lyerly et al. 2008).

In qualitative research, the exclusion of participants from research due to vulnerability leads to a potentially problematic omission of stakeholder views on issues affecting the most vulnerable. This might result in a potentially biased narrative on issues affecting these members. This lack of voice is particularly concerning from the advocacy perspective in nursing which is focused on giving a voice to, and showing respect for, experiences that are otherwise left unheard and unrepresented (MacDonald 2007; Hanks 2008; Smith 2008). Carter captures the tension between vulnerability protection and exclusion in her statement, regarding children's research, that "the discourse of child vulnerability competes with the discourse of child participation and involvement" (Carter 2009, p. 858). This concern is also captured by the slogan "nothing about us without us", which is frequently used in disability rights activism, linked to the Convention on the Rights of Persons with Disabilities (CRPD) (2008). Concerns related to participation and empowerment will be discussed in further detail in the following section.

## 4 The Autonomy and Agency of Research Participants

Concerns regarding the agency of research participants are captured in traditional research ethics primarily through requirements regarding informed consent. Autonomous decision-making is perceived as a core expression of human agency, and informed consent is generally seen as the most important way of realising and documenting autonomy in research. The assumption is that giving persons sufficient information about what research entails and offering them uncoerced choice regarding participation is a meaningful way of enabling them to exercise their agency.

Informed consent, understood traditionally, requires meeting a set of conditions. These conditions apply equally in the context of research and healthcare practice. Nurses are familiar with the practice of informed consent in healthcare. The difference between consent in research and healthcare contexts is that the participant's interest in research participation is usually different from their interest in obtaining healthcare. According to Beauchamp and Childress (2012), there are six conditions of informed consent that need to be met. First, there are two preconditions of consent that need to be in place: (1) participants should have the *capacity* to consent, which includes the cognitive and emotional ability to understand information, reflect on their preferences and make decisions in light of their preferences; (2) participants should not experience any *coercion* in their decisions to participate, which could involve explicit pressures to participate or more subtle psychological influence, across what is sometimes called the "spectrum of coercion" (Szmukler and Appelbaum 2008). Then there are the so-called information elements. This includes (3) provision of relevant information that the participants require to make a well-grounded decision, including information on what research participation entails, and what risks and benefits may arise from participation. This is closely related to (4) ensuring participants' understanding, both through presenting that information in an accessible manner to participants, where necessary, specifically tailored to their information-processing abilities, and through providing opportunities to check understanding and address any questions and emerging gaps in understanding. Finally, consent will be achieved through (5) the participant's own active decision to participate, ideally following their careful deliberation on the information provided; and (6) the authorisation for the researcher to go ahead with research activities, either through completing a written informed consent form that usually contains various items that the participant agrees to, or through oral consent. It is assumed that by going carefully through these six conditions, it can be ensured that the participant's decision is truly their own.

Closely related to consent, confidentiality is another core requirement of research ethics that is generally considered to be linked to the participant's autonomy and agency. Confidentiality requires that participants' contributions are kept confidential and will only be accessible to those who have explicitly been authorised by the participant to access the information. Meeting confidentiality requirements means giving the participants control over who can receive information relating to their research contributions. Data protection legislation, as covered by the European General Data Protection Regulation 2016/679 (GDPR), embodies this focus on individual control of the use of personal data through its primary reliance on consent as grounds for data processing.

However, understanding autonomy and agency as residing fully in the individual who makes the decision has been criticised by feminist authors as misunderstanding the relational nature of human decision-making and ignoring the realities of shared social life. The concept of "relational autonomy" (Mackenzie and Stoljar 2000) has been proposed as a counterpoint to an understanding of autonomy that centres around a thoroughly individualised idea of psychological self-sufficiency. The value of this concept has been recognised in nursing ethics (MacDonald 2007, 2002). It has been argued in the feminist literature on relational autonomy that autonomy should not be understood to be as something purely internal that happens in a person's head (Oshana 2006). Instead, autonomy is viewed as the "socially constituted capacity" (Mackenzie 2008) of a person that is intimately bound up with their social context. The latter recognises that person as someone who has the authority to make decisions and thereby facilitates their autonomous engagement with options that are actually available in the world. In nursing, the realities of patients' embeddedness in social structures that may help or hinder them in forming and expressing their views are on constant view in care situations.

