The virtue of nursing: the covenant of care

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Abstract

It is argued that the current confusion about the role and purpose of the British nurse is a consequence of the modern rejection and consequent fragmentation of the inherited nursing tradition. The nature of this tradition, in which nurses were inducted into the moral virtues of care, is examined and its relevance to patient welfare is demonstrated. Practical suggestions are made as to how this moral tradition might be reappropriated and reinvigorated for modern nursing.

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Introduction

There is now acknowledgement by both government¹ and opposition² that current British nurse education has failed to produce practical carers, and may deter potential recruits. Over the last two decades, the role of the British nurse has become increasingly unclear with, on the one hand, the health care assistant and nursing auxiliary taking over what was previously thought of as "hands-on" nursing work and even more invasive procedures^{3,4}; and on the other hand, nurses expanding their role to include work done by doctors.⁵ Alongside this there is a review of the effectiveness of current nurse education⁶; a push by some for an all-graduate profession⁷; a crisis in recruiting and retaining nurses to work at the more basic grades⁸, and increasing evidence of patients being given inadequate nursing care at even basic levels.^{9,10}

Underpinning this issue of the nature, purpose and status of British nursing is the profound change in nursing values over the preceding decades. No longer should nurses be "branded" as having a vocation¹¹; rather nursing needs a new professional status and a new ethic to match this status.¹² And it has often been argued that women should shake off economically valueless and self-denying "caring".^{13,14} The values of empowerment and assertiveness have displaced the traditional nursing virtues of self-sacrificial service. As the nursing role expands, so conversely, the feeding, comforting, washing and bathing activities of care, basic to nursing, have become unattractive, mundane and menial tasks, devalued

by those who seek to make the nurse into an autonomous and above all, academic, professional. The central question is whether the desire and willingness to undertake apparently menial activities involved in looking after people who are ill is sustainable without an underlying ethic of altruistic service.

The lesson from history: the Nightingale tradition of nursing

This tradition of nursing was ushered in by the early church in both the West and the East, and spread by religious orders and secular Christian philanthropy in the community. It arose from the Judaeo-Christian imperative of care for the stranger as *agape*, exemplified in the story of the Good Samaritan. Nightingale's revival of altruistic care, care as a covenant rather than a contract, was directly connected to the evangelical religious movements of the Victorian era.¹⁵⁻¹⁸

Such was the impact of this reinvigorated tradition that it affected the deeply entrenched class system of the period. At St Bartholomew's Hospital, for example, nursing probationers 1888-1890 were daughters of architects, clergymen, farmers, manufacturers, medical men, merchants, military and naval officers, solicitors, tradesmen and stockbrokers.¹⁹ The daughter of a duke was working as an ordinary nurse in one of the wards.²⁰ By choice and inclination nurses of all classes worked with patients of all classes, cleaning, cooking, washing and dealing with bodily fluids, ingrained dirt, and infestation. Genteel and educated upper-middle-class ladies became as servants and even paid for their training. But what made these privileged women take on such physically demanding work that was both dangerous and low in status, and with little pay?

Evidence for the traditional nursing ethic

From whatever class the woman originated she was taught to be willing to turn her hand to any work that she saw needed doing. A nursing writer in 1893 said that: "...work, that some people term 'menial', is not menial when done by her with that 'tincture' which George Herbert says, makes even 'drudgery divine'."²¹ The purpose of nursing was

not occupational status, or the fulfilment of the individual nurse, it *was* the patient.

Because the end or purpose of nursing was clear, the aim of the apprenticeship training was to produce practitioners fit for the purpose. This was seen to involve producing nurses not only with certain skills, but most importantly, who had the right qualities and attributes: a good "character". This word was constantly used by Nightingale to her probationers. In Nightingale's view: "A woman cannot be a good and intelligent nurse without being a good and intelligent woman".²² Nursing training was ultimately a holistic, moral, educative process into which student nurses were inducted.

The nurse's primary responsibility was to the patient, the epicentre of her thinking: "The nurse must have simplicity and a single eye to the patient's good. She must make no demand upon the patient for reciprocation, for acknowledgement or even perception of her services; since the best service a nurse can give *is* that the patient shall scarcely be aware of any - shall perceive her presence only by perceiving that he has *no* wants."

Nightingale, a passionate statistician, was intensely practical. Her training was not merely the presentation of an ideal, but was concerned with real practice. The nurse's character was manifested through the tasks and procedures of care and the diligence and precision they involved. This was the *carefulness* of care. Nightingale described such procedures in minute detail. Seemingly unimportant and insignificant matters such as how urinals should be washed and chamber utensils should be kept were the vital details that differentiated good care from bad.

