CHAPTER 1

An Introduction to Law and Ethics

Learning outcomes

By the end of this chapter you should be able to:

- Recognise the key ethical and legal concepts and principles that underpin health care policy and practice;
- Describe the role of law in developing health care policy and practice;
- Understand how ethical problems occur and the basis on which ethical decisions can be made;
- Critically evaluate the relationship between law and ethics, in particular their interaction in resolving problems that arise in practice.

Introduction

If nurses are to understand the key role played by the law in regulating the relationship between health professionals and children, they need to know how it sets and maintains standards of care and how it ensures that children have access to adequate medical assistance and health care. They need to know, in short, what this introductory chapter sets out to do, i.e. describe the nature of law and explain where it comes from and how it develops. That nurses should study ethics has also been so widely accepted that its inclusion in nurse education is now commonplace. This chapter therefore also attempts to introduce nurses to what we mean when we talk about 'ethics' in health care. However, after a brief analysis of key terms, it focuses on the skills that are required to 'think ethically', i.e. to recognise moral problems and dilemmas in everyday practice and make decisions that can be morally justified.

1.1 What is Law?

Almost every introductory text about the law begins with the obvious question: what is law? Typically, however, no answer is immediately given or even attempted. Instead, the reader is swiftly reminded of the pervasiveness of the law and its ever-increasing control of our professional and social lives. Soon too, there will be an acknowledgement that there are probably as many definitions of law as there are theorists seeking to identify its essential nature – the conclusion being that it is therefore impossible to agree on what it 'is'. That this should be so is then justified by explaining that there are many different ways of thinking about the law. For example, some legal theorists focus on legal structures and processes and therefore claim that law is what legislators, judges and lawyers 'do'. Others, by contrast, prefer to study how law operates 'in context', i.e. how law is inextricably linked to other social phenomenon such as economic, moral and

political interests (and the extent to which these contexts shape and are informed by the law). Another common approach is to analyse the law in terms of the functions it performs (e.g. to maintain public order and facilitate cooperative action). Evaluating the law in an attempt to establish criteria for what constitutes 'good' or 'bad' law is another approach in which the relationship between law and morality is the central issue. With so many different perspectives – all asking equally valid questions about the nature of law – it is not surprising that debates about the subject remain as fervent as they were when the ancient Greeks first sought answers to man's place in the social order and the nature of human society some 2500 years ago (see further McLeod, 2009).

1.1.1   Law as a system of rules

The approach taken here to the question, 'What is law?' is a much less ambitious one. It examines basically the extent to which law is a system of **rules**. This approach is a useful starting point not only because it is the most practical way of unravelling the complex range of rules that shape and define professional practice but also because most people have a basic idea of what a rule is, i.e. a statement of accepted standards of behaviour, guiding conduct or action in particular circumstances or situations. Most people, too, can instinctively recognise what many legal rules (or rules of law) seek to achieve; for example, that the criminal law prohibits certain types of behaviour, family law regulates various aspects of marriage and cohabitation, and health care law (or medical law) governs professional practice. That law is in some way different from the web of moral and social 'rules' by which people run their lives is also widely recognised. The difference between legal rules and the wide variety of other formal and informal professional and institutional rules, guidance and policies and practices which regulate nursing practice may, however, be less well understood (see below).

1.1.2   The nature of legal rules

At this stage the distinctive feature of all legal rules that should be grasped is that they must be:

1. Reasonably definite, consistent and understandable,
2. Known in advance, and
3. Recognised and enforced by the courts.

Rules become law when they are recognised by the majority of people in society and are given official backing to enforce them; i.e. they are recognised and applied by the state. A more complex analysis of law which has focused on the role of rules in providing the foundation of a legal system is provided by H.L.A. Hart (1907–1992). In his hugely influential book, *The Concept of Law*, Hart (1994) distinguished between two different types of legal rules (which he categorised as either **primary** or **secondary** rules). Each of these sets of rules interacts with each other in a hierarchical way and when combined, constitute what we commonly understand by the term 'a legal system'. According to Hart, the content of these two sets of rules is determined by five basic features (or *truisms*) of human society.

These are that human beings are:

1. Vulnerable,
2. Approximately equal in power,
3. Capable only of limited altruism (i.e. are generally selfish),
4. Have limited understanding and strength of will, and
5. Live in societies with limited resources.

Given these five generalisations about the human condition, Hart argues that primary legal rules are essential for every society's survival and protect people and their property and ensure that promises are kept. As such, these rules will prohibit violence, theft and deception and will also include how people relate to each other, for example, making contracts and wills. Primary rules can be described as **duty-imposing** because they specify what people can (or cannot do). They therefore create obligations with which members of the society must comply.

In complex and developed societies, primary rules alone need to be supplemented by secondary legal rules to resolve three problems:

1. Uncertainty, e.g. it may not be clear whether a certain rule is a rule of law or some other type of rule.
2. Laws may need adapting or new ones may need to be created as society develops and changes.
3. Inefficiency, i.e. without a mechanism to resolve disputes, primary rules would be ineffective.

To remedy these defects, the secondary rules (which are mostly **power conferring**) must consist of the following: (a) *rules of adjudication*, conferring authority on officials (such as judges) to resolve disputes; (b) *rules of change*, these change legal obligations (whether in the public or private sphere), i.e. they enable people to alter their legal relationships and also facilitate legislative or judicial changes which may be necessary to modernise outdated law; and (*c*) *rules of recognition*, which establish criteria for validating legal rules, i.e. deciding which ones have legal force. Note that rules of recognition are the most important secondary rules since they provide the definitive test of whether a particular rule qualifies as a rule of a legal system (Adams and Brownsword, 1996, p. 5).

Hart insists that it is the union of primary (which apply to all members of society) and secondary rules (which confer authority on officials) that is at the heart of a legal system. Both must coexist before any society can be said to have a legal system.

As was noted earlier, Hart's approach to law is only one of several possible alternatives. Mindful, too, that this brief and simplified account does little justice to wider aspects of his analysis (on which see Doherty, 2005, Chapter 10), nor to the many other ways legal theorists have distinguished various types of legal rules, it has nevertheless been credited with 'charting the precincts of modern legal theory' (Wacks, 2006, p. 26).