What the concept of relational autonomy highlights for research ethics is that the mere fact of including an informed consent step in the research process is not going to guarantee the participant's substantive agency. Not only would it be important to involve participants actively in consent throughout their participation, as captured in the notion of "process consent" (Dewing 2007; McKeown et al. 2010). To achieve genuine agency, the participant must also find themselves in a situation where they feel they have options and where they would see themselves to be in a position to be heard. Informed consent as currently practiced, with a primary focus on participants reading and signing informed consent forms, does not seem to facilitate this more demanding and more situated understanding of agency.

Social positioning can be seen as a further impediment to a genuine agency, due to the impact of power asymmetries between researcher and participant (Boser 2007). Alderson and Morrow argue that for ethical practice it is essential to take steps to remedy these asymmetries: "Research ethics involves the transfer of as much information and control as possible from researchers to participants, who may be far less confident and knowledgeable than the researchers" (Alderson and Morrow 2006, p. 8). However, existing social power relationships may be entrenched and not so easily remedied through once-off well-meaning actions by researchers, especially when the choices available to participants in the research situation are already structurally limited for participants to a mere "yes" or "no" to participation. In addition, the options for participants may become even more limited due to requirements of the research ethics system itself, as Boser points out: "application of the conventional IRB framework in reviewing the ethics of participatory inquiry can itself harm human participants in such projects by limiting the participants' field of choices" (Boser 2007, p. 1060), especially when "participatory researchers … struggle to translate practice informed by values of shared power to the IRB as audience" (Boser 2007, p. 1065).

While researchers are generally the ones interpreting and writing up the research results, as Preissle states "the writing itself, who writes whom, creates imbalances of power and an inevitable 'othering' of participants" (Preissle 2007, p. 525), there is at the same time risk in labelling research participants as always powerless and researchers as always more powerful. In reality, the power dynamics characterising the researcher-participant relationship are generally more complex, as

Karnieli-Miller et al. (2009) point out in their analysis of the mutual dynamics of power within qualitative research relationships. In their view, traditional research assumes that “the division of roles between researcher and participant is dichotomous, unequivocal, constant, uniform, and predetermined … the researcher [is seen] as a neutral observer who objectively examines various human phenomena” (Karnieli-Miller et al. 2009, p. 280). In contrast, once power dynamics are taken into account, especially in the process of qualitative research, participants have many opportunities to shape the research process and research results by deciding what to share, withhold or distort. Accordingly, “[t]he relationship changes according to the researcher’s personality, world view, ethnic and social background, perceptions derived from the researchers’ [sic] professional discipline, the qualitative paradigm, the theoretical base of the research, the type of the research and its goals” (Karnieli-Miller et al. 2009, p. 280). To address the resulting hermeneutic challenges, attention has been given in qualitative research to creating opportunities to balance the power of interpretation, for example by exploring fully collaborative methodologies with the participant as co-researcher (Groot et al. 2019), or by asking participants to review not just transcripts of interviews, but the interpretations drawn from them.

Participatory research is one prominent methodology for research that aims to achieve the empowerment of research participants. It is frequently chosen as a research methodology by feminist researchers and others whose research is sensitive to giving voice to marginalised or underrepresented individuals. Participatory research is built on the assumption that participants need to be considered experts in the issues that affect them. It is designed to allow participants to take an active and creative role throughout the conduct of research, including identifying research goals on the basis of their needs and lived experience, being actively engaged in the process of interpretation, and in developing meaningful dissemination opportunities (Wilson et al. 2018; Flicker et al. 2007; Banks et al. 2013). Instead of understanding participants’ agency simply to be a matter of informed consent, that is, primarily relevant at the participants’ entry point to research participation, participatory research aims to ensure that participants’ autonomy and their agency are respected and facilitated throughout the entire process of research. Accordingly, in this research methodology, research is understood as a practice rather than an instrument for the creation of objective knowledge outcomes; it is focused on the process of participatory knowledge creation and social change as a way of respecting and empowering participants (Preissle 2007).