Precision, infinite carefulness, was the basis for nurse training. It was for every ward sister to *show* every new probationer how to do her work, not only how it should be done, but also to guard against how it should not be done. Education that would fulfil this purpose was vital. Adequate medical knowledge in subjects such as chemistry, anatomy and physiology, was to be learned from a medical instructor, and examined both orally and in writing, in order that the nurse's powers of expression to train others would thereby be developed. A good library was important. Careful jottings of doctors' comments and notes of cases were to be recorded, so that the nurse learned to observe and understand her own cases and "learn the reason of what is done" so that she would be enabled to teach others.

Although the nurse was expected to obey the physician's or surgeon's directions, this was an intelligent obedience, using discretion, realising that her obedience to the directions was

conditional.²³ The key to authority, in having control over others, according to Nightingale, was to have control over oneself by "the silent power of consistent life". Here there could be no pretence or dissimulation. In exercising authority nurses should not "try to 'seem' anything, but to *be* what we would *seem*".²⁴

Nursing textbooks for a century reflected the Nightingale tradition. Matrons, tutors and ward sisters constantly reiterated the same message, even as their books changed through editions to recognise scientific advances: the ethical basis of nursing arises from the moral character of the nurse and the moral ethos in which she, and later also he, was trained and worked. This was the framework on which rested technical knowledge and skills, powers of observation, attention to the intimate practical details of personal hygiene and comfort. Order, structure, diligence, supervision and method were crucial. Character formed the kindness of the nurse's manner and approach towards the patient.

The inexperienced nurse was inducted gradually into the role of care in which the wisdom and sensitivity needed to touch the human body were learned. The good nurse did not regard some tasks as menial and unworthy, to be handed down to others who were less elevated. Washing a patient, dealing with excrement, urine, vomit, sputum, and cleaning his or her soiled body, was an essential part of care. Nurses in this Nightingale tradition were not dealing with the managerial, technical, spiritual or emotional only, as if this was a higher plane, they were dealing with the *person* in his or her wholeness, including the managerial, technical, spiritual and emotional, but including also, and crucially, the base physical of the diseased and often broken body. To become a nurse was not just to enter into a contractual obligation dependent on reward, it was to enter into a covenant that was regardless of reciprocation.

The relevance of the moral tradition of care to modern nursing

What has been described above is a tradition of nursing practice in which the good nurse was the virtuous nurse. There was a moral agreement about what the duty of the nurse involved, that of caring for the sick. But in the modern world, MacIntyre has argued in *After Virtue*,²⁵ such moral consensus has disappeared. This has affected the ethical basis of nursing. Contemporary disagreement about morality, referred to by MacIntyre, arguably underlies the current disorder and malaise in the nursing profession. The result, in Britain, is evident in a crisis and confusion about

the identity of the nurse, as the tradition of simple service is in fact if not in theory being abandoned. The moral principles which underpinned the nature and purpose of nursing practice have weakened and an interprofessional battle about the occupational status of nursing is occurring.

Evidence shows that the current British system is problematic in aspects of both its science and its art.^{17 26 27} It is questionable whether nurse education, because the biomedical model has been sidelined, now provides nurses with the knowledge necessary to become practically competent in modern clinical technology. It is also questionable whether nurses are prepared for basic caring. The parliamentary committee, to whom the health service ombudsman reports, was shocked to discover that some patients were left in soiled beds, without oral hygiene, unwashed and unfed. Such instances are not isolated, but are constantly repeated.²⁸⁻³⁰

Core principle

Yet, the core principle of caring for the sick, which can be argued to be rooted in the moral imperative of *agape*, remains critical for nursing as its primary *raison d'être*. While prevention of disease is important, sickness has not gone away. Neither has dying. Human beings remain susceptible to illness, vulnerability, dependence, and ultimately, death. The moral objective and imperative to care for the sick remains. The moral reasons to submit oneself to the service of people who are strangers, and who may seem at times unappreciative, unattractive, difficult and even dangerous, giving the kind of self-denying and compassionate service of washing, cleaning, holding, that being a nurse involves, still apply as they did in Nightingale's day. This is evident in modern Britain, but also internationally and interculturality.

Because this is so, the nursing community needs to rediscover an intelligible moral language with which to speak of the values and practices that caring for the sick involves. From history it can be learned that the objective of care for the sick requires certain virtues: those of diligence, patience, loyalty, respect, duty, fidelity and benevolence. Above all, the good nurse needs the virtues of compassion, dedication and self-discipline as well as the humility that engenders sacrificial service. Such virtues do not merely derive from attitudes, preferences or feelings, but are embodied in universal moral principles. These virtues are the dispositions which enable the person to become a good nurse - to achieve the well-being of those who are vulnerable - which is still the core purpose of nursing.