Key point

Rules become law when they are recognised and applied by the state.

1.2 How the Law is Made – the Sources of Law

In this section, we look at how legal rules are made, i.e. the principal sources from which English law is derived.

1.2.1 Legislation

There are two types of legislation – primary and secondary (note that the terms primary and secondary are concerned with the law-making process and should not be confused with Hart's two categories of legal rules).

Primary legislation

Primary legislation (also called statute law) is the most important source of law for several reasons. Firstly, it is enacted by Parliament, the principal law-making body in the UK. Parliament passes about 50 statutes (also called Acts) a year. Secondly, Parliament has the right to pass any law it wishes, although it is subject to European law (see below). Thirdly, Parliament has the authority to delegate law-making powers to other bodies, such as government departments. All statutes have to pass through various stages (as bills) during which they are debated in both houses of Parliament before they reach the statute book.

Whatever its origins, a bill only becomes law when it receives the Royal Assent. Even then the Act may not be immediately implemented, i.e. be brought into force straightaway. Another complicating factor is that not all sections of an Act may come into force at the same time (and some may never be implemented). Much of the structure, organisation and administrative framework of the health service is governed by legislation, some of the most important being the National Health Service (NHS) Act 2006, the Health Act 2006, and the Health and Social Care Act 2008 (note that all statutes passed since 1988 are on the internet and can therefore be easily accessed at http://www.direct.gov.uk).

Activity

Read the Explanatory Note of the Health Act 2006. Does it explain the background to the Act and its main aims clearly?

Secondary legislation

Secondary legislation (also called delegated or subordinate legislation) is the other major source of law. Parliament has the power to delegate to other bodies or persons such as government departments and local authorities. It typically exercises this power when much more detailed rules are needed to flesh out a particular Act. Delegated legislation consists of **Statutory Instruments** or **Orders in Council** in the form of rules, regulations and by-laws. Approximately 3000 such items are produced each year. Secondary legislation is clearly, therefore, a very important source of law. Yet, despite having the same legal force as primary legislation, it is not subject to the same rigorous parliamentary scrutiny (although it can be challenged in the courts). Secondary legislation plays an important role in regulating health care provision (e.g. the Abortion Regulations 1991 and the Medicines for Human Use (Clinical Trial) Regulations 2004.

1.2.2   Statutory interpretation

Once a statute has come into force, the courts may be involved in applying and interpreting it. Thus, although legal language is supposed to be precise, clear and unambiguous, all too often words, phrases or even whole paragraphs may be vague and confusing. Also, many modern statutes deal with very complex subjects. They can therefore be very long and complicated, and errors are almost inevitable – the NHS Act 2006, for example, has 278 sections and 22 schedules. Cases may therefore come to court in which judges have to decide whether a statute applies to the particular facts in question.

So how do judges interpret the words of a statute or find the 'intention' of Parliament as the process of statutory interpretation is often called? Over the years, the courts have developed a variety of techniques, presumptions and aids to interpretation – the so-called rules of interpretation. These rules are not, however, applied by judges in a rigid scientific way. Instead, they give judges a wide discretion to select the approach they think is the most appropriate. This raises a further important question, namely, how 'creative' should

judges be in cases where there appears to be no 'right' answer. Given that there may be several different ways of interpreting a particular word or paragraph, all of which could be correct, this is not an uncommon scenario. And if, as it is generally now conceded, judges do have a far more creative role in 'difficult' cases than was previously acknowledged, what limits should be imposed on them to ensure that they do not frustrate the intention of Parliament? Clearly, there are no simple answers to these questions. But what is self-evident is that the process of statutory interpretation owes much to the outlook and influence of those who have the authority to apply the law (see further Elliott and Quinn, 2009, Part 1).

Activity

Read Hendrick (2004, p. 16), *Law and Ethics: Foundations in Nursing and Health Care*. Follow the guidance on how to read a statute.

Key points

- There are two types of legislation: (1) statute law and (2) secondary legislation.
- Statutory interpretation refers to the judicial process of interpreting confusing or ambiguous legislation.

1.2.3 Common law

Common law consists of a system of legal rules that has evolved through court cases over the past 800 years. It is also known as case law or judge-made law. Much of the law regulating the relationship between health care practitioners and patients has developed through case law (in particular, consent and negligence law). When a case comes before a judge, there are two tasks for the court. Firstly, it must decide what facts are relevant, i.e. it must establish what actually happened, and secondly, how existing law applies to the facts. Case law develops from this second task. So how do judges carry out it?

System of precedent
The basic rule is that judges are legally obliged to follow any previous decision that has been made in a higher court. Known as **judicial precedent**, this process essentially requires courts to interpret similar cases – i.e. cases raising similar legal principles and involving similar facts and circumstances – in a similar manner. The system of binding precedent is based on the hierarchy of the courts – i.e. in general, the lower courts are bound to follow the higher courts even though appeals are sometimes possible.

Precedent in practice
Although simple to describe, precedent is much harder to apply in practice. Firstly, it depends on clear and accurate written records being kept of the arguments used in important cases and the legal principles on which the decision is made. This has developed into a system of law reporting of which the two most widely used are the All England Law Reports (All ER) and the Weekly Law Reports (WLR). In addition to paper reporting, there are several legal electronic databases (and the internet can similarly be used to access up-to-date information). Secondly, despite the system of law reporting, it is not always easy to decide what the precedent is – perhaps because two decisions

in the law reports are inconsistent. Problems can occur, too, if the legal principles are expressed too narrowly or too widely for them to be useful in later cases (see further McLeod, 2009, Chapter 7).

