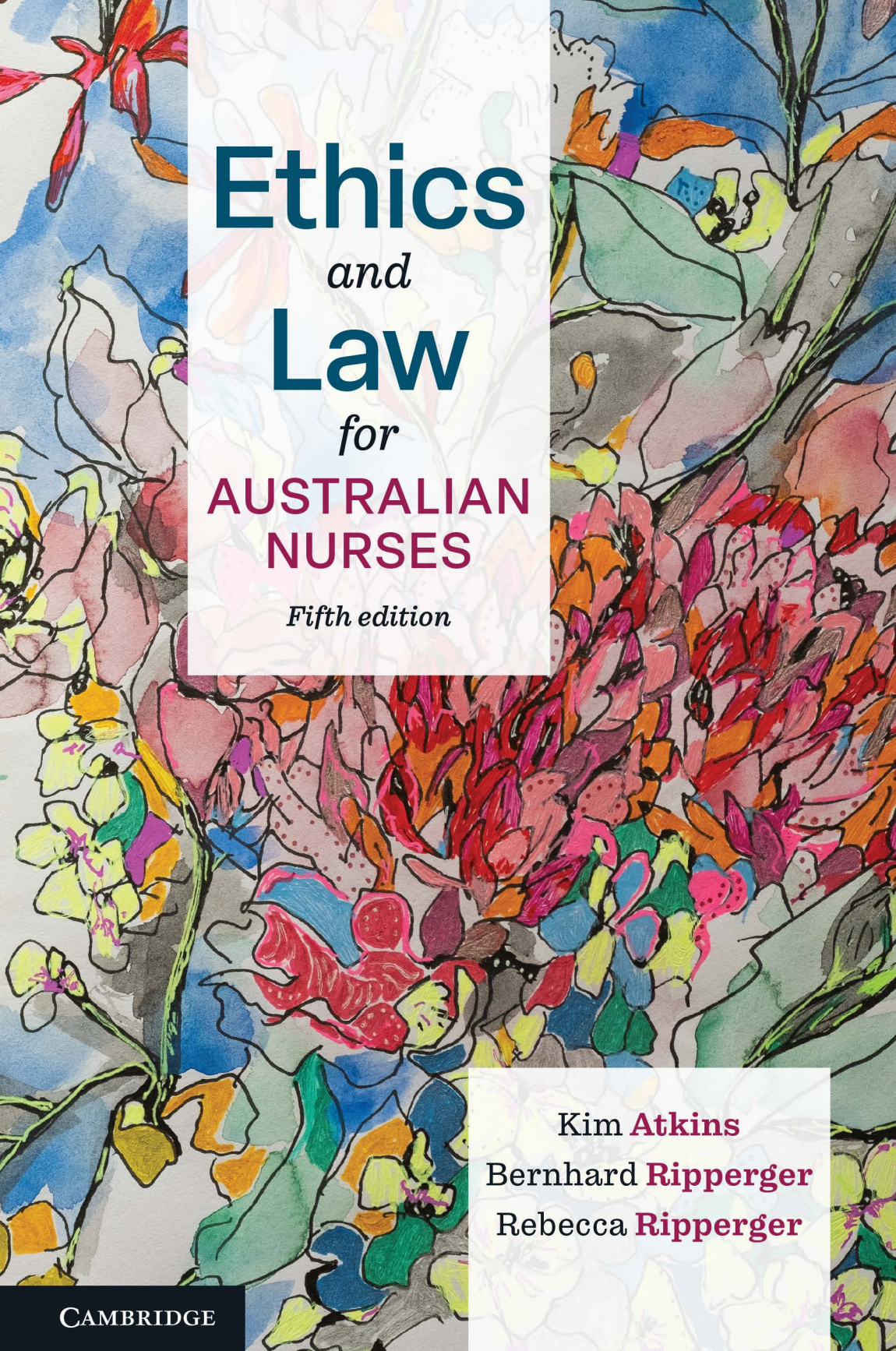
Ethics
and
Law
for
AUSTRALIAN
NURSES
Fifth edition
Kim Atkins
Bernhard Ripperger
Rebecca Ripperger
CAMBRIDGE

Ethics *and* Law *for* AUSTRALIAN NURSES

Fifth edition

Every day, registered nurses are required to act and make decisions based on their moral and legal obligations. They must build professional, culturally safe relationships with patients, understand patient rights and the requirements of consent, and prevent and manage clinical mistakes in order to avoid negligence and abuse of power.

