BEING A GOOD NURSE AND DOING THE RIGHT THING: A QUALITATIVE STUDY

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Key words: ethics; good nurse; nursing ethics; virtue ethics

Despite an abundance of theoretical literature on virtue ethics in nursing and health care, very little research has been carried out to support or refute the claims made. One such claim is that ethical nursing is what happens when a good nurse does the right thing. The purpose of this descriptive, qualitative study was therefore to examine nurses’ perceptions of what it means to be a good nurse and to do the right thing. Fifty-three nurses responded to two open-ended questions: (1) a good nurse is one who . . . ; and (2) how does a nurse go about doing the right thing? Three hundred and thirty-one data units were analysed using qualitative content analysis. Seven categories emerged: personal characteristics, professional characteristics, patient centredness, advocacy, competence, critical thinking and patient care. Participants viewed ethical nursing as a complex endeavour in which a variety of decision-making frameworks are used. Consistent with virtue ethics, high value was placed on both intuitive and analytical personal attributes that nurses bring into nursing by virtue of the persons they are. Further investigation is needed to determine just who the ‘good nurse’ is, and the nursing practice and education implications associated with this concept.

Background and significance

Research on the place of virtue ethics in nursing practice is essentially non-existent, despite increased attention in the theoretical nursing and health care literature. According to Kelly, ‘ethical nursing is what happens when a good nurse does the right thing’ (p. 27). This study explores qualitatively the meaning of ‘good nurse’ and ‘doing the right thing’ from the perspective of the American nurse in practice. While other cultures and countries use the term good nurse more freely than is found in the American literature, the American nurses in this study acknowledged the importance of being, as well as doing, as they describe the good nurse and the efforts made to do the right thing.

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Nursing is by nature a moral endeavour. Literature in the field has long reflected an interest in the moral development of nurses and how ethical decisions are made. Most of the early studies in nursing were based on the theoretical work of Lawrence Kohlberg, and focused on a variety of issues, including moral development, ethical decision making and actions, effects of education on moral development and ethical decision making, and instrument development.

Based on the theory of cognitive development, Kohlberg claimed that moral judgement consisted of a sequence of stages that represent a consistent logic that can be abstracted from the content of a variety of situations. Although quickly recognized as the predominant theory of moral development, Kohlberg’s work met with growing criticism in the mid-1980s. From a nursing perspective, the most serious criticism was that of gender bias. Kohlberg’s model was developed using an all-male sample. When applied to male and female groups, the women’s moral development results were consistently lower than those of the male participants.

Gilligan claimed that the lower levels of moral development identified in women did not reflect lower levels of moral maturity. Instead, she argued that women operate from a different perspective to men, and that this perspective is not accounted for in Kohlberg’s theory. Gilligan, and others, claimed that women evaluate ethical situations according to an ethic of care. This ethic of care, which emphasizes relationships and responsibility, is different from the ethic of justice, which emphasizes individuality, autonomy and rights. Although Kohlberg’s theory measured the ethic of justice used primarily by men, it did not effectively measure the ethic of care used predominantly by women.

Parker responded to the controversy as it relates to nursing: ‘Should the nursing profession subscribe to an ethic of justice or an ethic of care? The answer is probably not either/or but both/and’ (p. 217). Based on the realization that the past conceptualization of moral development and ethical decision making had been too limited, a new paradigm began to emerge by the mid-1990s, which embraced both justice and care perspectives. However, while the empirical literature began to reflect both the justice and the care perspectives, the general theoretical literature in health care ethics was already taking a new, more comprehensive, view of moral philosophy. Virtue ethics, with its roots in Aristotelian thought, was gaining new attention and led many to question if even the broader principle-based (i.e. justice and care) understanding of morality was still too narrow.

Virtue theory

As part of the larger field of moral philosophy, virtue ethics theory focuses on the character of the agent. According to Aristotle, moral virtue is a state of character. Virtues are located within the character of the person. Loewy argues that the basic issue of health care ethics is the character of the person, not whether or not that person comes in contact with ethical quandaries. In virtue ethics, the formation of the character determines conduct. There is an ‘internal subjective element [that is] not ... easily accessible to the public’, which provides the normative standard for action.
Acts cannot be understood without knowledge of the inner character and intention of the actors. Character and values precede conduct and relationships. Values are embedded in what it is to know the good, and are reflected in the character of the person. One seeks an excellence – a telos – in traits of character that is based on reason, not emotion, centred on practical judgement, and learned by practice. Virtue ethics focuses on the agent, on his or her intentions, dispositions and motives. The normative standard is the good person. Furthermore, virtue is acquired, not inherited. One learns by seeing what the virtuous or good person does. The theoretical basis for virtue ethics is that the person wants to do good, to be good, and to act on the good.