In the same way that statutory interpretation raises questions about the creative role of judges, so has the system of precedent provoked much debate about the precise role of the judiciary in developing common law. Are they just neutral decision-makers who simply 'discover' the law and then declare it – i.e. they find previous binding decisions and then apply them to the facts of the particular case in question – or do they actually make new law and so have a powerful law-making function? Few now take seriously the claim that judges do no more than find and apply existing legal principles. Indeed, the system itself gives judges wide choices – not just because they can make creative selections from the mass of relevant precedents but also, when faced with an 'inconvenient' precedent, they can resort to various techniques to avoid following it (e.g. by 'distinguishing' cases, see further McLeod, 2009, Part 2, especially Chapter 14).

That judges make new law is also apparent when a novel set of circumstances comes before the court. This happened in the landmark case of *Airedale NHS Trust v Bland* [1993] AC 789, in which the courts had to decide whether the withdrawal of artificial hydration and nutrition from a 21-year-old patient in a persistent vegetative state was lawful. There was neither a precedent to which the courts could refer nor any relevant legislation. So the Law Lords, albeit reluctant to make such a momentous 'wholly new moral and social decision', nevertheless had to decide on the legality of stopping medical treatment (see further Chapter 12).

Activity

Read Hendrick (2004, p. 18). Follow the guidance on how to read a law report.

Key points

- Precedent is the system whereby decisions by judges create laws for later judges to follow.
- Precedent is based on the idea that it is fair and just that 'like cases are treated the same way'.

1.2.4 European law

European Union law

As a member of the European Union (EU), the UK is subject to European law (EU law). Because EU law takes precedence over national law, it can override both UK legislation and the common law. Although the fundamental purpose of the EU is to create a free market for the provision of good and services, EU law has had a significant impact on various aspects of health care law. These include the marketing and manufacture of pharmaceuticals (in particular the quality, safety and efficacy of 'novel' health care products) and the regulation of medical research. EU Directives also now regulate the collection, testing, processing and storage of blood and blood components. Note that it was also as a result of EU law that UK nationals can receive health care services outside national boundaries in certain circumstances (*Watts v Bedford PCT* [2003]). The impact of EU law on public health has similarly been significant, covering, for example, food safety and health promotion (for a detailed discussion of EU legislation, see Hervey and McHale, 2004).

Human rights law

A different source of law – that also originated in Europe – is the European Convention on Human Rights (ECHR). Now that the Convention has been incorporated into English law by the Human Rights Act 1998, it is no longer necessary for individuals to go directly to the Court of Human Rights in Strasbourg (the special court set up to hear breaches of the ECHR), although they still can. The impact of the Human Rights Act 1998 is that, since October 2000, individuals taking a case to the court in England can allege a breach of their human rights, and in reaching their decision, judges must interpret English law in a way which is compatible with the ECHR.

Public bodies, including the health service, must also comply with the Convention. This has led to the courts being much less likely than in the past to routinely, for example, sanction sterilisations on girls and women. Consent law has been the subject of several important human right-based claims (likewise mental health law, access to health services and confidentiality).

1.2.5 Non-legal sources of law

In this section, the impact of what is commonly known as 'soft law' (or quasi-law) will be briefly discussed. This category includes types of rules which, although not law in the strict sense, i.e. they are not usually legally binding, nonetheless play a very important role in regulating professional practice – by, for example, setting the standards by which practitioners will be judged in any legal action. As such, they clearly do have some legal force. The primary source of this type of 'law' derives from communications from the Department of Health (DoH). These typically take the form of health service circulars. Described by the DoH as quasi-legislative, these explain aspects of health care and regulation more fully. They can cover a variety of matters and can be linked to a particular statute or case. The *Gillick* case, for example (*Gillick v West Norfolk and Wisbech AHA* [1986] AC 112), which famously established the legal principle that 'mature minors' could give consent to medical treatment and advice without their parents' knowledge or permission, was swiftly followed by guidance from the DoH, explaining the implications of the case and identifying good practice in providing contraceptive treatment and advice to young people under 16.

National Service Frameworks also have a significant impact on practice. Targeted on key patient groups, the one for children was published in 2004 (see Chapter 6). Other influential guidance may originate from the National Institute of Clinical Excellence (NICE). NICE's primary function is to advise on the most useful and cost-effective treatments. Although the precise legal effect of NICE guidance is uncertain, it is clear that health professionals would need to justify their failure to follow it if 'anything went wrong' (Mason and Laurie, 2006, p. 424).

Another major type of 'soft law' worth noting here is the code of practice. Codes supplement legislation (e.g. the Mental Capacity Act 2005 and the Human Tissue Act 2004) by providing detailed practical guidance on how to make decisions under the Act in question. They are not a definitive guide to the law and most of them do not have the force of law. Nevertheless, they are so influential as to be almost directive, i.e. practitioners are expected to follow them. Hence, failure to do so will not in itself be unlawful but any breach may be used in evidence in any subsequent legal proceedings. Finally, the role of the Nursing and Midwifery Council (NMC) needs to be briefly explained. As a statutory body, one of its key functions is to set standards and guidelines for nursing, midwifery and health visiting. It also publishes a code of professional conduct. Both the code and other guidelines issued by the NMC will be taken into account in disciplinary and complaint proceedings.

> **Activity**
>
> Access the NMC website (http://www.nmc.uk.org). Critically evaluate its key functions, in particular how it regulates the profession.

1.3 Divisions within the Law

Law can be classified in several ways. Some common divisions are the following.

1.3.1 Civil law

Civil law deals with private disputes between individuals and other bodies – such as health authorities and NHS Trusts – claiming or enforcing a legal right. The main aims of civil law are to establish what rights and duties people have towards each other and to provide a system of remedies to resolve disputes. Civil law includes many different areas. Those that are most likely to involve practitioners working with children and young people are as follows.

Tort law
A tort arises from a breach of a general duty imposed by law; i.e. it does not depend on any prior agreement between the parties involved. The main aim of tort law is to compensate the victim (i.e. someone who has been harmed by another's unlawful act). Tort law covers several different areas, but in health care settings negligence and consent-related claims are the most common.

Family law
Family law regulates relationships within the family and so includes disputes about the care and upbringing of children. Child-centred disputes which are most likely to involve nurses will typically relate to controversial medical treatment, disputes about treatment and child abuse and neglect.

