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Nurs Ethics 2007 14: 360
DOI: 10.1177/0969733007075874

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The Respectful Nurse

Ann Gallagher

Key words: disrespect; engagement; objects; respect; value; virtue

Respect is much referred to in professional codes, in health policy documents and in everyday conversation. What respect means and what it requires in everyday contemporary nursing practice is less than clear. Prescriptions in professional codes are insufficient, given the complexity and ambiguity of everyday nursing practice. This article explores the meaning and requirements of respect in relation to nursing practice. Fundamentally, respect is concerned with value: where ethical value or worth is present, respect is indicated. Raz has argued that the two ways of encountering value are to respect and to engage with it. The former requires acknowledgement and preservation. Respect in nursing practice necessarily requires also engagement. Respect is an active value and can be conceptualized within the context of virtue ethics as a hybrid virtue having both intellectual and ethical components. Examples from the literature are provided to illustrate situations where the respectful nurse requires these components or capabilities.

Introduction

The sign at the entrance to the small mammals enclosure at London Zoo, England, reads: 'Shhh . . . Please respect the animals by walking quietly'.

Seldom is there such clear action guidance concerning respect in human circles. There is much current rhetoric regarding respect in health care and little clarity about what it means. Professional codes include many references to respect. Respect is also high on the UK government's agenda. Respect seems to be an all-encompassing value and frequently appears in everyday conversation with its opposite, disrespect, or, in street terms, to 'diss'. The boundaries, scope and implications of the application of respect and its relationship to nursing practice are less than clear. Is respect still a meaningful professional value for nurses, and is the idea of a 'respectful nurse' still relevant in the twenty-first century?

Respect is not a new ethical concept in nursing ethics writings; it has appeared from the earliest days. Writing in 1916, American nurse Sarah Parsons referred to respect in her text *Nursing problems and obligations*:

> She [pupil nurse] has definite rights as well as definite obligations. There is much that she should *respect*, but nothing that she need fear, so long as she is entirely honorable in

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> her personal and professional relations. Her soul should be full of courage and aspiration (p. 10).[1]

Contemporary codes make much reference to respect. The UK Nursing and Midwifery Council code,[2] for example, states that nurses must respect the patient or client 'as an individual', must respect patients or clients as 'partners in their care', and must respect their autonomy.

Provision 1 of the American Nurses Association code begins:

> The nurse, in all professional relationships, practices with compassion and *respect* for the inherent dignity, worth, and uniqueness of every individual ... (p. 4)[3]

The Canadian Nurses Association code[4] requires that nurses respect autonomy, wishes, informed choices, a person's advance directive, a person's method of decision making, dignity, physical and informational privacy, all persons, policies, safeguards and the values and responsibilities in the code.

The preamble to the International Council of Nurses code emphasizes respect in relation to rights:

> Inherent in nursing is respect for human rights, including cultural rights, the rights to life and choice, to dignity and to be treated with respect. Nursing care is respectful of and unrestricted by considerations of age, colour, creed, culture, disability or illness, gender, sexual orientation, nationality, politics, race or social status.[5]

Respect has also been adopted by the UK government as a key political idea. The government released a Respect Action Plan and set up a respect task force and a 'respect tsar' focusing on antisocial behaviour. The Respect Action Plan suggests that respect is an unproblematic concept and asserts that:

> Respect is an expression of something that people intuitively understand. It relies on a shared understanding and clear rules and is strengthened by people acting together to tackle antisocial behaviour (p. 5).[6]

What the 'shared understanding' reveals, and what the 'clear rules' are, is not as obvious as the UK government suggests. Respect also appears as a key plank of UK government health policy[7] and there are ongoing concerns about the lack of respect shown to patients in the UK health care system.[8] Respect, then, is a commonly occurring idea but its meaning is not clear and in some instances it is confusing. How should we understand respect and what is the scope of its concern?