The common goal of nursing, as it fits into health care, needs to be reaffirmed and restored. Nurses today and in the future need to be highly trained scientists and technicians to meet increased technology in health care. The nurse must therefore be intellectually capable of learning and practising the skills needed to implement technologies. But the nurse must also be a person who is genuinely kind, compassionate and altruistic, committed to performing "menial" and basic caring tasks for the patient, ready and willing to meet the practical needs of an increasingly elderly and perhaps atomised society. It is crucial that people who are recruited into nursing are inducted into both these inseparable aspects. The balance is, and always was, fundamental to the development of the nursing service.

But current nurse education, seated in higher education, does not seem to prepare the nurse for either of these aspects. As the secretary of state for health has affirmed, nurse education needs changing: "Many nurses, when they qualify, think that they lack the practical skills necessary on a ward. The transfer of responsibility to the education sector from the health service has broken the old links between individual hospitals and nurses in training, to the disadvantage of both. Many nurses and nurse managers recognise the need for change, so I hope to carry the profession with us - but reform there must be."³¹ This view is supported by an opposition member, who despite her own part in nursing change, had now come to realise that nursing is ultimately a practical task.³²

The reason for the current problems may be because nursing is not, and cannot be, what it has been made, an intellectual activity to be discussed and analysed; it is primarily, and at its heart, a practical activity, lived out daily in real situations with people needing help. Nursing is not articulated, it is demonstrated by its authenticity. For, as Nightingale taught, the best service a nurse can give is unspoken. The patient is not aware of being nursed, because the best nursing leaves the patient without need.

Theoretical mode

As the government and opposition now recognise, the once practical nature of nurse education has been usurped by a theoretical mode of education. Nurse education has replaced nurse training. For many, the assumption is that nursing should remain, in essence, a vocation: "After all, nursing is a vocation, is it not?"³³ That this is now questionable is related to the fragmentation of the tradition. The problem with nursing is that it has become divorced from its vocational tradition,

and the realisation has dawned that there needs now to be a reformation.

There is an alternative which builds on nursing tradition, and by recovering its purpose could revive its core values. Hospitals, as large health care institutions, could again consider providing nurse training to a recognisable standard of qualification and registration, as they have done in the past. Clinical experts, including physicians, surgeons, psychiatrists, senior clinical nurses, social workers, physiotherapists, dietitians and occupational therapists, could teach nurses. Nurses could learn in the classroom in sandwich-type courses, and on the wards and in community health centres, which might also contribute learning expertise. As with the Nightingale tradition, the objective would be practical, the learning of skill, procedure and technique, together with intellectual and technical knowledge relevant to the clinical context and patients' conditions.

Most critically, however, the emphasis should be learning how to care by developing the necessary virtues, the personal qualities of character that make a clever, knowledgeable and efficient nurse into a "good" nurse. For this to occur, however, student nurses need to learn the truth of moral precepts by example, to see them embodied in the day-to-day care of patients, so they can learn by watching what is done, and the way it is done, not merely by what is said and written. This means reviving the role of the ward sister as both teacher and ward leader, with the primary duty of care, clinical responsibility for both the wellbeing of patients and the clinical development of staff. The ward sister should be central to the observation and supervised instruction of the student in the health care team. This form of apprenticeship is intrinsic to the way of learning to be and become a nurse. In order to make this possible, clinical practice settings need to develop mechanisms of order, routine, structure, method and procedure. As they gradually learn the practicalities of nursing, by the central focus on its purpose - the patient - so student nurses will learn how to care. They will be inducted into a moral tradition, and the moral tradition would thereby be reinforced and reinvigorated. This may appeal to many nurses who come into nursing because they want to be practical carers. It is also reminiscent of the Nightingale model, a creative reappropriation of it.

Conclusion

Comforting, chatting with, holding hands with, feeding, washing, bathing, cleaning, other people when they are sick, were all traditional nursing tasks, and in many circumstances essential for patient care.³⁴ This is no less true at the end of the

twentieth century. Nightingale thought that so tedious a role could not be undertaken as just another paid job; it needed love to do it. For Nightingale the virtue of nursing was inextricably the covenant of care. This was its core moral function and objective, which has fragmented, and now needs to be reinvigorated. In the modern world, it would seem clear that some core moral traditions should be maintained through the professional communities that have embodied them. The moral tradition of nursing is a very good example of this truth.

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News and notes

European Master in Bioethics

A new master's programme in bioethics, European Master in Bioethics, has been developed and is now being offered by four European universities: the University of Nijmegen, the Netherlands, the Catholic University of Leuven, Belgium, Complutense University, Madrid, Spain and the University of Padova, Italy.

It is a two-year programme with sixteen one-week courses on all issues currently relevant to bioethics.

The courses will be held in Nijmegen in March 2000,

in Madrid in September 2000, in Leuven, in March 2001 and in Padova in September 2001.

The programme fee is 15,000 Euro. This includes tuition fees for two years, course material, congress facilities, excursions and four months full board accommodation during the residential months.

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