Contract law
Contract law is about agreements and promises that are legally enforceable. Employment disputes are contract based, as are those that involve private patients. Contract law can also be used by a victim of a drug-induced injury.

Administrative law
Administrative law governs how public bodies such as local authorities, the courts and other public institutions operate. It therefore includes the law relating to the provision of health services and how health authorities and NHS Trusts exercise their powers and duties. Patients are most likely to use administrative law to, for example, try and force a health service body to provide a drug they have been denied.

1.3.2 Criminal law

The least likely branch of the law to concern nurses in their everyday dealings with patients is criminal law. Put very simply, the basic aim of criminal law is to protect society by prohibiting and controlling behaviour the state considers harmful and disruptive as well as punishing offenders. So, for example, a nurse whose gross negligence led to a patient's death could be criminally liable.

1.3.3 Public law

This comprises criminal law and constitutional and administrative rules governing how public bodies – e.g. local authorities, the courts, civil service and other public institutions – operate. It thus includes law enabling citizens to question how public agencies such as health authorities and NHS Trusts exercise their powers and statutory duties.

1.3.4 Private law

Private law deals with the legal relationship between private individuals and organisations. It has several functions. These include regulating the provision of health care and providing a system of compensation for the victims of malpractice. It also creates rights and duties and other liabilities arising from 'private' arrangements such as property and commercial transactions.

1.4 What is Ethics?

The question, 'What is ethics?' may seem unimportant not least because most health care professionals will be aware – at least on a very general level – that ethics is about what is 'right' and 'wrong', 'good' and 'bad' in human actions. They are likely to be aware too that their professional code of practice sets outs 'ethical' standards which they are expected to follow and that many of their judgements and actions have a 'moral' dimension. Most will also know that the duty to promote the interests and dignity of patients is an ethical obligation arising from the unequal professional–patient relationship – in which patients will almost always have a more vulnerable and dependent role.

But an instinctive awareness of the ethical nature of health care and the moral content of decision-making may be of little use when a 'new' situation arises. It may be new to the individual practitioner or new because no health professional has had to face the kind of issue before. Either way, the intuitive techniques that have been relied on in the past may fail to provide an adequate moral framework for working out how to make the 'right' decision.

It is at this point that the importance of the question, **what is ethics**, becomes more apparent. This is not because it can necessarily be fully answered, but rather that in asking the very question we begin to realise that 'thinking ethically', i.e. understanding and examining how best to live a 'moral life' (Beauchamp and Childress, 2009), may require more than intuition. Instead, we may need an 'ethical toolkit' that can be systematically used to help practitioners identify the most ethically important problems and dilemmas and provide a step-by-step process to resolve them.

The ethical toolkit outlined below (which is based on various decision-making models commonly found in the nursing literature) is not designed to provide a comprehensive and detailed account of every ethical concept or approach to problem solving. Nor will it provide a magic formula for analysing and resolving all ethical questions that will always guarantee that the 'right' solution is reached. Its purpose is rather less ambitious, namely, to provide practical step-by-step guidance to thinking ethically and making moral judgements about what to do in real-life situations and how to justify those actions and decisions within some kind of philosophical framework.

First, however, the convention (adopted in this book) of using the terms 'ethics' and 'morals' (and 'morality') more or less interchangeably must be explained. Although the two terms derive from different roots – ethics coming from ancient Greek and morals from its Latin equivalent – it is common in philosophic literature to assert that there is no real difference between them, in the sense that an 'ethical' action is one that is morally acceptable. Nevertheless, distinctions can be drawn between them. Thus when we use

the word 'moral', we are usually describing the standards by which an individual runs his or her own life. Similarly, to describe something as 'immoral' implies that it contravenes the morality of a particular society (in a general sense). In contrast, 'ethics' tends to refer to the science or study of morals, which is a much more theoretical and academic approach.

1.5 Ethical Toolkit

1.5.1 Step 1: Distinguish between facts and values

The first step in deciding what is ethically the right thing to do it is to distinguish between factual information about a patient and value statements. Facts about a patient come from several sources, such as the health care record, diagnostic tests, nursing assessment and the patient's history (provided by the patient and/or his family or carers). But that information alone will not lead to an ethical decision unless the nurse considers the 'facts' within a framework or context of values – from a personal, communal, professional and patient's perspective (Fry and Johnstone, 2008).

So what are values? Values are ideals, beliefs, customs and characteristics that an individual or social group considers valuable and worthwhile. Moral values are those which generally reflect a belief about the value of, for example, human life, self-determination, truth-telling and well-being. Values influence behaviour and help us make choices and decisions because they provide a frame of reference to help us understand new experiences. A person's value system is influenced by many factors including cultural, ethnic, educational, religious and environmental experiences. Some values will remain consistent throughout a person's life, while others may change. The relative importance of particular values may also change over time, and although people will have values in common, there will also be differences.

Facts and values are inextricably linked and can exert considerable influence on each other and our conceptions of them. As a consequence, the more an issue – particularly one with ethical implications – is worked out, the more what counts as a factual consideration is likely to change. In other words, some 'facts' may be initially ignored only to emerge later as the most significant while others that are considered important at the outset are soon forgotten.

Key point

Moral values are concerned with ethical issues and dilemmas such as human life and self-determination.

Activity

Think of an ideal or value that you cherish. Work out when you become aware of its importance.

1.5.2 Step 2: Recognise the moral issues

The second step in moral decision-making is to recognise the moral dimension in a particular situation. Some health care situations will be instantly recognisable as morally significant, e.g. abortion, euthanasia and organ donation. But the moral considerations in deciding, for example, how much information to give a 15-year-old (so that his or

her consent can be 'informed') or whether to tell a young person the truth about his or her prognosis may be much less obvious. And some routine aspects of everyday practice such as moving patients or deciding which of several patients in pain to treat first may even appear (wrongly) to be morally neutral. What is ethically important in all these situations, however – and so what gives them their moral dimension – is that they are concerned with the promotion and protection of patients' well-being and welfare. Or to put it another way, the question of 'harm' or 'benefit' to patients is a central issue, likewise the 'duties', 'responsibilities' and 'obligations' health professionals owe to them. Other terms and concepts typically used to denote a situation with a moral element are 'rights' best interests, guilt and shame. Often, too, there will be reference to the rightness or wrongness of a decision or to whether an action is good or bad (or whether something should or should not have been done).