Some critics argue that virtue ethics lacks a standard of reference in the circular reasoning that is evident in the claim: the good is what a good person does. Without an accepted societal norm for the good person, virtue ethics can be difficult to apply. However, others contend that the absence of a moral compass for all humans does not preclude the establishment of normative standards for professions based on the telos (or ends) of that profession. Therefore, the notion of doing good, being good, and acting on the good can be effectively situated within the normative practice and standards of the profession of nursing.

Contemporary nursing authors have used the term good in virtue or existential contexts. Good is addressed in Nightingale’s nineteenth-century writing: ‘You cannot be a good nurse without being a good woman,’ she was fond of saying. Personality traits may lead the nurse to nursing; however, these inclinations ‘may not be sufficient when exposed to the conflicts inherent in healthcare’. Davis speaks of the being and doing of nursing in relation to a telos or ideal of nursing: ‘We all look not only at doing, but at being, not only at duties and obligations but also at virtues, not only at conduct but also at character’. According to Sarvimaki’s model of moral knowledge, morality is a way of being that presupposes moral integration, ‘that is, the integration of theoretical, personal situation and action knowledge’. Virtue and character are complementary to principles and rules for action.

To Bishop and Scudder, being a good nurse means that the nurse’s concern for patients is:

- integrally related to efficient, effective and attentive care which fosters the well-being of my patient. Even when I am not directly concerned with my patients’ well-being, I am focused on ways of fostering their well-being because I am engaged in a practice with an inherent moral sense (p. 36).

Kelly echoed Bishop and Scudder’s position in claiming that ‘ethical nursing is what happens when a good nurse does the right thing.’

Although the terms ‘good nurse’ and doing ‘good nursing’ are often mentioned in nonresearch-based nursing publications from other countries, American references are rare. Of the nine research reports about the ‘good nurse’ in the Cumulative Index of Nursing and Allied Health Literature for the period 1982 to March 2001, only one involved American subjects. Four of the studies were from the UK, and one each was from Sweden, Finland, Canada and China. Five of the nine studies focused on nursing students, leaving four that examined the responses of nurses in practice.

Hicks research with nurse managers in the UK utilized descriptors of the...
good clinician randomly selected from a list of adjectives that appeared in basic nursing and clinical nursing textbooks. The four adjectives randomly selected were: kind, compassionate, good communicator and reflective. However, the analysis of randomly selected adjectives from nursing texts adds little to a comprehensive understanding of virtue ethics in nursing. Häggman-Laitila and Åstedt-Kurki found a discrepancy in client expectations of nurses when compared with nurses’ views of their own roles. The clients in this Finnish study identified personal traits such as appropriateness and kindness, just and equal treatment, and genuineness and honesty. Nurses believed they should provide holistic, health-orientated, patient-centred care. The affective and virtue-orientated nature of patient expectations could be important in defining the fundamental moral requirements of nursing practice. Kelly’s follow-up study of nurses in the two years following graduation found that the informants tended to evaluate their own actions against their moral convictions and their standards of what a good nurse would do.

Robertson sought to determine if ethics theory was useful in describing the approaches doctors and nurses take in everyday patient care. His ethnographic study on more than 20 doctors and nurses on a Canadian medical ward revealed that, while a common commitment to liberal and utilitarian principles was evident among both doctors and nurses, nurses placed much greater weight on relationships and character virtues when applying the principles. The commitment to beneficence was evident in all staff, but virtue and relationship conceptions of beneficence were voiced far more often by nurses (16 events) than by doctors (three events). One nurse responded: ‘Many qualities needed to become a good nurse [as opposed to a good doctor] have more to do with character and morality’ (p. 295).