## 5 Care for Research Participants

It is generally acknowledged that researchers have a duty of care towards participants, similar to the duty of care that healthcare professionals have towards their patients. However, the conceptualisation of this duty of care in traditional research ethics is conceived quite narrowly and differs substantially from its conceptualisation in feminist research ethics. In traditional research ethics, the duty of care primarily refers to the duty to protect the research participant from harm. Accordingly, a core obligation in research ethics is to identify potential risks to participants' well-being and focus on risk-prevention and risk-mitigation strategies. This is understandable in light of previous abuses of participants in research that endangered the lives and well-being of participants, such as in the Tuskagee or Willowbrook studies mentioned earlier. However, this narrow focus on risk is potentially problematic because the focus on risk prevention leaves out the importance of other values in research, such as empowerment, solidarity or even just grasping the richness and real-life complexity of the phenomena under investigation. It may also lead to discouraging forms of research that do not conform to highly standardised and predictable approaches, especially methods where risks are less clearly predictable, such as in participatory action research, creative methodologies, or group- or community-based research.

In a feminist approach to research ethics, thinking about the duty of care demands engagement with the concept of caring and care ethics. As discussed in previous chapters, care ethics has its origins in the 1980s, when it was developed in opposition to traditional universalist morality (Gilligan 1982; Noddings 1984). What characterises care ethics is its deeply relational understanding of moral thinking. When the research relationship is understood as a caring relationship it requires from the researcher more than fairness and following general principles. Care ethics draws attention to the uniqueness and particularity of each participant, the need for empathy and holistic understanding of the participant's perspective, care for their well-being and development, flexibility in adjusting to their individuality, and a certain degree of mutuality in the relationship of researcher and participant. Even if research interactions require a certain level of uniformity, according to the care ethics perspective, researchers have the responsibility to create research relationships in which participants are not treated like numbers and in which space is given, however limited, to establishing a genuine encounter between researcher and participant.

The duty of care extends not just to the treatment of the participant within the research interactions themselves, but also extends beyond the research encounter. As already indicated in the reflections on power above, the researcher's work with the research data provides opportunities to exert power in the process of interpretation and representation of results. Preissle refers to this as the "Ethics of Representation", which she describes as "the good or ill that results from how participants are represented in publications, presentations and other reports of research. … Will research participants be distressed when they learn how they are described, characterised and interpreted? … Will other people … face difficulties in their lives because of how those who share their attributes are represented?" (Preissle 2007, p. 525). Feminist research ethics of care realises the sensitivity of the choice of representations and the value that participants assign to such representations.

The researcher's duty of care to participants also includes post-research responsibilities, both for individuals and affected communities. It is becoming increasingly common for researchers to see their role not just as obtaining research data from individuals and communities, but as engaging with them after the completion of the research. Most immediately, that involves debriefing, in the sense of providing participants with opportunities of reflecting on their experience of research participation. This is traditionally considered mandatory for any research involving the deception of participants (Miller et al. 2008) but can also be important for other types of research (McShane et al. 2015), for example, research that involves longer term engagement with the research activities. In addition, research projects may also provide their participants with the research results and mark the completion of research by honouring the contribution from their participants (Naidu and Prose 2018).

In addition, in light of the concept of relational autonomy, it is also important to consider the individual as a member of groups and communities, either their local communities or other groups. Accordingly, researchers also have the obligation to consider how their results might affect more than the individuals that they have included in their research and take into account the perspectives of those individuals and communities themselves (Groot et al. 2019). For example, there have been cases especially in ethnographic research where communities felt stigmatised after research had been published about their locality or subculture. This can be especially risky when such groups are already marginalised. For example, nursing research investigating the health behaviours of marginalised groups in community settings would need to reflect on whether their results might potentially be used to discriminate against these groups. Researchers have the ethical responsibility to conduct and frame their research in a way that does not leave their results open to misunderstandings or misuse.