1.5.3 Step 3: Classify the moral problem

Once it has been established that the situation has a moral dimension, it is then necessary to decide whether a **problem** exists and, if so, which type it is. A moral problem can be defined as anything – matter, person, issue, etc. – that is difficult to deal with or hard to understand and requires a moral solution. According to Johnstone (2004), there are at least ten different types of moral problems. Outlined here are some of the most common.

Moral unpreparedness
The problem of moral unpreparedness arises when a nurse lacks the moral knowledge to recognise the moral dimension in a problem situation. She therefore fails to deal with it either appropriately or effectively. Nurses working in a paediatric intensive care unit should, for example, be aware of the moral issues (e.g. the sanctity of life doctrine) surrounding the care and treatment of premature or terminally ill newborn infants so that they can support parents facing very difficult choices, such as whether to withdraw life-sustaining treatment.

Moral indifference
A morally indifferent nurse is one who is not interested in working out what is the right thing to do even though she is well aware that there is a moral problem which should be resolved. Put crudely, she has a 'don't care' attitude. An example would include a nurse who fails to make sure that the wishes of a 15-year-old patient – who does not want surgery – are made known to the relevant person. A nurse who could not be bothered to relieve a patient's pain is another example.

Immoralism
An immoral nurse is one who knowingly and wilfully does something (or fails to do something) that violates a widely accepted ethical standard of professional or general behaviour. Knowing a patient does not want to be included in a research study, for example, but including them anyway would be an example of a deliberate disregard for both national and international codes of practice on ethical research. Note that such conduct would be unethical even if the patient did not suffer any harm.

Moral disagreements
One of the most difficult moral problems to resolve in practice is the moral disagreement. Such disagreements may arise because of different views as to the moral relevance of certain 'facts' or the interpretation and application of various moral standards or concepts. In the abortion debate, for example, although two people may agree that killing an innocent human being is wrong, they may fundamentally disagree about the morality

of abortion because of their different views about the moral status of the fetus. Thus, for the person who does not regard the fetus as a human being, abortion will not be morally wrong. On the other hand, the person who claims that the fetus is a human being will consider abortion morally wrong because it involves killing an innocent human being. Moral disagreements can also arise because health professionals may interpret or evaluate moral concepts differently. They may both accept, for example, that the autonomy of mature young people should be respected but disagree about when it should be qualified – particularly perhaps when a young patient is refusing life-saving surgery. Truth-telling and confidentiality may also both be regarded as important moral duties, but again health professionals may disagree about the circumstances when these should be breached.

Moral dilemmas

Basically, a moral dilemma occurs when two or more mutually exclusive moral claims (e.g. a moral principle or duty) clearly apply and both seem to have equal weight, i.e. a difficult problem that seems to have no satisfactory solution because whichever claim is prioritised or chosen results in the other, equally valid moral claim, being violated. A nurse for whom the sanctity of life is a sacred doctrine, for example, will have a difficult moral choice to make when caring for a terminally ill patient in great pain. To alleviate the patient's suffering, she may be required to administer large (and potentially lethal) doses of pain-relieving drugs. The dilemma here is that the sanctity of life principle conflicts with her duty to do 'good' and minimise harm to patients. One of the options the nurse can choose – to resolve the dilemma – is to select one principle over the other. Or she could choose another principle altogether, such as respect for autonomy.

Activity

Read the chapter on 'Making Decisions that are Ethical' in Hawley (2007), *Ethics in Clinical Practice*. Critically consider how she describes an ethical problem.

1.5.4 Step 4: Refer to an overarching ethical theory

Step 4 involves considering two 'parent' competing theoretical perspectives that have dominated Western moral philosophy, namely, consequentialism and deontology. Although these moral theories may provide little practical guidance to resolving concrete ethical problems, they provide an overarching justification for pursuing one course over another.

Consequentialism

According to consequentialist theories, the rightness or wrongness of actions depends on their consequences. Put simply, this means that when a nurse is faced with two (or more) possible courses of action, she should choose the one that has the best overall consequences. The right (or moral) thing to do is that which produces the best possible outcome. In health care contexts, this would include the prevention, elimination or control of disease, relief from pain and suffering, the prolongation of life, and so on. More specifically, the best outcome will depend on the goal chosen by the particular consequentialist theory in question.

The principal example of consequentialist ethics is **utilitarianism** (Grayling, 2009, p. 89). This famous theory comes in many forms, but in essence a utilitarian does not regard actions as inherently good or bad. Rather they are valuable only in so far as they maximise benefits and minimise harms. The theory of utilitarianism is most closely associated with John Stuart Mill (1806–1873) whose famous slogan, 'the greatest good

for the greatest number', sums up the central concern of the theory, namely, the welfare of society as a whole, rather than individuals. As a utilitarian therefore, a nurse would make a decision about, for example, truth-telling, by asking this question: what would be the consequences of telling the truth? The morally right approach would be then to act in the way that leads to the desired consequences, i.e. the net balance of pleasure, happiness (i.e. what is good) over pain, unhappiness, suffering, etc. (i.e. harms). Although very popular – not least because it reduces all moral judgements, however complex, to a seemingly straightforward calculation – there are significant weaknesses in Mill's utilitarianism. These include the following:

- Because utilitarians treat human beings as means rather than ends in themselves, the theory can lead to injustice, with individual rights being sacrificed for the sake of the greater quantity of happiness for the collective.
- The theory assumes that concepts such as pleasure, happiness and pain can be accurately measured and estimated (Thompson et al., 2006).
- The theory also assumes (wrongly) that the consequences of actions can always be reliably predicted.