Respect: etymology and objects

The etymology of respect from the Latin *respicere* means 'to look back' or 'to look again', to 're-spect'. The 'respect' entry in the *Stanford encyclopedia of philosophy* offers a particularly helpful explanation of the meaning of respect:

> a relationship between a subject and an object, in which the subject responds to the object from a certain perspective in some appropriate way. Respect necessarily has an object: respect is always for, directed toward, paid to, felt about, shown for some object. While a wide variety of things can be appropriate objects of one kind of respect or another, the subject of respect is always a person, that is, a conscious rational being capable of recognizing things, being self-consciously and intentionally responsive to them, and having and expressing values with regard to them. Though animals may love or fear us, only humans can respect – and disrespect – us or anything else (s. 1.1).[9]

The Stanford discussion of respect focusing on the relationship between subjects and objects is a helpful key to understanding respect in relation to nursing ethics. Nurses are both subjects and objects of respect. They are conscious and rational and are 'capable of recognizing things, being self-consciously and intentionally responsive to them, and having and expressing values with regard to them.' From other colleagues' and, perhaps, patients' and societal perspectives they may also be objects of respect. Self-respect requires that they recognize and are responsive to themselves as objects.

'Object' may be considered a contentious term in relation to respect because it may be related to 'objectify' or 'objectification', suggesting that entities are treated or thought of as objects, perhaps reminiscent of Buber's[10] 'I–It' mode of relating, implying detachment and instrumentality. This is quite the opposite of respect. The term 'object' should be taken here to mean the focus or potential focus of respect rather than suggesting how the object is to be treated. These objects are many and various within professional codes and in the literature and media more generally.

Professional codes point to a range of 'objects' that nurses are to respect, for example, individuality, autonomy, dignity, worth, uniqueness, privacy, persons, policy, human rights, cultural rights, and the values and responsibilities within the codes. The distinction between and means to arbitrate among these references to respect within codes is not made explicit. In the literature and media more generally, objects of respect are wide-ranging and are said to include 'religions and their symbols',[11] nurses,[12] clients' homes,[13] students,[14] 'elders',[15] a patient's spiritual needs,[16] and 'persons'.[17] Respect for animals at a zoo and the Stanford definition indicate that, although all these may be objects of respect, they do not have the capability to be subjects of respect because this requires intellectual capabilities in addition to other responses, such as love or fear. This may also apply to humans who have diminished autonomy, for example, people with severe learning disabilities or Alzheimer's disease. There is a wide range of 'objects' that nurses can and should respect. The issue of how nurses negotiate and prioritize these sometimes conflicting 'objects' and what it means to respect them is both interesting and challenging.

Values and the objects of respect

The most influential philosopher of respect is arguably Kant, but later philosophers such as Downie and Telfer, Donegan and Gautier have also been credited with an ethics of respect for persons.[18]

Kant's account focuses on persons as ends in themselves, as entities who have dignity and are worthy of respect on the basis of a person's rational nature and autonomy. In chapter 2 of *Groundwork of the metaphysic of morals* Kant states:

> Rational beings, on the other hand, are called *persons* because their nature already marks them out as ends in themselves – that is, as something which ought not to be used merely as a means – and consequently imposes to that extent a limit on all arbitrary treatment of them (p. Q1).[19]

The concept of '*personhood*' has received attention from contemporary philosophers working in applied ethics to develop arguments regarding who or what is deserving of membership of the moral community and, therefore, deserving of rights. What follows from this are decisions about the treatment of human entities (eg in the abortion

debate, what can and cannot be done to an embryo or fetus[20]). A distinction is made between being human and being a person. Criteria suggested for personhood include reason, consciousness, self-awareness and communication,[21] and the capability to value one's own existence.[17]

There is much to commend a personhood focus for respect because it highlights and, arguably, values the special characteristics of many humans. In working with adult patients or clients who are competent, able to weigh up information given to them and make autonomous decisions, the views of Kant and his followers appear helpful and legitimate. These views prescribe that patients or clients are not to be exploited, disregarded or treated as means to an end. A view of respect that focuses exclusively on rational and autonomous persons has, however, limitations for nursing practice. Nurses provide care to many people who are neither rational nor autonomous and who have compromised capacity. Patients or clients are generally vulnerable and none should be excluded from ethical consideration.