Now in its fifth edition, *Ethics and Law for Australian Nurses* guides students through foundational concepts such as personhood, autonomy, trust, consent and vulnerability, and considers a nurse's responsibilities in relation to voluntary assisted dying, abortions and advanced care directives. It explains the Australian legal system and how it relates to nursing practice.

This edition discusses the impact of the COVID-19 pandemic, particularly on elderly Australians, as well as on injury and negligence claims. It includes updated discussions on guardianship, assisted dying, abortion and 'not for resuscitation' orders. This book uses thought-provoking reflective questions to help students broaden their own perspectives and consider various ethical dilemmas, with answers for each question available online. Law and Ethics in Practice case studies show how concepts can be applied in real-world scenarios.

Ethics and Law for Australian Nurses is a comprehensive guide for nurses on providing morally and legally responsible and culturally safe care for patients in Australia.

Kim Atkins is Adjunct Associate Professor of Philosophy at the University of Tasmania, and Education Manager at Laurel House. She was previously a registered nurse and specialised in intensive care nursing for over 20 years.

Bernhard Ripperger is Director, Community Protection in the NSW Department of Communities and Justice. He has worked as a government lawyer for almost 25 years, and has taught philosophy at Macquarie University and the University of Wollongong.

Rebecca Ripperger works in the NSW Department of Communities and Justice. She was previously a registered nurse and worked in the hospital system for over 20 years.

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INTRODUCTION

KIM ATKINS

This book has been written specifically for nurses training and practising within Australia, to assist and encourage them to develop a strong and well-defined sense of professional and moral identity. It endeavours to provide an integrated, practical framework for understanding the ethical and legal dimensions of nursing practice in Australia by referencing Australian law and reflecting the Australian clinical context and cultural norms.

This book refers to 'patients' rather than 'clients'. The question of which term is most appropriate is not easily resolved – if it can be at all – because there are many ways to interpret both terms. Consequently, we have made the decision to use the term 'patients' because it best approximates our use of the concept of vulnerability. We do not regard patients as people who are either in a contract with the nurse or merely passive and dependent on the nurse; rather, they are people who are in a relationship of power with the nurse because they are in specific situations of need. Under Australian law, this is considered a fiduciary relationship – that is, one in which the nurse is recognised as having superior knowledge and therefore more power than the patient, but the patient's authority in decision-making carries more legal and moral force. To represent patients as people who have a merely contractual or dependency relationship with a nurse would be to misrepresent their situation and to obscure the ethical and moral implications of the context of care. A patient's need and vulnerability in the context of a nurse's power constitute the source of the nurse's moral and legal obligations. Therefore, the nurse–patient relationship occupies centre stage throughout this book.

This book takes a 'relational' approach: it emphasises the centrality of relationships to nursing practice at both the theoretical and practical levels. For example, at a theoretical level the book explains personhood as a set of capacities that develop from birth and are sustained throughout life through relationships with other people. It traces the moral basis of law to our need as human beings to live together in societies, and the accompanying need to be protected from harm produced through the activities of people living in close proximity to one another. It also describes how, at a personal level, particular relationships can facilitate or erode an individual's sense of self and self-respect. This can occur, for example, through giving recognition of achievement and providing affection and encouragement, or by withholding these. The ability of relationships to impact profoundly on our lives

underpins the importance of having professional boundaries and legal constraints on what nurses can do in their clinical relationships with patients.

Nurses are required to care for and protect the interests of people who are sometimes vastly different from them. How nurses respond to these differences is a measure of their humanity. In being permitted to take a role in the innermost personal lives of people, nurses have a rare opportunity to experience a relationship that can be emotionally and morally profound. Some of the most intimate experiences of life can be found in nursing: delivering a new child into the world; holding the hand of a dying man as he takes his final breath; restarting a person's heart; or consoling someone after a death in the family. In sharing these fundamentally defining experiences of human mortality, the nurse–patient relationship can deeply affirm our connections to one another.

Nurses discover that relationships work in both directions. Nurses receive far more from their patients than is often understood because when nurses honour their patients' needs – their feelings, their hopes and fears, and their bodies – they show themselves to be trustworthy, compassionate, respected and professional. By having the opportunity to act with integrity, compassion, confidentiality and competence, nurses make themselves worthy of trust and respect, and experience their lives as worthwhile and meaningful. This is why so many find nursing to be a deeply satisfying and sustaining occupation.