In an attempt to respond to some of these criticisms, different versions of utilitarianism have been developed (for a summary, see Pattinson, 2006). Yet the theory has significant strengths. Firstly, it seems to provide a 'scientific' clear answer to the question about what to do in certain situations. Secondly, it seems to treat individual persons equally because everyone's happiness (and unhappiness) counts. Thirdly, even though concepts such as happiness and pain are not straightforward, they are considered very important features in our lives (Hope et al., 2008).

Key point

Utilitarianism is a moral theory that does not regard actions as inherently good or bad – they are valuable only in so far as they maximise benefits or minimise harms.

Deontology – duty-based theories and rights-based theories

Like utilitarianism, deontology is committed to promoting 'good' outcomes but, unlike its rival, deontology places the individual at the centre. Because rights-based theories and duty-based theories both hold that certain sorts of acts are right or wrong in themselves because of the sort of act they are rather than what effect they have (or may have), they are both commonly referred to as deontological.

Duty-based theories are sometimes described as Kantian because of their association with Immanuel Kant (1724–1804). Kant believed that morality was about complying with a set of compulsory fundamental principles and rules that must be followed whatever the consequences. So, for example, the basic question a nurse should ask in deciding whether to tell the truth would be: what kinds of duty or obligation do I owe? According to Kant, it was wrong to tell a lie no matter how beneficial the consequences. Other Kantian duties include promise keeping, not lying, not betraying, and so forth (the list consists mainly of prohibitions). The key to Kant's version of deontology is the maxim that to act morally you should always treat other human beings as 'ends in themselves' and never merely as 'means'. In other words, it is always wrong to treat people as objects, i.e. mere tools to be used to further your own or others' ends.

Duty-based theories are concerned with the moral quality of a person's acts because they suppose that it is wrong for an individual to fail to meet certain standards of behaviour. At the centre of such theories is the person who must follow the rules (or be punished or corrupted if she does not). **Rights-based** theories also make use of moral rules

(and codes of conduct), but they do so in an instrumental way, i.e. to protect the rights of others. As such, these moral rules have no essential moral worth in themselves. At the centre of rights-based theories is the person who has the right to make demands on others (and can thus benefit from others' compliance with those rules). Rights-based theories seek to protect interests or activities that are generally considered of great importance to us, such as the right to be respected and treated as an equal and rational person capable of making his or her own decisions, the right to the truth, the right to privacy and the right not to be injured. There are several types of rights, for example, absolute rights which cannot be infringed and conditional ones which can be qualified in certain circumstances.

Although deontology is regarded as an important response to consequentialism, there are problems with the approach. These include the following:

- It imposes rules that are too absolute and rigid and so cannot take account of differences between cases or accommodate any exceptions to the compulsory rules it prescribes.
- It provides no guidance on how choices should be made when duties or rights conflict (e.g. between telling the truth and lying to protect someone). What should a nurse do, for example, if she is asked by a terminally ill child patient not to tell his parents the truth that he knows he is dying? Keeping that promise may mean that she has to lie to the child's parents.

Finally, it should be noted that the distinction between consequentialism and deontology is not as clear-cut as first seems apparent. Hence, deontologists often accept that where there is no absolute principle to apply, it is appropriate to assess the morality of an action by the consequences it produces. Consequentialists too may borrow from deontology in certain circumstances. For example, they may respect the principle of the sanctity of life – even though killing a patient would produce more good than harm (for that patient). They would do so because the impact on society as whole, over a period, of not respecting the sanctity of life, would be a detriment to that society (Herring, 2008, p. 14).

Key point

Deontology is a moral theory that asserts that, if you wish to act morally, you should never treat others solely as a means but always as an end: it is therefore wrong to treat people as objects.

1.5.5 Step 5: Consider nurse-oriented ethical theories

Two ethical theories that are particularly apposite for decision-making by nurses are **virtue ethics** and **nursing ethics**. Both theories approach ethics from a similar perspective, namely, nurses' experience, i.e. the 'actual business of caring for people' (Campbell et al., 2005). Both theories, too, are often linked together because they adopt a broadly 'feminist' approach to ethical thinking, in other words, the view that women use different strategies (from men) in making ethical decisions. This means they focus on relationships – how they can be nurtured and positively maintained – rather than abstract principles and rules (McHale and Fox, 2007, p. 10).

Virtue ethics

Virtue ethics – first developed by Aristotle in the fourth century – has as its central concern the character and virtuous traits of a person rather than his or her actions. A virtue is a trait of character that is intrinsically valuable or linked to human *flourishing* (Pattinson, 2006). Although the concept of flourishing is problematic – it is, for example, hard to analyse – it is nevertheless generally understood to mean a kind of deep happiness

(Hope et al., 2008). Applied to health care contexts, virtue ethics focuses on the virtues needed to be a 'good' nurse, midwife, physiotherapist, and so on; in other words, the kind of practitioner someone ought to *be* and not just what they ought to *do* in a particular role. According to Beauchamp and Childress (2009, pp. 38–45), the cardinal virtues for health professionals are compassion, trustworthiness, discernment, integrity and conscientiousness. For Johnstone (2004), 'virtuous caring' is integral to moral nursing practice and so would include empathy, genuineness, warmth, kindness, gentleness, nurturance and enablement (amongst others).

It is perhaps not surprising that there has been a resurgence of interest in virtue ethics. As Herring (2008, p. 28) notes, in the heat of the moment, health professionals faced with an appalling ethical dilemma, may not be confident of choosing the 'right' course of action. They are, however, far more likely to be confident that their decision was a compassionate and kind one. Another strength of virtue theory is that it tends to be pluralistic – expressing a number of aspects that are widely considered morally relevant. Note that there is an indeterminate number of specific virtue theories (Hope et al., 2008, p. 28, see further Crisp and Slote, 1997).

Yet, notwithstanding the appeal of virtue ethics, the theories have been criticised on several counts, for example:

- To have any practical application, they need to tell us (but rarely do) how to recognise virtuous persons and virtuous traits.
- They fail to explain adequately their force as a moral action guide (that is compared with, say, other duty-based theories that can rely on moral principles and maxims to justify moral action).
- They impose too high expectations on people to be 'good'; i.e. while many nurses can claim to be, for example, trustworthy and compassionate, few can claim to be 'exemplary' (Pellegrino, 1995, pp. 262–263).