A number of responses can be made to this limitation. The definition of personhood could be adjusted to include those who do not fit the philosophers' criteria. One could also agree that personhood is not the only legitimate object of respect and consider its implications in relation to other values, such as those referred to in professional codes.

There are more inclusive and less limiting perspectives on persons. In writing of personhood in relation to those who experience dementia, Kitwood,[22] for example, emphasizes the relational aspects of personhood. Rather than stressing autonomy and detachment, as suggested in some views of personhood, the interdependence and interconnectedness of human life should, according to Kitwood, be emphasized. Such an approach includes people who experience dementia. Kitwood defines personhood as follows:

> It is a standing or status that is bestowed upon one human being, by others, in the context of relationship and social being. It implies recognition, respect and trust (p. 8).[22]

The connection between respect and persons is made here, but not elaborated on by Kitwood. This view does not exclude those with compromised autonomy and rationality. Respect for persons can then be viewed in less restrictive ways. However, it might be said that respect for individuals or humans (Kitwood writes of 'human beings') works just as well to include those who do not satisfy the criteria referred to above.

Personhood is not the only object of respect and nurses have to negotiate a wide range of objects. What the discussion of respect for persons supports, however, is the importance of working to understand these objects and looking for meanings that are compatible with the philosophy and professional values of nursing practice. If none is found then it seems the object is, perhaps, not an appropriate object of respect. Deciding how and what to value and how to prioritize or rank what is valued with a view to acting in such a way as to convey respect for a particular object requires some understanding of the nature of value and valuing.

People have the potential to value a wide range of objects, both human and non-human. Examples are friendship, music, rugged landscapes, art, meaningful employment, children's jokes, a vegetable patch, privacy, football, celebrity, chess, fast cars and real ale. These objects are valued in different ways and for different reasons. Some may be valued for their own sake and can be said to have intrinsic value (friendship, music and art, for example) and others because they are useful, bring about good

consequences or have instrumental value (they make one laugh, enable one to drive faster or give a warm feeling inside). Some objects could be said to have both intrinsic and instrumental value, for example, privacy and meaningful work. Friendship, music and art may also be said to have instrumental value because a good deal of pleasure and satisfaction can be derived from them. Celebrity does not appear to fit with either category but that is not to say that an argument could not be presented to defend its value, for example, in drawing attention to health problems and in fund raising.

The objects identified in professional codes, such as dignity, privacy, rights, autonomy and so on, are arguably of intrinsic and instrumental value. They are good in themselves as professional values and also bring about good for patients or clients. Persons can also be viewed as having value in themselves, as ends in themselves and as adding value to the lives of others.

Thus far only different kinds of value have been considered; but there is also the nature of valuing in relation to respect. Raz makes explicit the relationship between respect and value, arguing that respect in general 'is a species of recognising and being disposed to respond to value, and thereby to reason' (p. 160).[23] Raz says there are two ways of relating to what is valuable and distinguishes between respecting it and engaging with it as follows:

> We must respect what is valuable and it is wrong not to do so. We have reason to engage with what is valuable, and it is intelligible that we should do so. Sometimes it is foolish, rash, weak, defective in some other specific way, or even irrational to fail to engage with what is of greater value than available alternatives, or to engage with what is of lesser value. But it is not, generally speaking, wrong to do so (p. 6).[23]

Raz describes respect as a 'minimal form of engagement with value'. He outlines three stages of correct response to value. First, there is 'the appropriate psychological acknowledgement of value', meaning that objects are regarded in accordance with their value. Thoughts, imaginings and emotions should be in keeping with the value of the object in question. The second stage refers to preservation and non-destruction. There is, according to Raz, a general reason to 'preserve what is of value' (p. 162).[23] Raz gives the example of respect in relation to the work of Michelangelo:

> Respect for Michelangelo's work consists primarily in acknowledging his achievement in what we say, and think, and in caring for the preservation of the work. This fact reflects another: one need not be among those who spend time examining it and admiring it. Not everyone need be an art connoisseur, or a devotee of Michelangelo's work. But everyone ought to respect his work (p. 161).[23]