**Significance**

Nursing’s preoccupation with dilemma ethics and the care/justice debate has slowed progress in developing a more comprehensive moral philosophy for nursing practice. This has, in turn, slowed the implementation of research-driven approaches. A growing interest in virtue theory in the health care literature, and a mirrored interest in the theoretical nursing literature, led the authors to use Kelly’s statement that ‘ethical nursing is what happens when a good nurse does the right thing’ to explore qualitatively the meaning of ‘good nurse’ and ‘doing the right thing’ with American nurses in practice.

**The study**

A qualitative study was conducted to answer the research question: who is the good nurse and how does he/she go about doing the right thing? One of the two researchers was conducting a series of one-day conferences around a midwestern state on the topic of ethical nursing practice, and Institutional Review Board approval was received to recruit study participants from among the conference attendees. Before the conference started (so participants were not biased by the conference content), attendees were told about the study and given the opportun-
nity to participate. Conference attendees who chose to participate were asked to respond in writing to the following two open-ended questions: (1) a good nurse is one who . . .; and (2) how does a nurse go about doing the right thing? Fifty-three registered nurses responded to the two questions, many providing multiple responses to each. Content analysis, which is designed to categorize words according to their theoretical importance, was used to analyse the data according to the following steps: (1) determine the unit of analysis; (2) develop the set of categories; (3) define the categories; and (4) provide illustrations to guide the coding of data into categories. The first step of the content analysis yielded a total of 331 separate meaningful data units, which included the responses to both questions, with each unit referring to one meaningful thought (in the form of a word, a phrase, or a group of sentences). Each written data piece was placed on a separate index card, and the researchers immersed themselves in these 331 pieces of data, separating similar data pieces into a variety of evolving categories. Eventually, seven categories emerged from this analysis process that were consistent with, and inclusive of, all the data pieces. Although the data from the two respective questions were analysed separately, they fell into the same seven categories (step 2), and their respective definitions (step 3) and illustrations (step 4) followed.

Results

The seven categories that emerged from the content analysis were: personal characteristics, professional characteristics, knowledge base, patient centredness, advocacy, critical thinking, and patient care. The following presentation provides the definition of the categories, examples of the raw data that fit in those categories, and the number of data units in each category.

Personal characteristics

This category consists of all those attributes the good nurse brings into nursing by virtue of the person he or she is, and how he or she demonstrates those attributes in everyday life. Examples include, but are not limited to: caring, compassion, respect for self and others, and general communication patterns. Participants wrote such comments as: ‘Truly cares about people’, ‘flexible’, ‘compassionate’, ‘respects self’, ‘having outstanding “people” skills’, ‘she listens’, ‘takes good holistic care of self’, and ‘respects others’ feelings and beliefs’. This category accounted for 49 of the responses to the first question and 22 of the responses to the second question.

Professional characteristics

This category consists of all those aspects of the nurse’s practice that exist by virtue of his or her being a member of the nursing profession. This includes his or her commitment to those he or she serves, as reflected in: (1) the nursing profession’s code of ethics; (2) various nurse practice acts; (3) various standards of care; (4) his or her own philosophy of nursing and code of ethics; and (5) role
modelling to further the profession of nursing. Specific comments in this category included: ‘acts within the scope of current nursing practice’ and ‘being a role model to the public and the profession’. Although this category represented only 11 responses to the first question and seven to the second, the content area was unmistakable.

Knowledge base
This category reflects all the facts, information and skills necessary for the nurse to be or recognize himself or herself as competent, or to admit when he or she needs help. The knowledge base includes both: (1) a professional knowledge base, which is general nursing knowledge attained through basic and continuing education and experience; and (2) a situational knowledge base, which is patient-specific knowledge acquired through assessment. Comments in this category included: ‘open and willing to enhance skills and knowledge base’, ‘is competent in performing nursing procedures’, and ‘trust[s] her previous experience’. Twenty-six of the first question responses and 13 of the second fell into this category.

Patient centredness
This category reflects the principle of being patient orientated, sometimes to the extent of giving the patient priority over all others (including self). In this category, participants made comments such as: ‘always keeps patient needs and desires first ahead of standards or policies’, ‘puts her patient’s best interests first’, and ‘I believe that nurses have a responsibility to all members of a care team, but more importantly to the patient.’ A small category in terms of responses (11 from the first question and nine from the second), this content was stated explicitly by the participants and could not be ignored.

