Lack of care in nursing: Is character the missing ingredient?

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The nature of nursing, the role of nursing in the health service of today, and public and professional disquiet regarding a “crisis of caring in nursing” (Darbyshire and McKenna 2013) are all matters of current debate. Looking particularly at the UK, but not only at the UK, there does indeed seem to be a crisis in caring – at least in some institutions, among some nurses and in terms of some patients and patient groups (Carter 2007, Francis 2013, Parliamentary and Health Service Ombudsman (PHSO) 2011, UK Patients Association 2012). The message that comes from this list of sobering reports is that it is not only individual practitioners who are to blame for providing at best insensitive, disengaged “care” and at worst causing untold distress, danger and even death to very vulnerable people. The leadership, culture, structures and financial imperatives within which these practitioners worked, and perhaps continue to work, are also significantly blameworthy. From my perspective this is a very clear, stark and important message. It is a message we as nurse academics, leaders, members of the public and as potential patients need to heed and engage with.

I have argued previously that an analysis of caring in nursing practice highlights the need for practitioners to develop skills of attention and imaginative identification. These skills enable the nurse to provide constructive care for patients. Constructive care (perhaps like the intention underlying the current nomenclature “compassionate care”) is care which is patient-oriented and rooted in the needs of the individual patient. The identification of patient need is the stimulus and the focus of the nurse’s response (Scott 1995).

".. for constructive care to become an actuality, agent attention must be an ever-present possibility for the practitioner. Agent attention demands the presence of imaginative activity. I also suggest that constructive care,.. assumes the potential for the therapeutic use of the self by the practitioner. This potential only exists if the practitioner has developed the skills involved in attention and imaginative identification. These skills are also central to high-quality role enactment and moral strategy." (Scott 1995: 1200)

Constructive caring places significant demands on the person of the nurse. In other words constructive caring places significant demands on the nurse's character.

I hold the view, confirmed by Mayben (2008) among others, that constructive care, in the above-defined sense is, ideally, the type of care which practitioners wish to provide for their patients. The capacity to provide such care requires that the qualities of character of the practitioner be given some consideration, in the development of programmes used to train or educate practitioners. It also demands consideration of the experiences nursing students are exposed to in clinical placement. The refined and consistent ability to attend and to exercise the faculty of imagination, in a way that enables a compassionate, empathetic response requires the development of dispositions or traits of character in the individual.

In order to provide high quality, sensitive patient care the nurse thus needs to develop qualities or virtues of character in the Aristotelian sense of both virtue and character (Scott 2007). That is the nurse develops enduring traits or dispositions of

character that ensure that s/he, as a practitioner (and as a human being), works from the perspective of habituated good nursing behaviours and, via the help of role modelling and education, develops educated emotion and perception. This enables the nurse to develop *phronesis*, practical reason. Practical reason ensures that the nurse works from the rights motives, at the right time, in the right way and to the right degree. From an Aristotelian perspective (Aristotle 2009) the virtues (excellences of character) integrate fully into the character of the good nurse (as good human being).The good nurse is the nurse who fulfils the function of nursing excellently. As Corbin (2008), Griffiths (2008) and others have argued it is therefore vital to reach agreement on what the function of nursing is and what are, in fact, the excellences of nursing practice.

A preliminary review of the international literature provides clear evidence that nurses and (nursing practice) makes at least two key contributions to patient care: nursing increases the safety and quality of the care received and humanises the patient experience (You *et al*., 2013; Aiken *et al.,* 2002; Institute of Medicine (IoM), 2004; Papastavrou *et al.,* 2011; Needleman *et al.,* 2006; Needleman *et al.,* 2011; Griffiths *et al.,* 2010). Empirical work over the past 10 to 15 years also clearly portrays nursing as multi-dimensional and inclusive of technical, physical, co-ordinating and psychosocial elements or domains of care (see for example Buller and Butterworth 2001, Jinks and Hope 2000, Scott et al 2006).

Griffiths et al (2012) in a qualitative study involving patients / service users and carers reported recently that from a patient/user and carer perspective while technical competence, knowledge and the willingness to seek information are

important, it is the humanising, caring elements of nursing interventions that are particularly valued by patients and health service users. Griffiths et al's research participants "overwhelmingly prioritized 'a caring professional attitude'" (Griffiths et al 2012: 121)

Such caring and caring attitude does not just happen automatically. It must be modelled, taught, worked at and supported. This is precisely what the Aristotelian framework for developing virtues of character would lead one to expect. In order for the nurse to consistently and from the perspective of integrity of character, develop and portray caring – in other words to be a caring practitioner – the nurse must be educated and supported to develop the virtues that underlie caring practice - virtues such as attention, imaginative identification, compassion and the therapeutic use of self.

As Griffith (2008: 331) states:

"Caring is hard and it always has been. I am not sure that I have the answers to our present challenges but the one option that is not open to us is to throw our hands up and to simply say that it is too hard. … Surely the true purpose of our professional training is to give us the practical tools to meet patient need in such a way as to make our humanity sufficiently resilient to shine through. Circumstances may make this more difficult at times but if we cannot add some value to patient care we have surely failed utterly."