These stages of respect beg some interesting and challenging questions in relation to nursing practice. Professional codes provide guidance on what the appropriate objects of respect are (rights, autonomy, individuality, dignity and so on) and the idea 'I acknowledge the value of each of these' seems legitimate. It is less clear what thoughts, imaginings and emotions are appropriate in relation to each of these objects where there is conflict when, effectively, there is a need to prioritize one value object over another. It seems there is also a need to strive to acknowledge value when it is difficult, for example, to work with clients/patients one does not like[24] or find the expression of their autonomy challenging. Similarly, with the second stage of respect, there may be occasions when value is acknowledged but preserving it may conflict with nurses' own values. Providing opportunities for patients to express their autonomy or

individuality and not to diminish their dignity or privacy may be examples of the second stage of a correct response to value and respect.

Engagement is the third stage and goes beyond respect. Raz writes of engaging with value in 'appropriate ways'. It is the first two that he takes to relate to respect but these are 'not enough for a fulfilled life' (p. 163).[23] Respect in relation to nursing, however, requires more than this: it also requires engagement.

Engagement and respect

A weaker and a stronger view of respect is discernable. The weaker view comprises the first two stages of the correct response to value as outlined by Raz, that is, in acknowledging and preserving/not destroying objects of value. A stronger view, going beyond Raz's two-stage view of respect, would also include engagement. It is this latter version of respect that is necessary within nursing practice. Nurses are required to engage with objects of value in addition to acknowledging and preserving them. They are required to engage with value in 'appropriate ways'. Raz offers some guidance here:

> We do so when we listen to music with attention and discrimination, read a novel with understanding, climb rocks using our skill to cope, spend time with friends in ways appropriate to our relationships with them, and so on and so forth.
>
> The first two stages of relating to value contrast with the third. Ultimately, value is realised when it is engaged with. There is a sense in which music is there to be appreciated in listening and playing, novels to be read with understanding, friendships to be pursued, dances to be joined in, and so on. Merely thinking of valuable objects and preserving them is a mere preliminary to engaging with value . . . Yet, obviously no one has to engage with all valuable objects. We need not read all the novels, listen to all the music, climb all the mountains, go to all the parties, dance in all the dances, which are worthwhile (pp. 162–63).[23]

Similarly, it may be argued that nurses need not engage with all objects of value and it is sufficient that they acknowledge and preserve or not destroy them. This could be said, for example, of the hospital environment or the car park attendant. However, in discussing respect in relation to patients, clients and colleagues, engagement is what is required. How nurses engage with such objects of value in 'appropriate ways' requires consideration.

The significance of engagement in nursing practice, particularly in mental health, is acknowledged and, as with respect, is not a new idea. Stuhlmiller relates engagement to the giving of 'full attention' on the part of the nurse. She cites Florence Nightingale as being supportive of this idea:

> All hurry of bustle is peculiarly painful to the sick . . . Always sit down when a sick person is talking business to you, show no signs of hurry, give complete attention and full consideration if your advice is wanted (p. 561).[25]

Thurgood writes of engagement in mental health settings as follows:

> Establishing and maintaining relationships with clients that are experienced as helpful is fundamental to engagement. To do this requires nurses to learn about their clients' unique perspectives and to respect them as valid and meaningful. Respect for the client's viewpoint provides the basis for collaborative working and open negotiation around informed choices for care and treatment (p. 650).[26]

An empirical investigation[27] also found that the values and attitudes that mental health service users most wanted in relationships with mental health workers included respect, optimism, openness and belief in the value of a trusting relationship.

The literature and empirical work relating to engagement is compatible with the third stage of correct value outlined by Raz. All three stages (acknowledgement, preservation and engagement) are necessary components of a meaningful and professional approach to respect. The respect required goes beyond acknowledgement (this client/patient is valuable for his or her own sake and in relation to others) and preservation (I need to do what I can to preserve and not destroy her or his dignity, privacy or autonomy). It requires also engagement. Engagement as a component of respect requires effort, paying close attention to clients, getting to know them in all of their individuality, listening actively, taking them seriously and working with them to respond appropriately. This may involve speaking up on their behalf and intervening when their own perception of self-respect is inadequate to uphold a sense of their own worth. That is, it has positive elements requiring action or intervention and also negative elements requiring withholding, passivity and non-intervention.