## 6 Trust and Relational Ethics in Research

The ethical importance of relationship factors has been addressed as a core feature of feminist ethics in the preceding discussion. In the following, the risks to the relationships between researchers and participants will be explored with regard the question of trustworthiness. Trust and trustworthiness have been drawn on as a crucial ethical concept in moral theory (Baier 1986) and healthcare ethics (O'Neill 2002). Nursing ethics codes frequently include a reference to trust, and there has been increasingly widespread worry about a crisis of trust in experts and government in contemporary society (O'Neill 2018), including in some aspects of healthcare provision, such as vaccines (Attwell et al. 2017).

One core element of trustworthiness is expertise and professional competence. This is particularly essential for healthcare provision. In health research, the professional expertise from nursing that the researchers bring to the research situation can be instrumental in ensuring ethical research. For example, nursing researchers in dementia who interact with persons with dementia will need to draw on their professional competence in engaging persons with dementia in conversation, identifying their mental state and capacity to participate, or addressing difficult topics sensitively (McKeown et al. 2010). In addition, the researchers also need scientific competence that allows them to conduct valid research (Emanuel et al. 2000).

Trustworthiness in research relationships also requires that the researcher shows a noticeable interest in fulfilling their ethical obligations towards the research participant. Research relationships can be understood partly as asymmetric relationships in which specified research roles and dynamics of power and privilege underlie the researcher's specific obligations of care and protection towards the participants, but also partly as relationships where researcher and participant meet as equals where obligations are derived from mutual respect. The more differences there are between the researcher and the participant, the more challenging it may appear to researchers to do justice to the requirements of equality. Preissle points out that traditional research roles might encourage over-identification with the role of detached expert, forgetting that participants also need to be engaged as fellow human beings. Feminist research ethics instead poses a "challenge to the assumed division between who is the researcher and the knower and who is the researched or known" (Preissle 2007, p. 524). Treating participants not primarily as data sources, but as human beings whose experience and interest matter is likely to convey the element of respect and moral obligation that is one element of trustworthiness.

In addition, trustworthy researchers also need to ensure that any potential divergences in expectations regarding the researcher-participant relationship are proactively addressed so that the participants' expectations align sufficiently with the researchers' role. For example, the therapeutic misconception (Appelbaum et al. 2004) is known to be a particularly common challenge in health research, where participants who encounter healthcare professionals in the research role expect them to continue in a role in which the healthcare needs of the participants are the primary concern. However, research interests are frequently focused primarily on gaining new knowledge rather than directly improving the research participants' health status. Accordingly, it is essential for nursing researchers to be aware of these potential differences in expectations and address them proactively in the establishment of the research relationship. This includes taking into account the potential diversity of implicit expectations and interests of participants (Horng and Grady 2003) and taking these seriously, despite the difficulties that might entail (Wilson et al. 2018).

The potential lack of alignment in expectations and interests in the research relationship can also manifest itself in dual roles. Dual roles exist when the researcher embodies different roles simultaneously that are significantly different in goals and purposes from the research relationship. This might lead to potentially complex sets of divided loyalties towards participants and towards employers (Nutt 2002a). One particular concern for nursing research are relationships that might exert implicit pressures on the participant to participate in research. For example, if the researcher is also a healthcare provider of the research participant (Judkins-Cohn et al. 2013), an educator (Loftin et al. 2011) or a peer potentially working alongside participants in insider research settings (Bonner and Tolhurst 2002), the participant may be incentivised to participate in research in order to preserve or enhance the quality of these other relationships. In addition, there can be more subtle consequences arising from engaging in research with dual roles, as Nutt and Bell (Nutt 2002b) point out with regard to a social worker's research experience with foster parents. Participants may tailor their research contributions to the professional's role; researchers may respond to participants on the basis of their professional experience, or they may potentially alienate participants by presenting themselves in their research role as more naïve with regard to the professional realities on the ground than they are.