Activity

To find out more about ethical theory and other approaches to ethics, read Appendix 1 in Fry and Johnstone (2008), *Ethics in Nursing Practice*. Identify two advantages and disadvantages to each approach.

Nursing ethics of care

Nursing ethics, which may be taken as a generic term covering the concerns of all those professions allied to medicine, can be simply defined as what nurses do that doctors (and others) do not characteristically do (Hunt, 1998). This means that moral issues should be approached from a nursing perspective, i.e. one that regards caring, rather than cure, as fundamental. It is further claimed that because caring (i.e. the assessment, planning, implementation and evaluation of care) is a different kind of activity from curing (with its emphasis on diagnosis, treatment and prognosis), a distinctive approach to ethical thinking is also required, namely, one that focuses on the relationship between the 'carer' and the 'cared for' (McHale and Fox, 2007).

In brief, nursing theorists – influenced by notions of 'care' first formulated by Gilligan (1982) and Noddings (1984) – assert that given the intimate and ongoing nature of the nursing process, nurses are more likely to identify the ethical issues in everyday, routine practice in contrast to doctors whose medical interventions are more transitory. They are also more likely to see the human, personal, cultural and social aspects of care such as patient's self-esteem and privacy, pain alleviation and comfort (Johnstone, 2004).

But like all other ethical theories, the ethics of care approach has been criticised. A common criticism is that the notion of care is too vague. If it is to form a sound basis for ethical decision-making, a much clearer idea of what 'good' care involves is needed (Allmark, 1995). And some feminists are critical of the approach because they believe it glorifies caring and dependency – both aspects of women's lives, which they claim is harmful to women because it leads to their oppression and subordination (Herring, 2008, p. 28).

1.5.6 Step 6: Use ethical principlism

Principlism is one of the most influential approaches to moral decision-making. It is based on a set of principles, i.e. general standards of conduct that can be applied to any ethical problem. The four principles are **respect for autonomy**, **justice**, **beneficence** and **non-maleficence**. The approach was developed by two Americans, Beauchamp and Childress, in the mid-1980s. It was designed to provide a basic analytic framework and a basic moral language, which health professionals could use as an ethical checklist when faced with contentious moral problems. Principlism can be described as a compromise position in so far as it draws on elements from several other theories. These are, in particular, deontology – because it propounds four distinct ethical duties, and consequentialism – because using the four principles should maximise good outcomes (McHale and Fox, 2007, p. 108).

The four principles are briefly outlined here as they will be explored in detail in later chapters.

Respect for autonomy
Autonomy refers to an individual's ability to come to his or her own decisions, i.e. basically how we decide to live our lives. In health care contexts, respect for autonomy means consulting patients and obtaining their informed consent to care and treatment. Respect for autonomy also means protecting those who are incapable of making their own choices because of illness, injury, mental disorder or age.

Justice
In simple terms, justice requires equal treatment of equal cases and the equitable distribution of benefits – in other words, no discrimination on the basis of sex, race, religion, age, and so on. For health professionals, justice is mainly concerned with the fair distribution of scarce health resources (such as money, medicines and beds).

Beneficence
The principle of beneficence stresses the moral importance of 'doing good'. In practice, this means health professionals have an obligation to act for the benefit of their patients, i.e. promote and safeguard their health and welfare. As such, it can require positive action, for example, becoming an advocate for a patient who is vulnerable – because of their age perhaps (see Chapter 4).

Non-maleficence
Non-maleficence is sometimes considered alongside the duty of beneficence but also sometimes distinguished. The principle imposes a duty to do no harm (or to minimise harm). Less onerous generally than beneficence in the sense that it generates fewer obligations to take positive actions, non-maleficence nonetheless requires health professionals to refrain from doing anything that could be detrimental to others, i.e. violating or 'setting back' a person's significant welfare interests. As we see in Chapter 3, beneficence and non-maleficence will normally have to be considered together. In other words, the

benefits and harms of any proposed action will need to be balanced. From this balancing exercise, it will be possible to establish what actions cause the least harm and the most good.

The appeal of principlism lies in its relative simplicity and accessibility – it is much easier to apply to most of the moral problems health professionals face than abstract theories (such as consequentialism). It is also claimed that as the four principles are culturally neutral, they can be respected within all societies, i.e. they can be applied worldwide. Moreover, by applying them in all situations, a degree of consistency can be achieved, i.e. ensuring that all cases will be approached and considered in the same way.

Despite its popularity, the approach has several weaknesses. These include the following:

- Because each principle can be interpreted in many different ways the approach is liable to be applied in an inconsistent way.
- How to decide correctly what relative weight to give each principle and how they should be balanced when they clash. Should autonomy, as Gillon (1994), a leading supporter in the UK of principlism, has suggested, be the 'first among equals'?
- Relying on the four principles leads to a very narrow approach, i.e. making sure that the four principles fit every ethical problem results in decision-making becoming sterile, uniform and boring (Harris, 2003). More seriously, it is likely to result in other relevant issues and arguments being ignored.

Key point

Principlism asserts that there are basic and obvious moral truths that guide deliberation and action.

1.5.7 Step 7: Make a decision

After having considered and evaluated all the options outlined in the six previous steps, the penultimate step is to make a decision. It is important to realise, however, that there is rarely a single correct answer to an ethical problem. So take five nurses using the above step-by-step toolkit. Three may, for example, select consequentialism, and two, deontology (in Step 4) or the principle of autonomy rather than justice (in Step 6). Furthermore, even those choosing the same theory, e.g. consequentialism or the same principle (i.e. autonomy), may interpret them differently and so reach different conclusions. Why? Because moral judgements inevitably reflect an individual's value system. But importantly, this does not reduce the whole decision-making process to mere opinion and 'intuition' (i.e. the idea that something just feels right or wrong even though we cannot explain why), for each choice made must be morally justified, i.e. supported by more objective reasoning.