We begin by setting out a description and philosophy of what a person is, and endeavour to show throughout the book how that understanding of persons underpins the moral and legal obligations of nurses. Understanding persons also means understanding the different stages of life, and the different needs, concerns, aspirations and possibilities experienced at these different stages. Rather than proclaim what those needs and possibilities are, this book encourages nurses to talk to their patients, to listen to them and to learn from them. Patients teach nurses much more, and do so far more effectively, than any book ever could. To this end, case studies in this book have been taken from real life, with many of them providing a view of the clinical setting from the patient's point of view.

This book does not set out to provide a narrative of the good nurse. Rather, it provides a coherent set of conceptual resources and information to guide nurses in their relationships with vulnerable people in the clinical context. It promotes a patient-centred approach, for example, by emphasising the need for decisions about care to be informed by the patient's perspective and personal circumstances; for the patient to actively participate in decision-making; and for the patient to set their own terms for the clinical relationship and treatment wherever possible.

In focusing on the nurse–patient relationship, this book foregrounds the patient's vulnerability. Vulnerability is here used in a technical sense, and it is

important for readers to understand this. Vulnerability refers to the fact that we are constantly affected by, and responsive to, other people and the world around us, in both positive and negative ways. In other words, vulnerability simply means *being affected by* people and things. We can be affected positively – for example, by the pleasure and nutrition of good food. We can be affected negatively by the pain and disability of injury or disease. This book presents the view that no person is immune to being affected and influenced by others. This view is significant because it underpins the central claim of this book: that it is our ability to be affected by another person that makes it possible for us to care for each other.

The vulnerability of people receiving nursing care is recognised in law. There are some specific pieces of legislation that relate to particular situations of vulnerability, such as the various Mental Health Acts in each state and territory, the *Disability Discrimination Act 1992*, and the *Children and Young Persons Act 2008* (ACT) (and its equivalent in the other states and territories), while other situations of vulnerability are recognised more generally in common law. Because nurses are also vulnerable, they have certain legal and moral entitlements and protections. For example, nurses have a moral entitlement to be treated with respect, and have legal protection from accusations of assault in relation to certain professional activities – for example, some involving touching or restraining patients. The connections between each clinical situation and its relevant legislation will be explained throughout the book.

Chapter 1 describes how we each *become* persons over time and through our relations with other people. This makes personhood fundamentally relational and interpersonal: we become who we are – with our tastes, talents and abilities – as a result of our interactions with the environment around us and the people in it. Moreover, this is a lifelong process. The idea that we are always in formative relations with the environment and other people is part of the concept of human vulnerability. Vulnerability can be understood as an expression of our belonging to the world with other people, and it is this belonging together in the human world that drives our capacities to care for one another. This is why skills in managing interpersonal relations and communication are central to the nursing role.

Chapter 2 provides an overview of the Australian legal system, its structure, function and philosophical underpinnings. It explains the differences between legislation, common law, criminal law and civil law, and illustrates how these are relevant to nurses and the profession.

Chapter 3 focuses more closely on the nurse–patient relationship. This relationship is called a therapeutic relationship because its function is to have a beneficial effect on the patient. In other words, the nurse–patient relationship is itself a form of therapy because nursing care is inseparable from the relationship. This chapter explores several different models of professional relationship,

and explains the nature and obligations of the fiduciary relationship. It then discusses how the therapeutic relationship embodies the moral principles of non-maleficence, beneficence, autonomy and justice. Consistent with the two-way direction of relationships, it also considers some moral dangers of the relationship to both nurse and patient, and concludes with a consideration of the ways in which the therapeutic relationship can promote capacity-building in patients.

Chapter 3 also describes the regulation of nursing practice in Australia and explains why this is a necessary part of ensuring the safety and quality of clinical care. It sets out the roles of the Australian Health Practitioner Regulation Agency (AHPRA) and the Nursing and Midwifery Board of Australia (NMBA) in setting the training and practice standards for nurses and midwives, and handling complaints, investigations and disciplinary hearings.

Chapter 4 addresses the legal framework for valid consent to treatment and refusal of treatment, which is based on the right to autonomy (as discussed in Chapter 3). It considers situations where a person cannot legally consent – for example, where the person is a child or is unconscious – as well as situations where consent is not needed, such as in a medical emergency, where there is serious mental illness or where a patient needs to be restrained for their own safety. The chapter also explains the place of guardianship, advocacy and the use of advance directives in protecting a person's autonomous decision-making.