Advocacy
This category reflects the principle of empowering others, or, if necessary, looking after and/or intervening on behalf of patients’ or clients’ interests. Specific comments included: ‘strongly advocates for the patients’ choices (although these may not be her [the nurse’s] own)’ and ‘able to perfect the fine art of being supportive’. Again, although this content accounted for a relatively small number of responses (13 responses to each question), they were so explicit that this category was essential.

Critical thinking
This category consists of the reflective analysis needed to make appropriate and/or right judgements or decisions, to make the judgement or decision itself, and to plan and evaluate the outcome. This requires that the nurse should continually ask questions, clarify information, and consider a variety of options. This also requires that the nurse should broadly consider a variety of different and sometimes conflicting perspectives in the light of personal and professional
morals or codes, clinical or patient knowledge and information, and affective or intuitive knowing, as he or she makes decisions about patient care. Participant nurses wrote such comments as: ‘finds a balance between obligations and patients’ rights’, ‘she needs to follow her gut feelings’, ‘think through situations – not just react and follow standard nursing procedure’, ‘by following their [nurses’] conscious [conscience]’, ‘requires introspection’, and ‘by looking at all sides of the situation at hand’. The second question produced 47 data units in this category, while the first produced only six. However, the six responses to the first question clearly referred to critical thinking as defined in this study; for example, in answering the first question another participant said: ‘uses sound judgement to select a course of action to solve a patient’s problem and/or provide care’.

Patient care

This category refers to the actual application or performance of safe, competent nursing care, including the unique way the nurse expresses himself or herself in caring for and about patients. This includes emphasis on communication and teaching, and particular attention to addressing individual patient needs. This process also includes the use of available and appropriate family members, health care team personnel, and health systems resources to provide holistic care to the patient and the family. In the hands of the good nurse, this process culminates in the best quality care possible. For example, participants wrote: ‘following through with what the patients’ needs are’ and ‘collaborates with the entire health care team to facilitate care’. This category had a large number of responses to both questions: 53 for the first and 51 for the second.

Reliability and validity

One of the weaknesses of content analysis is the risk of subjectivity in the analysis of data. To address this issue, the co-investigators conducted a weekly analysis of the data individually, as well as a joint weekly comparative analysis. When the categories and definitions were established, the two co-investigators checked inter-rater reliability, using the formula that reliability equals the number of agreements divided by the number of agreements plus disagreements per category. The initial reliability ranged from 0.85 to 1.0 for the first question categories, and 0.78 to 1.0 for the second. Reliability was re-established six weeks later with a range of 0.70 to 0.96 for the first question and 0.75 to 1.0 for the second.

After establishing reliability between the two investigators, a graduate student was given a list of the categories and their definitions, and asked to sort the data units accordingly. The reliability between the graduate student and two investigators ranged from 0.70 to 0.96 for the first question and 0.67 to 1.0 for the second. After discussion, two category definitions were slightly revised (as reflected in this article): the phrase ‘supporting others’ was removed from the advocacy category because it was easily confused with support provided in the patient care category; and the phrase ‘identifying and’ was removed from the patient care category because it was easily confused with the assessment aspect of the
knowledge base category. With these two minor revisions, the final reliability coefficients ranged from 0.86 to 0.96 for the first question and 0.86 to 1.0 for the second.

Limitations

Four limitations to this study bear mention before discussing the results. First, this was a small study that needs further research support. Secondly, the convenience sample of conference participants who volunteered to take part may reflect a bias based on the ethical topic of the conference they were attending. However, although the sample may have had a preset interest in ethical issues, that did not necessarily include a bias towards any particular ethical stance. Thirdly, the interview questions indicated a bias towards the language and issues presented in the literature: the ‘a good nurse is one who . . .’ question reflects a predominantly virtue ethics approach, while the ‘how does a nurse go about doing the right thing’ question reflects a predominantly quandary ethics approach. The questions were also biased towards positive, as opposed to negative, responses. Finally, collecting written data from anonymous participants made it impossible to gain clarification or elaboration on the responses, which may have limited the study results.