A related, particularly problematic ethical concern regarding the researcher-participant relationship is the potential for exploitation. Traditionally, exploitation has been identified primarily with regard to global clinical trials research where research participants from lower income countries may join trials as a means to obtain income or access treatment that would otherwise not be available to them, in return for carrying the unknown risks of research participation. A core problem is the exploitation of the vulnerable position of these participants that allows members of developed countries not to carry that burden themselves (Benatar 2002; Hawkins and Emanuel 2008). Even outside the global context, research with marginalised communities may raise similar issues where burdens for participants may contrast with benefits for researchers. For example, conducting research with trauma survivors comes with many risks for participants and needs to be carefully designed to navigate and respect the complex vulnerabilities and harms experienced by survivors, including the avoidance of re-traumatisation (Newman et al. 2006).

And finally, trustworthy researchers also need to be accountable to participants and the communities that were involved in or could be affected by their research. Debriefing and other forms of knowledge transfer within and after research activities can function as accountability measures (Naidu and Prose 2018). Active stakeholder consultation activities and other forms of knowledge exchange during research facilitate accountability, insofar as they make the knowledge creation process more accessible and transparent for stakeholders. "Member checking", understood as validation of research results by participants, is considered particularly important not just for ensuring scientific validity, but also for doing justice to the co-constructed nature of knowledge in qualitative research (Birt et al. 2016). It has, however, been argued that member-checking activities are themselves dynamic social interactions that are not just straightforwardly confirming or negating the validity of research results, but instead reflect active navigation of social dynamics and negotiations between participants and researchers where the initial positioning of expert and layperson may be re-enacted (Madill and Sullivan 2018).

## 7 Conclusion

As this chapter has shown, feminist ethics provides valuable insights into ethical challenges encountered in research. This chapter aimed to combine core concepts from traditional research ethics with insights from feminist ethics to inform an ethically sensitive practice for nursing research. The discussion included reflections on ethical challenges associated with the role of power in research ethics review, understanding the vulnerability of research participants, engagement with agency and autonomy in research within and beyond informed consent, responsibilities associated with caring for participants, and the role of trustworthiness in research relationships. It has been shown that drawing on conceptual resources from feminist ethics may help achieve a more ethically sensitive practice in nursing research than would be possible through reliance on traditional research ethical requirements alone.

## References

Ackerly, Brooke, and Jacqui True. 2008. Reflexivity in practice: Power and ethics in feminist research on international relations. *International Studies Review* 10 (4): 693–707.

Alderson, Priscilla, and Virginia Morrow. 2006. Multidisciplinary research ethics review: Is it feasible? *International Journal of Social Research Methodology* 9 (5): 405–417.

Appelbaum, Paul S., Charles W. Lidz, and Thomas Grisso. 2004. Therapeutic misconception in clinical research: Frequency and risk factors. *IRB: Ethics & Human Research* 26 (2): 1–8.

Ashcraft, Karen Lee. 2001. Organized dissonance: Feminist bureaucracy as hybrid form. *Academy of Management Journal* 44 (6): 1301–1322.

Attwell, Katie, Julie Leask, Samantha B. Meyer, Philippa Rokkas, and Paul Ward. 2017. Vaccine rejecting parents' engagement with expert systems that inform vaccination programs. *Journal of Bioethical Inquiry* 14 (1): 65–76.

Baier, Annette. 1986. Trust and antitrust. *Ethics* 96 (2): 231–260.

Banks, Sarah, Andrea Armstrong, Kathleen Carter, Helen Graham, Peter Hayward, Alex Henry, Tessa Holland, et al. 2013. Everyday ethics in community-based participatory research. *Contemporary Social Science* 8 (3): 263–277.

Baylis, Françoise, and Chris Kaposy. 2010. Wanted: Inclusive guidelines for research involving pregnant women. *Journal of Obstetrics and Gynaecology Canada* 32 (5): 473–476.

Beauchamp, Tom, and James Childress. 2012. *Principles of Biomedical Ethics*. 7th ed. Oxford: Oxford University Press.