Chapter 5 takes a detailed look at the concept of negligence, and how it is tied to the nurse's duty of care towards their patients. It explains how a failure to meet that duty of care can lead to a legal finding of negligence against a nurse. It describes how a nurse's required standard of care is determined in law, and how negligence is proven (or defended). It also explains a nurse's legal liability and professional indemnity, as well as the employer's vicarious liability for the actions of nurses.

Chapter 6 looks at the cultural and ethical considerations that are relevant to nursing people from diverse cultures, with a focus on nursing Aboriginal and Torres Strait Islander people. It is important to remember that Aboriginal and Torres Strait Islander peoples are diverse groups who live a variety of lifestyles, from highly traditional to highly modern, on tropical islands, in remote deserts and in suburbia. Indigenous culture encompasses elements from ancient practices to contemporary technology. Appreciating the complexity of Indigenous Australian culture and its historical context is fundamental to providing ethical and therapeutic care.

Chapter 7 continues the focus on the nurse–patient relationship by examining legal and moral requirements around patient privacy and confidentiality, and mandatory reporting. It explains requirements in relation to the management of patient information, including reporting of child abuse, family violence and professional misconduct.

Chapter 8 takes up themes of power, autonomy and advocacy in decision-making about care. Trust is central to negotiating treatment in the nurse–patient relationship because the patient does not choose to enter into a relationship with the nurse. The chapter looks at the nature and scope of trust, and considers the extent to which nurses can be expected to accommodate patients' wishes.

Chapter 9 turns the focus more closely onto the nurse through a discussion of issues of professional self-respect, with a special focus on reporting mistakes and clinical incidents. It looks at factors that influence nurses' decisions about reporting, and explains the importance of dealing effectively and ethically with clinical errors and incidents – for the sake of both patients and nurses. Admitting to mistakes has a number of important moral and practical effects for nurses, including restoring their self-respect and putting the patient back at the centre of care.

Finding the courage and the words to admit mistakes can be facilitated in the workplace by employing specific approaches. Chapter 9 discusses an approach developed in the United States, and adopted worldwide, known as 'Giving Voice to Values' (Gentile 2010). This is a structured practical approach that helps individuals develop the skills they need to speak out when they know they should. The chapter concludes with an explanation of the open disclosure process as a means of restoring trust and justice to the clinical relationship.

Chapter 10 looks at some of the legal and ethical dimensions of two high-profile situations: abortion and euthanasia. These situations are often discussed together because they concern the limit of human vulnerability (in death) and the limit of human freedom (in determining who can legitimately kill). Our mortality matters to us; accordingly, how we die matters to us, as individuals and as a society. For these reasons, issues relating to abortion and euthanasia have tended to attract considerable public attention and invoke powerful emotions, regardless of which point of view is taken. Much of the debate around abortion and euthanasia concerns how successful the law can be in protecting the vulnerable from harm while respecting individuals' autonomy. This chapter considers some of the main ethical arguments for and against euthanasia and abortion, and sets out the relevant legal frameworks for nurses. In the previous few years, voluntary assisted dying laws have been introduced to all Australian states, but not the Australian Capital Territory and Northern Territory, which are subject to Commonwealth legislative control. While nurses often have a special interest in the morality of abortion and euthanasia, the nurse's role is clearly prescribed by law, and failure to act within the law can result in criminal charges of assault or even manslaughter.

Chapter 11 discusses ethics and aged care, with a special focus on the ways in which nurses can support the autonomy of elderly people. An older person's autonomy begins to deteriorate as the processes of biological decline begin to

affect a person's mobility and mental acuity to a degree that obviously impacts their normal activities of living. One of the implications of the process of ageing is that the greatest potential for the nurse to have an impact on a person's autonomy lies within the sphere of activities of daily living. While ethical issues such as euthanasia tend to capture the public imagination, it is at the level of everyday living that the most profound ethical impact is felt. It is at this level also that the dangers (and complexities) of elder abuse typically manifest.