Discussion

Kelly suggests that, as student nurses move into the real world, moral distress results because their actions cannot be reconciled with their ‘moral convictions and their standards of what a good nurse would do’. Such references to the ‘good nurse’ suggest some standard, but there are no empirical data to support what that standard is, much less how it changes as one moves from student nurse to practicing nurse. This study investigated practicing nurses’ understanding of who the good nurse is and how he or she goes about doing the right thing; several interesting findings emerged.

The authors were surprised to find that the responses to both written questions fell naturally into the very same seven categories. When this interpretation first emerged it produced great consternation that was assuaged only as further analysis continued to support the emerging categories. Although the two questions were undoubtedly biased towards the prominent perspectives in the literature (quandary ethics and virtue ethics), nothing suggested that they had to be answered similarly. This finding may indicate that, in these nurses’ minds, there was a strong connection between being a good nurse and doing the right thing. Davis also refers to the being and doing of nursing: ‘[W]e all look not only at doing, but at being, not only at duties and obligation, but also at virtues, not only at conduct but also at character.’ This connection between being and doing supports the recent popularity of virtue ethics, which, rather than focusing only on the moral actions themselves, looks to the person’s character as the foundation and source of ethical action.

In addition to this connection between being and doing was the unexpected
emphasis placed on the category of the personal attributes that nurses bring into nursing as the persons they are. Almost 30% of the 169 responses to the first question fell into the category of ‘personal characteristics’. Although the ‘patient care’ category also accounted for about 30% of the responses to this question, that finding was far less surprising to the authors because of the historical importance that care giving has had for nurses. The personal characteristics pattern was further emphasized by the fact that the third highest percentage category (‘knowledge base’) accounted for only 15% of the responses, and the remaining four categories combined accounted for only 25% of the responses to the first question. Wilson and Startup reported a similar abundance of personal traits when asking sisters and charge nurses in Wales to describe the ‘good nurse’. Personal characteristics identified by the nurses included: is pleasant, keen to learn, empathetic, dedicated, conscientious, and able to communicate; possesses common sense; and takes initiative. Similarly, when Häggman-Laitila and Åstedt-Kurki asked patients about their expectations of nurses, they reported personal characteristics such as appropriateness and kindness, just and equal treatment, and genuineness and honesty. This emphasis on personal characteristics supports the inclusion of virtue ethics in the ethical decision-making discussion.

Another point of particular interest was the variety of critical thinking approaches (from ‘follow her gut feelings’ to ‘think through situations’) to ethical nursing taken by the participants. This finding supports the position that the traditional justice or care dichotomy for explaining nurses’ ethical decision making is far too confining. It also supports the variety of findings on ethical decision making in the nursing literature, which range from structured process, to interrelated processes with varying degrees of structure, to no process at all in lieu of a collection of experiences and feelings used by nurses to make moral choices. These various critical thinking approaches, when taken in conjunction with the emphasis on the character of the nurse taking action, suggest the need for a much broader interpretation of ethical decision making. Ethical nursing is more than just analytical skill, and perhaps even the addition of intuitive prowess does not capture the whole experience. Rather, ethical nursing is embedded in the wholeness of each person as he or she becomes the good nurse doing the right thing.

**Implications**

These findings suggest several implications for nursing education, practice and research. Character is established at a young age and fostered throughout childhood and adolescence, so schools of nursing need to reconsider how best to assess not only the objective, but also the subjective, characteristics of applicants. In addition, schools of nursing need to preserve the didactic portion of their programmes while, at the same time, designing affective components of their curricula to foster the development of a strong professional ethos. The results of this study also apply to practicing nurses. Continuing education programmes must incorporate teaching strategies that address both the cognitive and virtue aspects of ethical decision making. Practicing nurses must also help to establish the standard reference for the good nurse as that concept emerges from nurses’ collective...
experience, and professional codes and standards. This study clearly supports the necessity of including virtue ethics in the ethical decision-making conversation and, with so little research conducted on this topic to date, these findings open a floodgate of potential research studies in this subject area.

**Summary**

Virtue ethics, seen as the notion of a good nurse and good nursing, is apparently alive and well, but exactly what that means or who it refers to is still in question. Perhaps the terms have been used so often that a simple shared meaning is assumed or the lack of empirical data has been overlooked as being too obvious; but, what little empirical data are emerging on the topic suggest that what it means to be a virtuous, good nurse, is anything but simple or obvious. Rather, it is an extremely complex notion that needs more investigation.

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