Benatar, Solomon R. 2002. Reflections and recommendations on research ethics in developing countries. *Social Science & Medicine* 54 (7): 1131–1141.

Birt, Linda, Suzanne Scott, Debbie Cavers, Christine Campbell, and Fiona Walter. 2016. Member checking: A tool to enhance trustworthiness or merely a nod to validation? *Qualitative Health Research* 26 (13): 1802–1811.

Bonner, Ann, and Gerda Tolhurst. 2002. Insider-outsider perspectives of participant observation. *Nurse Researcher* 9 (4): 7–19.

Boser, Susan. 2007. Power, ethics, and the IRB: Dissonance over human participant review of participatory research. *Qualitative Inquiry* 13 (8): 1060–1074.

Bosk, Charles L. 2007. The new bureaucracies of virtue or when form fails to follow function. *PoLAR: Political and Legal Anthropology Review* 30 (2): 192–209.

Carr, Caleb T. 2015. Spotlight on ethics: institutional review boards as systemic bullies. *Journal of Higher Education Policy and Management* 37 (1): 14–29.

Carter, Bernie. 2009. Tick box for child? The ethical positioning of children as vulnerable, researchers as barbarians and reviewers as overly cautious. *International Journal of Nursing Studies* 46 (6): 858–864.

Convention on the Rights of Persons with Disabilities (CRPD). (2008). https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities/convention-on-the-rights-of-persons-with-disabilities-2.html.

Council for International Organisations of Medical Sciences (CIOMS). 2016. *International ethical guidelines for health-related research involving humans*. https://cioms.ch/publications/product/international-ethical-guidelines-for-health-related-research-involving-humans/.

Dewing, Jan. 2007. Participatory research: A method for process consent with persons who have dementia. *Dementia* 6 (1): 11–25.

Dingwall, Robert. 2008. The ethical case against ethical regulation in humanities and social science research. *Twenty-First Century Society* 3 (1): 1–12.

Dyer, Sarah, and David Demeritt. 2009. Un-ethical review? Why it is wrong to apply the medical model of research governance to human geography. *Progress in Human Geography* 33 (1): 46–64.

Emanuel, Ezekiel J., David Wendler, and Christine Grady. 2000. What makes clinical research ethical? *JAMA* 283 (20): 2701–2711.

Ferguson, Kathy E. 1984. *The Feminist Case Against Bureaucracy*. Philadelphia: Temple University Press.

Flicker, Sarah, Robb Travers, Adrian Guta, Sean McDonald, and Aileen Meagher. 2007. Ethical dilemmas in community-based participatory research: Recommendations for institutional review boards. *Journal of Urban Health* 84 (4): 478–493.

Gaylord, Nan, and Pamela Grace. 1995. Nursing advocacy: An ethic of practice. *Nursing Ethics* 2 (1): 11–18.

Gilligan, Carol. 1982. *In a Different Voice: Psychological Theory and Women's Development*. Cambridge: Harvard University Press.

Groot, Barbara C., M. Vink, A. Haveman, M. Huberts, G. Schout, and Tineke A. Abma. 2019. Ethics of care in participatory health research: Mutual responsibility in collaboration with co-researchers. *Educational Action Research* 27 (2): 286–302.

Haggerty, Kevin D. 2004. Ethics creep: Governing social science research in the name of ethics. *Qualitative Sociology* 27 (4): 391–414.

Hanks, Robert G. 2008. The lived experience of nursing advocacy. *Nursing Ethics* 15 (4): 468–477.

Hawkins, Jennifer S., and Ezekiel J. Emanuel, eds. 2008. *Exploitation and Developing Countries: The Ethics of Clinical Research*. Princeton: Princeton University Press.

Henderson, Saras. 2003. Power imbalance between nurses and patients: A potential inhibitor of partnership in care. *Journal of Clinical Nursing* 12 (4): 501–508.

Horng, Sam, and Christine Grady. 2003. Misunderstanding in clinical research: Distinguishing therapeutic misconception, therapeutic misestimation, & therapeutic optimism. *IRB: Ethics & Human Research* 25 (1): 11–16.