In any book that attempts to discuss law or ethics in relation to nursing practice, there is always much more that could be said – and so much more in a book that attempts to discuss both. This book has tried to steer a path between the need for detail and the need for economy of explanation in order to assist training nurses to orient themselves to the complex and sometimes perplexing world they will face: the world of working with fellow human beings. The world of nursing can be like the cosmos in miniature: stunningly beautiful, utterly amazing, compelling, alarming, hilarious and frightening. We hope this book is a reliable resource for navigating that world, and that it provides an opportunity for student nurses to reflect upon their own values, beliefs and attitudes as they work toward becoming the kind of people they want to be.

Online resources

Reflective questions appear throughout each chapter to help you to revise the content and draw connections with your own practice. Downloadable answer guides for these questions are provided in the online resources at www.cambridge.org/highereducation/isbn/9781009236027/resources.

Further reading

Cashin, A. (2017). Standards for practice for registered nurses in Australia. *Collegian*, *24*(3), 255–66.

Gentile, M. (2010). *Giving voice to values: How to speak your mind when you know what's right*, Yale University Press.

Hewitt, J., White, B. & Del Villar, K. (2021). Voluntary assisted dying in Victoria: Why knowing the law matters to nurses. *Nursing Ethics*, *28*(2), 221–9.

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1 UNDERSTANDING THE HUMAN PERSON

KIM ATKINS

LEARNING OBJECTIVES

In this chapter, you will:

- ➔ Develop your appreciation of the complexity of the concept of 'person'
- ➔ Develop your understanding of 'personhood' as a relation between the biological, interpersonal and social aspects of a human being
- ➔ Develop an understanding of human vulnerability, and how this makes the capacity to care for each other possible
- ➔ Reflect upon the ways in which your beliefs about yourself affect your capacity to care for yourself and others

In 2004, the Chief Justice of the Family Court of Australia, Alistair Nicholson, made a determination that a 13-year-old child (known as Alex) could proceed with medical treatment that would permanently change that child's gender from female to male. Justice Nicholson noted that Alex had the physical appearance of a girl and normal female chromosomes, but had a 'longstanding, unwavering and present identification as male' (*Re Alex* [2004], para. 80; see also Atkins 2005).

In coming to a coherent determination of what was in Alex's best interests, Justice Nicholson gave due consideration to Alex's personal and family history; Alex's subjective perception of his situation; the nature of Alex's relationships with family and friends; and the relevant scientific and medical information pertaining to Alex's mental, physical and sexual health.

The case of Alex has guided legal decision-making since 2005. Experiences such as Alex's raise questions about the nature of human identity:

- ❯❯ What is the connection between the physical body and a person's psychological outlook?
- ❯❯ What part do early life experiences play in shaping a personality?
- ❯❯ What part do social influences play in shaping a personality?
- ❯❯ Is there an essential defining quality that all persons share?
- ❯❯ What is gender, and in wat sense does it matter?
- ❯❯ Where do we get our ideas about persons, sex and gender, as well as what is proper or improper?

As a nurse, you will be called upon to support, care for and protect people who are vastly different from yourself. How you respond to the diversity of human beings will be a measure of your own humanity as well as your professionalism. The NMBA

Code of Conduct and the ICN Code of Ethics are designed to support you in this. Certainly, caring does not come as easily to some nurses as it does to others. After all, it is not always pleasant being around incapacitated, sick or grieving people. So why do people want to support the ill or incapacitated? What is it about human nature that causes people to care for each other *at all*?

This chapter will provide a response to this question through a philosophical account of being a person. This account describes being a person as a dynamic unity of personal factors (such as biology and psychology); interpersonal factors (such as relationships with immediate family and close friends); and social factors (such as type of education, or socioeconomic status). We each become an individual person with a unique identity as a result of complex processes involving all these factors (Atkins 2008; Laceulle 2018). The formation of our identity begins with the biological processes of sexual reproduction and pregnancy, followed by our early life experiences in the care of our parents. Later, we come under the influence of formative relationships of friendship, schooling and other social interactions. In addition, our personal identities are formed within our social context, which is itself the outcome of powerful historical and cultural forces. Consequently, a basic feature of being human is to be constantly affected by, and responsive to, other people and the world around us – in both positive and negative ways. This feature of human life – being affected by the people and things around us – is called vulnerability. This concept will be discussed in more detail later in the chapter, where you will see that vulnerability lies at the heart of our capacity to care for each other (Mackenzie 2020; Petherbridge 2021).

