



EDITORIAL

On 1 March this year, a Conservative member of the upper house in the UK made some remarks during a debate in the House of Lords that shocked most people who heard them. He had been a patient in a hospital some months earlier and described the nurses who had looked after him there as 'grubby ... slipshod and lazy ... [and] drunken and promiscuous'.¹ The reactions were strong in both the general and the nursing media and one cannot help but wonder if reactions were so strong because they contained some truth, or because they were so far from the truth that nobody recognized them. It was his generalization that upset most people. If he had legitimate complaints to make about individual nurses he should have addressed them to the relevant person, not voiced them in Parliament.

One comment made in the nursing press was that this criticism reflected the connection between the environment in which nurses work and themselves. 'It is not unreasonable that patients expect to be nursed in a clean environment by nurses whose personal grooming complies with organization policies as this may engender confidence in the care they receive.'² The author suggested that nurses had only themselves to blame as they had largely stood by and watched infection control, as a direct outcome of cleanliness, becoming politicized. 'Nursing needs not only to be responsive to patients' perceptions, but must be aware of where these perceptions come from and become more active within the agencies that shape them.'

Nurses are representatives of their institutions and the cleanliness of a hospital is not simply someone else's job. If cleanliness has become politicized, this may be due to many factors, not only if it is part of nurses' remit. The argument could be that nurses have other and more important things to be concerned about than dirty bathrooms and dusty corridors. Yet, it is also not unreasonable to consider the environment in which nurses work to have an influence on the nurse-patient relationship, the quality of care possible, the theoretical basis on which the profession rests, and, indeed, on an understanding of what care ethics is about. The best-written essays and articles on lofty themes of good care ring hollow when nurses are unable to ensure that their immediate care environment is up to acceptable standards.

The articles in this issue are not concerned with standards of cleanliness as such, but with various points about different orders of reasoning. Maybe an issue such as cleanliness and personal behaviour may also need to be addressed at some stage in order to have a rounded, even holistic, sense of what nursing is about.

A point of financial concern is described by Kristin Halvorsen and her colleagues, who studied decisions made in intensive care units in the light of national policies of rationing and justifying care costs. Perhaps not surprisingly, these authors found no significant decisions being made on the basis of finance in this setting. This may be a very different scenario from other health care systems and is an interesting study of societal decision making.

The Mexican health care system is undergoing a process of change, and Edith Valdez-Martínez and co-authors studied how health care workers of different ranks and competencies respond to the challenges faced. Working conditions that favour quality care and the establishment of recognizable values for staff to apply in the work environment do seem to be needed.

Barbro Wadensten and her team in Sweden and China compared working conditions of nurses in neurological care and found similar experiences of stress and concerns despite very different health care systems in these two locations.

Similarly, Tomasz Brzostek and colleagues compared newly graduated and experienced nurses' responses to questions about their views on palliative care and euthanasia. Not surprisingly, the new graduates were less often able to recognize the differences present in the situations concerned.

Marit Helene Hem and her team used a situation in a psychiatric unit to study trust, but found that it is actually distrust that seems to operate in such situations. To find out how trust can be built and maintained is their aim.

The restriction of freedom imposed on intellectually disabled people is used as an example in an essay about dialogical ethics by Tineke Abma and her colleagues. Explaining the reasons behind actions and involving the clients in discussion are seen as the way forward, but the point is that dialogue and how and why it is conducted matters in any relationship between clients and professionals.

Susan Instone and co-authors discuss a finding of 'therapeutic misconception' as a by-product of a study on informed consent. The understanding by study participants of drug trials as 'treatment', even when receiving placebo, is troubling and calls for clarification.

'When is patient education unethical?' asks Barbara Redman. She answers the question by highlighting patient capabilities as a necessity for them to be able to choose and act in their social setting.

Loredana Sasso and a group of nurses from different European countries describe the construction of a Code of Ethics and Conduct for European Nursing. Much of the Code is printed in an appendix.

A variety of topics are thus addressed in this issue, all with the clear intention of improving care for patients and clients in different ways. Does the profession also need to look at itself occasionally, at how it deals with the kind of issues discussed here in relation to patients? In order to act ethically with the people who are clients, we also need to look at ourselves and our motives and ways of treating each other ethically.

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References

- ¹ Nurses denounced as dirty lazy drunks [News item]. *The Times Online*, 1 March 2008. Retrieved 20 May, 2008, from: <http://www.timesonline.co.uk/tol/news/politics/article3462808.ece>
- ² Cole M. An honest account or fuel for the media fire? *Br J Nurs* 2008, **17**: 412.