Hurst, Samia A. 2008. Vulnerability in research and health care; describing the elephant in the room? *Bioethics* 22 (4): 191–202.

Jones, Kevin Edson, Alan Irwin, Michael Farrelly, and Jack Stilgoe. 2008. *Understanding Lay Membership and Scientific Governance*. Liverpool: University of Liverpool. https://www.researchgate.net/profile/Kevin_Jones30/publication/337915276_Understanding_Lay_Membership_and_Scientific_Governance/links/5df2b12d92851c836478cf37/Understanding-Lay-Membership-and-Scientific-Governance.pdf.

Joseph, Pathma D., Jonathan C. Craig, Allison Tong, and Patrina H.Y. Caldwell. 2016. Researchers', regulators', and sponsors' views on pediatric clinical trials: A multinational study. *Pediatrics* 138 (4): e20161171.

Judkins-Cohn, Tanya M., Kiersten Kielwasser-Withrow, Melissa Owen, and Jessica Ward. 2013. Ethical principles of informed consent: Exploring nurses' dual role of care provider and researcher. *The Journal of Continuing Education in Nursing* 45 (1): 35–42.

Karnieli-Miller, Orit, Roni Strier, and Liat Pessach. 2009. Power relations in qualitative research. *Qualitative Health Research* 19 (2): 279–289.

Klitzman, Robert. 2011. The ethics police?: IRBs' views concerning their power. *PLoS One* 6 (12): e28773.

Krugman, Saul. 1986. The Willowbrook hepatitis studies revisited: Ethical aspects. *Reviews of Infectious Diseases* 8 (1): 157–162.

Levine, Carol, Ruth Faden, Christine Grady, Dale Hammerschmidt, Lisa Eckenwiler, and Jeremy Sugarman. 2004. The limitations of "vulnerability" as a protection for human research participants. *The American Journal of Bioethics* 4 (3): 44–49.

Loftin, Collette, Hollie Campanella, and Sarah Gilbert. 2011. Ethical issues in nursing education: The dual-role researcher. *Teaching and Learning in Nursing* 6 (3): 139–143.

Lukes, Steven. 2005. *Power: A radical view*. Hampshire: Palgrave Macmillan.

Luna, Florencia. 2009. Elucidating the concept of vulnerability: Layers not labels. *IJFAB: International Journal of Feminist Approaches to Bioethics* 2 (1): 121–139.

———. 2019. Identifying and evaluating layers of vulnerability–a way forward. *Developing World Bioethics* 19 (2): 86–95.

Lyerly, Anne Drapkin, Margaret Olivia Little, and Ruth Faden. 2008. The second wave: Toward responsible inclusion of pregnant women in research. *IJFAB: International Journal of Feminist Approaches to Bioethics* 1 (2): 5–22.

MacDonald, Chris. 2002. Nurse autonomy as relational. *Nursing Ethics* 9 (2): 194–201.

MacDonald, Hannah. 2007. Relational ethics and advocacy in nursing: Literature review. *Journal of Advanced Nursing* 57 (2): 119–126.

Mackenzie, Catriona. 2008. Relational autonomy, normative authority and perfectionism. *Journal of Social Philosophy* 39 (4): 512–533.

Mackenzie, Catriona, and Natalie Stoljar, eds. 2000. *Relational Autonomy: Feminist Perspectives on Autonomy, Agency, and the Social Self*. Oxford: Oxford University Press.

Madill, Anna, and Paul Sullivan. 2018. Mirrors, portraits, and member checking: Managing difficult moments of knowledge exchange in the social sciences. *Qualitative Psychology* 5 (3): 321–339.

McKeown, Jane, Amanda Clarke, Christine Ingleton, and Julie Repper. 2010. Actively involving people with dementia in qualitative research. *Journal of Clinical Nursing* 19 (13–14): 1935–1943.

McShane, Kelly E., Caitlin J. Davey, Jennifer Rouse, Amelia M. Usher, and Shea Sullivan. 2015. Beyond ethical obligation to research dissemination: Conceptualizing debriefing as a form of knowledge transfer. *Canadian Psychology/Psychologie Canadienne* 56 (1): 80–87.