Central to this approach to the human person is the idea that we each *become* a person through a complex range of developmental processes. Becoming a person entails the acquisition of a range of physical, cognitive, emotional and interpersonal capacities, which develop over time as the human body develops, and grow through relations with other people. For example, as young children grow, they develop the ability to walk and climb, to communicate and to self-regulate emotions. These skills allow a child to understand the actions of others and to join in cooperative activity. As a result of participating in simple cooperative activities, children acquire the capacity for more sophisticated social skills, such as patience, perspective-taking and negotiation. The philosophical point here is not simply that a person has to acquire social skills to get on in life, but rather that the individual acquires the skills of personhood in a social context. Furthermore, it is from their social context that individuals develop the beliefs, attitudes and expectations that make up their personalities. Understanding individuals as (partly) the product of

the society in which they grow and learn reverses the commonly held assumption that a society is the result of individuals who come together voluntarily to secure goods that an individual could not acquire alone. This book takes the approach that persons only ever emerge *from* societies. This means that a person's culture and cultural identity are highly significant because culture is a fundamental source of the meaning a person can find in their life. This is why cultural safety – having one's culture acknowledged and treated with respect – matters to us all; it therefore has a central place in the delivery of appropriate and effective nursing care. We will discuss cultural safety in Chapter 6.

In the example at the beginning of the chapter, Justice Nicholson's decision about Alex can be seen to draw upon the personal, interpersonal and social factors that have influenced Alex's personal identity. Justice Nicholson considered Alex's physical condition, and the biological and medical data related to it. He also considered Alex's early life relationships, especially his relationship with his father. Finally, he considered Alex's experiences at school and his current (as well as possible future) social situation. Justice Nicholson placed these considerations in the context of the requirements of law, including relevant legal precedents and current medical consensus. In doing so, he put together a complex picture of Alex as a young person who is both affected by and responding to his circumstances, a young person with certain physical and psychological states who is part of a circle of family and friends, who has certain social responsibilities and disadvantages, and who – like most other people – simply wants to live a life that will allow him to overcome his personal and social difficulties and thrive. In short, we understand who Alex is when we grasp the 'story' (or narrative) about his life. Every person that a nurse will come across is someone who is both affected by and responding to their circumstances. They will be someone who has physical and psychological states; who is part of a circle of family and friends; who has certain social responsibilities and disadvantages; and who is striving to live a life of their own. The person and their health issues are part and parcel of that broader context.

In setting out guidelines for nurses' and midwives' conduct when caring for persons, the Nursing and Midwifery Board of Australia's (NMBA) Code of Conduct for Nurses and the International Council of Nurses' ICN Code of Ethics for Nurses recognise the personal, interpersonal and social factors that make up a person (NMBA 2018b; ICN 2012, 2021). These have been set out in Tables 1.1 and 1.2 respectively. The most up-to-date information, standards and guidelines for nurses and midwives can be found on the NMBA website (www.nursingmidwiferyboard.gov.au).

TABLE 1.1 NMBA's Code of Conduct for Nurses

PRINCIPLE	VALUE
1 Legal compliance	Nurses respect and adhere to their professional obligations under the National Law and abide by relevant laws.
2 Person-centred practice	Nurses provide safe, person-centred and evidence-based practice for the health and wellbeing of people and, in partnership with the person, promote shared decision-making and care delivery between the person, nominated partners, family, friends and health professionals.
3 Cultural practice and respectful relationships	Nurses engage with people as individuals in a culturally safe and respectful way, foster open and honest professional relationships, and adhere to their obligations about privacy and confidentiality.
4 Professional behaviour	Nurses embody integrity, honesty, respect and compassion.
5 Teaching, supervising and assessing	Nurses commit to teaching, supervising and assessing students and other nurses to develop the nursing workforce across all contexts of practice.
6 Research in health	Nurses recognise the vital role of research to inform quality healthcare and policy development, conduct research ethically and support the decision-making of people who participate in research.
7 Health and wellbeing	Nurses promote health and wellbeing for people and their families, colleagues, the broader community and themselves and in a way that addresses health inequality.

Source: NMBA (2018b).