This view is compatible with those of Dillon, who emphasizes perceptual and deliberative components of respect:

> The idea of looking belongs also to many words used synonymously with 'respect': for example, 'regard' (from 'to watch out for') and 'consideration' ('examine (the stars) carefully'). This suggests that respect is not merely *about* its object but is *focused* on it. So *attention* is a central aspect of respect: we respect something by paying careful attention to it and taking it seriously . . . This attention is, moreover, a kind of response to an object: we re-spect things that are worth looking at again . . . Thus there is, so to speak, a dialogic dimension to respect as well as a perceptual one. At the same time, respect is deliberative; it is a matter of directed rather than grabbed attention, of reflective consideration. In this way it differs from immediate attraction and fascination, for we can refuse to heed the call (p. 110).[28]

In short, respect requires acknowledgement, preservation of what is valuable and an active engagement with clients. Respect is necessarily an active value requiring reflection, understanding, appreciation, attention and action. 'Doing' respect in everyday practice is not, however, always a straightforward matter.

Respect, clarity and ambiguity

Perspectives on respect emanating from the dictionary definition[9] of subject and object and from the development of Raz's analysis to three rather than two stages of correct response to value, do much to clarify the nature of respect in everyday nursing practice. Nurses are both subjects and objects of respect. As subjects of respect they demonstrate value for objects considered worthy of value. Codes of professional conduct prescribe appropriate objects to be respected, for example, autonomy, individuality, rights, dignity and so on. To respect in the stronger and necessary sense requires that nurses acknowledge the value of objects, that they preserve and not destroy them and that they engage with them. In some situations this will seem reasonably straightforward. Nurses may, for example, acknowledge and preserve the value of autonomy in relation to competent clients. They may spend time with clients, request that a physician return to clarify a point of confusion and ensure that clients

have had sufficient opportunity to express their views and be heard. Nurses will then act upon clients' decisions. They have effectively acknowledged, preserved and engaged with clients and thus respected their autonomy. Many everyday nursing situations involving respect are not so clear. One such is relayed by Bennett.

In *Untold stories*, the novelist Alan Bennett[29] writes of the experience of visiting his mother in a nursing home in Weston-super-Mare, England. He finds that she is wearing a 'fluorescent-orange cardigan' and a skirt that she would, he surmised, have considered 'common'. Bennett poignantly describes how his efforts to obtain a response from his mother are in vain. Mrs Bennett's carers, on the other hand, take a different approach. They have taken to calling her 'Lily' and engage in banter. Bennett writes:

> The staff do it differently; make a good deal more noise than I do for a start, and one of the maids now erupts into the room and seizes Mam's hand, stroking her face and kissing her lavishly:
> 'Isn't she a love!
> 'Aren't you a love!
> 'Aren't we pretty this morning!
> 'Who's going to give me a kiss? . . .
> 'Aren't you good, Lily? You've eaten all your mince.'
> And Mam purses her lips over her toothless gums for a rewarding kiss. Twenty years ago she would have been embarrassed by this affectation of affection as I am. But this person is dead, or forgotten anyway, living only in the memory of this morose middle-aged man who turns up every fortnight, if she's lucky, and sits there expecting his affection to be deduced from the way he occasionally takes her hand, stroking the almost transparent skin before putting it sensitively to his lips.
> No. Now she is Lily who has eaten all her mince and polished off her Arctic Roll, and her eyes close, her mouth opens and her head falls sideways on the pillow.
> 'She's a real card is Lily. We always have a laugh.'
> 'Her name's actually Lilian', I say primly.
> 'I know, but we call her Lily' (p. 117–19).[29]

Bennett is in a position to know about and to inform the reader about his mother's past preferences and preferred name. He acknowledges that his efforts to engage with his mother are unsuccessful and that the noisy and affectionate interventions get a response.