1.5.8 Step 8: Justify the decision

Justifying a moral decision involves providing the strongest moral reasons behind it. In other words, being able to explain objectively why the decision is the 'right' one. This is a crucial step because clearly not all reasons are 'good' reasons. They may, for example, be mistaken, misguided or misinformed. And even if they are 'good', they may nevertheless be irrelevant or insufficient (Beauchamp and Childress, 2009). So, how can you be sure that a particular decision is morally justified?

Very briefly, we can say that a decision is morally justified if, at the very least:

- **It is based on an accurate assessment of the facts:** An assessment that a 15-year-old is not capable of giving consent must be based on convincing evidence, for example, that her cognitive and emotional ability is limited in some way.
- **The reasoning is valid:** Valid reasoning is an argument that is logical. An argument is a set of reasons supporting a conclusion. A logical argument should contain a series of statements (called premises) that lead logically to a conclusion. For example:
  a. **Premise 1**: All life is sacred.
     Premise 2: I have a life.
     Conclusion: My life is sacred.
     Any other conclusion, for example, 'my life does not matter' is therefore invalid (i.e. nonsensical). It is invalid because it has been shown that all life, including of course my own, is sacred. In other words, an invalid argument is where the premises do not lead logically to the conclusion. For example:
  b. **Premise 1**: No life is sacred.
     Premise 2: I have a life.
     Conclusion: My life is sacred
- **Ethical theories, principles, etc., are applied consistently**: The underlying principle of consistency means that if people conclude that they should make different decisions (or do different things) in two similar situations, then they must be able to point to a morally relevant difference between the two situations that accounts for the different decisions. Otherwise, they are being inconsistent (Hope et al., 2008).

Activity

Work through the case studies in the chapter 'Making Decisions that are Ethical' in Hawley (2007), *Ethics in Clinical Practice*.

Key point

Steps in the ethical toolkit are as follows:

- Distinguish between facts and values.
- Recognise the moral issues.
- Classify the moral problem.
- Refer to overarching theory.
- Consider nurse-oriented ethical theories.
- Use ethical principlism.
- Make a decision.
- Justify the decision.

1.6 The Relationship between Law and Ethics

In this final section, we compare the role of ethics and law in health care. That there is a close relationship between the two was recognised over a century ago by Lord Chief Justice Coleridge when he asserted that 'It would not be correct to say that every moral obligation involves a legal duty; but every legal duty is founded on a moral obligation'

(*R v Instan* [1893] 1 QB at 453). More recently, it has been observed that 'it is pointless to attempt to disengage the moral discourse from the legal dispute – when we talk about legal rules, we are inevitably drawn into a discussion of moral rules' (Mason and Laurie, 2006, p. 2). As we see below, however, although law and ethics are inextricably linked, there are fundamental differences between them too.

1.6.1 Similarities between law and ethics

- Both are usually normative; i.e. they tell us how we ought to behave. Both, therefore, are concerned with what a particular society views as right or wrong, good and bad. As such, they can be described as forms of social control, using rules, principles and standards to prescribe behaviour and so determine what kinds of actions are prohibited, permitted or required (McLeod, 2009).
- Both share a common vocabulary – in which terms such as rights, duties, responsibilities and obligations dominate, as do concepts such as fairness, justice and equality – and have common roots that can be traced back to custom and also Judaeo-Christian religious traditions.
- Both influence the formulations of codes of practice (e.g. *The Code: Standards of Conduct, Performance and Ethics for Nurses and Midwives*, NMC, 2008) as well as circulars and guidelines regulating health care practice.
- Issues that are typically ethically controversial such as abortion, reproductive technologies, the care and treatment of the terminally ill, embryonic stem cell research and the fair distribution of scarce health resources are usually also legally problematic. It is therefore not surprising that ethical principles and theories influence new legislation (such as the Mental Capacity Act 2005, which seeks to protect the autonomy interests of people over 16 who lack capacity). Judges too adopt philosophical arguments to justify their decisions, especially when they are required to develop the law to meet new situations – although they rarely use them explicitly. An exception was *R v Cambridge HA ex. parte B* [1995] 2 All ER 129. The case involved a 10-year-old girl with leukaemia who unsuccessfully challenged the health authority's decision not to fund further experimental treatment. In refusing to overturn the health authority's decision, one of the judges expressly applied utilitarian considerations, namely, the need to reach a decision that led to the maximum advantage of the maximum number of patients (Hendrick, 2000, p. 25).
- Both ethics and law reflect and respond to changes in society's value system – although the law can be changed at any time by human action, whereas something cannot just be decreed good or bad and automatically become so.

1.6.2 Differences between law and ethics

- Breach of a moral rule does not necessarily involve a formal or official sanction, but breach of legal rule will nearly always ultimately result in a sanction of some sort.
- The law is enforceable in court; morality does not necessarily attract legal sanctions (unless it also involves a breach of the law).
- Although what is ethical will usually be legal and vice versa, this is not always so. Thus, some ethical principles are too vague to be translated into law or the law may not be a suitable instrument to enforce a moral idea. Telling lies, for example, is widely condemned as immoral yet there are very few laws against it. Or the law may not be an appropriate tool for enforcing a moral idea – English law does not force people to be Good Samaritans, for example.

- Moral values are personal to the individual and are not always shared; legal rules affect everybody (or a particular group without exception).
- Ethical standards – as set out in the NMC Code (2008) – are designed to encourage optimum standards (i.e. the best you can do). In contrast, the law is concerned with setting minimum standards below which practitioners must not fall. As such, it accepts much lower thresholds of behaviour. Accordingly, the questions asked when legal decisions have to be made are likely to include, for example, 'What can I get away with?' 'Will I be sued if I pursue this course of action?'

From the brief comparison between law and ethics (and the outline of the law in the first section of this chapter), it is self-evident that the law provides a framework within which professional practice can develop. Whether health care decisions should always be subject to legal scrutiny and control is, of course, another question altogether. What is beyond doubt – as we shall see in subsequent chapters – is that the courts are increasingly likely to be involved in making decisions that are essentially matters of ethics.

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