Because caring consistently is hard, and demands the consistent development, honing and exercise of particular character traits (virtues) over time, such caring is

character forming and character shaping. As Iris Murdoch argues, “Where virtue is concerned we often apprehend more than we can clearly understand and *grow by looking*” (Murdoch 1970: 31)[1]. If one refuses to look, if one disengages from the weal and woe as well as the triumph and joys of human experience - which nurses are privileged to encounter as part of their every day practice - then one shrinks and desiccates as a person. Consequently one is also likely to provide dis-engaged and perhaps depersonalised care to one’s patients.

The notion of the ‘virtuous nurse’ as a regulative ideal (Oakley and Cocking 2001, Scott 2007), an ideal role model for example, is a useful mechanism in developing nursing virtues. The practising nurse may use such a role model, aspire to it each day, as she tries, in her practice, to rise to the ideals of excellent nursing practice

However, and this is the rub, good nursing care is not only down to the character development and skill of the individual nurse. As Aristotle pointed out over 2000 years ago, the virtues must be fostered in and must work for the virtuous man (or woman). It takes the correct environment and role models to see the virtues in action (Aristotle’s notion of correct exposure) and to develop the habits of the virtues in an individual (Aristotle’s notion of habituation). This individual, who has had exposure, over time, to virtuous action and who has been ‘shaped’, to develop the habits of the virtuous, can then be educated appropriately.

The environment – in this case the environment and culture of the health care organisation within which nurses work – must also support nursing excellence and

[1]Italics in original source.

the virtuous practice of the individual nurse. As the philosopher Nancy Sherman (1997: 5) argues “Virtues are character states that dispose us to respond well to the conditions of life through both wisely chosen actions and appropriate emotions. To live a good life requires acting from such states. But the activity requirement itself presupposes a certain measure of propensity and luck. That is, the good life owes much to agency and effort, but also it owes something to good fortune. Simply to act from virtue in a non-cramped way requires that the world be in some way hospitable to one’s intentions. In a sense, virtuous activity cannot be purely internal but must have some outward success in the world, and thus requires propitious conditions as well as external resources and goods.”

In a recent 12 country international study (Sermeus et al 2010), some results of which have been published in this journal (Van den Heede and Aiken 2013) it is clear that many front line nurses working in medical and surgical units across Europe are concerned with inadequate staffing levels, with rapid throughput of patients, with management’s willingness to respond to nurses concerns regarding safety and quality of care issues. Nurses surveyed in some countries have indicated high levels of burn out and job dissatisfaction (Aiken et al 2012). In considering the Irish data from this 12 country study, nurses have reported concern with regards to what they perceive as inadequate staffing levels and a marked lack of confidence in the willingness of senior managers to address nurses concerns regarding quality and safety of patient care. Nurse participants in 76.7% study hospitals (i.e. 74% of the larger acute hospitals in Ireland) report a lack of confidence that management in their hospitals would respond to patient care problems identified and reported to

management by staff. Moderate to high levels of burnout and job dissatisfaction was also found among the nurses in the Irish arm of the study. Nurses reported that on their last shift not only were a number of basic care tasks left undone – but these "tasks" tended to be those apparently most valued by patients – psychological support, comfort care / talking to patients, patient education and preparation for discharge (Scott et al 2013).

I suggest that we take seriously front line nurses claims regarding inadequate staffing and lack of resources / support. I further suggest that we engage with them in trying to come to a better understanding of what is required to provide excellent nursing care - care that is richly responsive to patient need, that is humane and compassionate as well as technically competent and cost effective – or by default we consider these nurses untrustworthy, misguided, or even miscreants who "couldn't care less" (Darbyshire 2011).

Our frontline nursing colleagues are expected to be not only clinically competent but also attentive, compassionate and sufficiently committed to regularly go the "extra mile" by working many hours per week, month and year beyond their shift to cover staff shortages. They are also expected to respond to each patient as an individual in need of care, to keep smiling, and caring and giving. Only when we really engage with them to map out the resource requirements (including engaged and competent unit/ward based nursing leadership), and then continue to engage with them to ensure such resources are made a reality – then and only then is there a right *simply* to call individual nurses to account. To punish them if they are found individually wanting. Only then can we reasonably absolve nursing and health service leadership

in situations of poor patient care. Only then is it reasonable to see nursing care that distresses, dehumunanises, and damages individual vulnerable people as solely the fault of the individual bad nursing apple; the nurse of weak character who lacks the virtues of nursing.

Treating the so called crisis of care as if it is the fault of individual nurses (or indeed of the academic curriculum), the bad apples of the pack, is not only misguided and dishonest. It is an abdication of professional responsibility. It is a denial of our responsibilities as leaders of our profession with a right and a duty to comment on the health service provided to our societies. If we do not stand up to become part of a solution we will continue to be part of the problem. We will continue to wring our hands and worry about where we as nurse educators of pre-registration nursing students are getting it wrong and /or join in the “stoning” of those who have stumbled. Perhaps our time and resources would be better spent demanding scrutiny of the conditions and clinical nursing leadership (or lack thereof) under which patients are cared for and some nurses are being required to work.

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