How should we think of the responses of Mrs Bennett's carers? Are these carers 'doing' respect? Without the carers' perspective on the scenario it is impossible to know. They may, for example, have acknowledged her value as a human being and could argue that they do what they can to preserve her physical and emotional well-being by ensuring she is fed and amused from time to time. They may have considered and tried out alternative ways to approach Mrs Bennett and concluded that this was the one that was most effective in eliciting a reaction from her and for obtaining some semblance of a pleasurable response. Equally, they may be unreflective in their practice and become accustomed to dealing with those in their care as incompetent beings rather than individuals with histories, experiences or preferences, treating them in an infantilizing way.

Working with clients who experience dementia or who are unable to express their preferences for other reasons is challenging. Bennett writes of his mother as a person who is dead or forgotten. It seems plausible that Bennett kissing her hand sensitively demonstrates respect, and that calling her 'Lily' when she had previously been called

'Lilian' and dressing her in clothes Mrs Bennett would have considered 'common' is disrespectful. A degree of engagement is demonstrated, but it is questionable if this is sufficient for respect. In situations like this it is not always clear what is respectful and what is not.

The philosopher and novelist, Iris Murdoch, talked of her experience of dementia as 'sailing into darkness.' Her husband, John Bayley, wrote of her deterioration in sometimes harrowing detail. He described how, for example, she was sometimes pacified by watching children's television and by being engaged in nonsensical talk. He writes:

> Just after ten, as part of the BBC 2 children's programme, the Teletubbies come on. One of the few things we can really watch together, in the same spirit. 'There are the rabbits!' I say quite excitedly. One of the charms of this extraordinary programme is the virtual reality landscape supplied. An area of sunlit grass – natural – dotted with artificial flowers beside which the real rabbits hop about. The sky looks authentic as well, just the right sort of blue with small white clouds ... The creatures emerge, four of them, in different coloured playsuits ... They trot about, not doing much else, but while they are there Iris looks happy, even concentrated (p. 158).[30]

How different are the responses of Bennett and Bayley to the predicament of their loved ones? Bayley is not unaware of the perceived status of those in similar states to those of his partner. He writes, for example, rather shockingly, of one woman's view of her husband who also had dementia:

> The lady who told me in her own deliberately jolly way that living with an Alzheimer's victim was like being chained to a corpse, went on to an even greater degree of facetiousness. 'And as you and I know, it's a corpse that complains all the time.'
>
> I don't know it. In spite of her anxious and perceptual queries Iris seems not to know how to complain. She never has. Alzheimer's, which can accentuate personality traits to the point of demonic parody, has only been able to exaggerate a natural goodness in her (p. 59).[30]

It may be said that detailing and making public the decline of Iris Mudoch in this way is not respectful of her memory. Bayley's excited response to the Teletubbies could also be viewed as not dissimilar to the jollying along of Mrs Bennett's carers. In both cases there may be an acknowledgment of the value of the women and the motivation to preserve them. The accounts also suggest that both men, in their different ways, aspire to engage with their loved one in challenging circumstances. These accounts suggest that, in similar situations, nurses need to consider what authentic engagement means so that they are in a position to respect patients in their care.

Respect and disrespect: a view from the inside

What should have become clearer is that knowing what respect requires and 'doing respect' in everyday nursing practice is not always easy. This is particularly so when working with clients who have difficulty expressing their preferences or views about their care. There continues to be a good deal of evidence (research and anecdotal) of disrespect in health care practices. Reflecting on perceptions, experiences and implications of disrespect sharpens our understanding and emphasizes the importance of respect. A throwaway remark, an askance glance, an avoidance or generally disrespectful treatment has the potential to impact negatively on aspects of human

flourishing. Disrespect has the potential to diminish, if not eliminate, the possibility of flourishing in all aspects of those involved, be they patients or relatives. Disrespect also makes those who are vulnerable more so and has the potential to harm in the most devastating ways. It has also been suggested that the 'disrespect of society' directed towards those experiencing dementia is 'extended, by association, to those who care for them.'[31] If further justification were needed, an aspiration to more respectful attitudes, care and treatment is also likely to benefit nurses who work with this and other vulnerable client groups.