Miller, Franklin G., John P. Gluck Jr., and David Wendler. 2008. Debriefing and accountability in deceptive research. *Kennedy Institute of Ethics Journal* 18 (3): 235–251.

Naidu, Thirusha, and Neil Prose. 2018. Re-envisioning member checking and communicating results as accountability practice in qualitative research: A South African community-based organization example. *Forum Qualitative Sozialforschung/Forum: Qualitative Social Research* 19 (3). http://www.qualitative-research.net/index.php/fqs/article/view/3153/4314.

Newman, Elana, Elizabeth Risch, and Nancy Kassam-Adams. 2006. Ethical issues in trauma-related research: A review. *Journal of Empirical Research on Human Research Ethics* 1 (3): 29–46.

Noddings, Nel. 1984. *Caring: A feminine approach to ethics and moral education*. Berkeley: University of California Press.

Nutt, Linda, and Linda Bell. 2002a. Divided loyalties, divided expectations: Research ethics, professional and occupational responsibilities. Tina Miller, Melanie Birch, Melanie Mauthner, and Julie Jessop (eds.). Ethics in Qualitative Research: 70–90.

———. 2002b. Divided loyalties, divided expectations: Research ethics, professional and occupational responsibilities. In Tina Miller, Melanie Birch, Melanie Mauthner & Julie Jessop (eds.). Ethics in Qualitative Research: 70–90.

O'Neill, Onora. 2002. *Autonomy and trust in bioethics*. Cambridge: Cambridge University Press.

———. 2018. Linking trust to trustworthiness. *International Journal of Philosophical Studies* 26 (2): 293–300.

Oshana, Marina. 2006. *Personal Autonomy in Society*. Farnham: Ashgate Publishing, Ltd.

Preissle, Judith. 2007. Feminist research ethics. In *Handbook of Feminist Research; Theory and Praxis*, ed. Sharlene Nagy Hesse-Biber, 515–532. Thousand Oaks: Sage.

Reverby, Susan M. 2009. *Examining Tuskegee: The Infamous Syphilis Study and Its Legacy*. Chapel Hill: University of North Carolina Press.

Rothman, David J. 1982. Were Tuskegee & Willowbrook' studies in nature'? *Hastings Center Report* 12: 5–7.

Schrag, Zachary M. 2009. How talking became human subjects research: the federal regulation of the social sciences, 1965–1991. *Journal of Policy History* 21 (1): 3–37.

———. Ethical Imperialism: Institutional Review Boards and the Social Sciences, 1965–2009. JHU Press, Baltimore 2010.

———. 2011. The case against ethics review in the social sciences. *Research Ethics* 7 (4): 120–131.

Smith, Linda J. 2008. How ethical is ethical research? Recruiting marginalized, vulnerable groups into health services research. *Journal of Advanced Nursing* 62 (2): 248–257.

Solomon, Stephanie. 2016. Too many rationales, not enough reason: A call to examine the goals of including lay members on institutional review boards. *Accountability in Research* 23 (1): 4–22.

Szmukler, George, and Paul S. Appelbaum. 2008. Treatment pressures, leverage, coercion, and compulsion in mental health care. *Journal of Mental Health* 17 (3): 233–244.

The National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research. 1979. *Ethical Principles and Guidelines for the Protection of Human Subjects of Research*. https://www.hhs.gov/ohrp/regulations-and-policy/belmont-report/index.html.

The Nuremberg Code. 1949. https://history.nih.gov/display/history/Niremberg+Code.

Wilson, Elena, Amanda Kenny, and Virginia Dickson-Swift. 2018. Ethical challenges of community based participatory research: Exploring researchers' experience. *International Journal of Social Research Methodology* 21 (1): 7–24.

World Medical Association (WMA). 2018. *Ethical Principles for Medical Research with Human Subjects*. https://www.wma.net/policies-post/wma-declaration-of-helsinki-ethical-principles-for-medical-research-involving-human-subjects/.