What is required, then, is a richer account of respect that goes beyond action guidance and that requires attention to human flourishing and ethical and intellectual capabilities that enable nurses to perceive and pay attention, to interrogate complex situations and to aspire to an engagement with patients that values and integrates their past and present selves. This may also require engagement with relatives. If, for example, carers had engaged with Mrs Bennett's son it is most likely that they would have learned more about her past preferences and there was the opportunity to incorporate this into her current care.

In professional codes and declarations respect is generally referred to as a right or as a duty. Rules from codes and declarations highlight what it is that nurses and other professionals should respect. However, considering respect as a virtue better accommodates this complex value. The virtue of respectfulness contributes to the flourishing of patients and nurses. The views based on Raz's approach provides a helpful framework for the stages of appropriate responses to value (acknowledge, preserve and engage) but it does not go far enough in suggesting how, when and to what degree nurses need to do this. Flourishing, or *eudaimonia,* is a central feature of virtue ethics and very relevant to discussions of a value that has such potential to enhance or diminish flourishing. The doctrine of the mean, a central component of an Aristotelian approach to virtue ethics, is particularly helpful in suggesting that the virtues could be expressed to excess or deficiency and, as Aristotle states:

> virtue aims to hit the mean. By virtue I mean moral virtue since it is this that is concerned with feelings and actions, and these involve excess, deficiency and a mean. It is possible, for example, to feel fear, confidence, desire, anger, pity and pleasure and pain generally, too much or too little; and both of these are wrong. But to have those feelings at the right time on the right grounds towards the right people for the right motive and in the right way is to feel them to an intermediate, that is, to the best degree; and this is the mark of virtue (p. 101).[32]

Aristotle does not discuss respectfulness, but the doctrine of the mean also applies here: if nurses are too respectful they are likely to be overly deferential and sycophantic. If they are deficient, they will be disrespectful. This perspective is also compatible with the view that respectfulness needs to be expressed towards the right objects and in the right way.

Respectfulness is both an other-regarding and a self-regarding virtue. If nurses are respectful, they will gain in terms of their flourishing and are likely to enhance the flourishing of patients and others. Respectfulness is also, necessarily, a hybrid virtue having ethical and intellectual components. Respectfulness does not only require the acknowledgement of value and the appropriate expression of thought and emotion in relation to value objects but also perception and deliberation to distinguish it from other related responses such as toleration. Given its complexity and the fact that it is

applied to a wide range of value objects in sometimes ambiguous and uncertain situations, respectfulness is very much a twenty-first century nursing value. Respectfulness also requires exercise of moral imagination to engage appropriately with the lives of people who are unable to express common to objects of respect such as autonomy. The challenge for nurses is to obtain and respond to views from the inside: from within the lives of patients and their families, engaging with their past interests and preferences and, where possible, present interests and preferences.

Conclusion

Respect and respectfulness, its virtue equivalent, are fundamentally important to human flourishing. Sennett says:

> Respect is an expressive performance. That is, treating others with respect doesn't just happen, even with the best will in the world; to convey respect means finding the words and gestures which make it felt and convincing (p. 207).[33]

Respect is not, however, only performance. Nor is it merely acknowledgement and preservation of value. It also requires meaningful engagement. It suggests the importance of views from the inside and, where possible, of the inside. This is particularly the case when patients are unable to express themselves and to make their preferences known. Respect also requires authenticity and not merely appearance. It requires a disposition to do and to be respectful. Respect is an active value requiring always an aspiration to betterment. The respectful nurse strives to acknowledge, preserve and engage with the intrinsic and instrumental value of all patients.

Acknowledgements

I wish to thank the two anonymous reviewers for thoughtful and challenging comments and Paul Wainwright for conversations and feedback that contributed to the development of this article. Thanks are also due to colleagues who attended a seminar and participated in discussion at Kingston University, where I shared the beginnings of this work.

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