TABLE 1.2 The ICN Code of Ethics for Nurses

ELEMENT	STANDARD
1 Nurses and people	The nurse's primary professional responsibility is to people requiring nursing care. In providing care, the nurse promotes an environment in which the human rights, values, customs and spiritual beliefs of the individual, family and community are respected. The nurse ensures that the individual receives accurate, sufficient and timely information in a culturally appropriate manner on which to base consent for care and related treatment. The nurse holds personal information in confidence and uses judgement in sharing this information. The nurse shares with society the responsibility for initiating and supporting action to meet the health and social needs of the public, in particular those of vulnerable populations. The nurse advocates for equity and social justice in resource allocation, access to health care and other social and economic services. The nurse demonstrates professional values such as respectfulness, responsiveness, compassion, trustworthiness and integrity.
2 Nurses and practice	The nurse carries personal responsibility and accountability for nursing practice, and for maintaining competence by continual learning. The nurse maintains a standard of personal health such that the ability to provide care is not compromised. The nurse uses judgement regarding individual competence when accepting and delegating responsibility.

ELEMENT	STANDARD
	The nurse at all times maintains standards of personal conduct, which reflect well on the profession and enhance its image and public confidence. The nurse, in providing care, ensures that use of technology and scientific advances are compatible with the safety, dignity and rights of people. The nurse strives to foster and maintain a practice culture promoting ethical behaviour and open dialogue.
3 Nurses and the profession	The nurse assumes the major role in determining and implementing acceptable standards of clinical nursing practice, management, research and education. The nurse is active in developing a core of research-based professional knowledge that supports evidence-based practice. The nurse is active in developing and sustaining a core of professional values. The nurse, acting through the professional organisation, participates in creating a positive practice environment and maintaining safe, equitable social and economic working conditions in nursing. The nurse practises to sustain and protect the natural environment and is aware of its consequences on health. The nurse contributes to an ethical organisational environment and challenges unethical practices and settings.
4 Nurses and co-workers	The nurse sustains a collaborative and respectful relationship with co-workers in nursing and other fields. The nurse takes appropriate action to safeguard individuals, families and communities when their health is endangered by a co-worker or any other person. The nurse takes appropriate action to support and guide co-workers to advance ethical conduct.

Source: ICN (2021).

Each of the chapters in this book is informed by this picture of the human person. Chapter 2 explores how the law has an important role in stabilising society and supporting relationships of trust between people. Chapter 3 focuses on the interpersonal nature of the nurse–patient relationship, and Chapter 5 looks at the legal obligations and implications of that relationship. The understanding of the human person as embodied, social and vulnerable is central to the discussions of consent and autonomy in Chapters 4 and 6, and the role of confidentiality, trust and respect is the focus of Chapters 7 and 8.

Nursing is a profession that encompasses a huge diversity of practices and practice settings. As the population of Australia ages, the focus of health care increasingly is turning to the management of chronic disease through primary health care, self-management and disease prevention through health promotion. That means that we can expect to see more nursing practice taking place in the

broader community rather than in acute-care settings, such as hospitals. This cultural shift highlights the importance of nurses having a good understanding of the nature and diversity of human beings, and of the many ways in which people live, flourish, become ill, age and die.

What is a person?

SOME BACKGROUND TO THE CONCEPT

Since the purpose of nursing is to support and promote the health and well-being of persons across the lifespan, it is important to good nursing practice that nurses have a robust understanding of the concepts of 'persons' and 'well-being'. In other words, in order to understand the needs of any individual person – as well as what constitutes a person's well-being – nurses need to have a sound understanding of what a 'person' is in general.

It is important to note that, at different times and in different places, there have been very diverse ideas about the characteristics of persons, and about who can be included in the community of persons. For example, the ancient Greeks believed that, in addition to purely human persons, there were people who were the offspring of humans and gods. Ancient Egyptian hieroglyphs depict people with a human torso and a dog's head (called 'cynocephaly'). Even today, a wide range of concepts exist pertaining to what a person is. Some people believe that ghosts are persons, or that the possession of a soul distinguishes persons from non-persons. Others – for example, the ethicist Peter Singer (1993) – believe that chimpanzees can be considered persons because they have self-awareness and a concern for their lives. Based on Singer's definition, rational, self-aware aliens from distant planets (if they were to exist) could also be considered persons.

On the other hand, at different times in history, various groups of humans have been excluded from the status of persons for a range of reasons. For example, in the past, women, Indigenous peoples and slaves were claimed to lack sufficient intellectual and moral capacity to make them full persons. Today, the concept of the person continues to be philosophically challenging. Recently, scientists in Italy successfully integrated human body tissue and artificial components to restore a man's limb function, and work has been underway for some time to repair paralysing spinal injuries with artificial nerve conductors. These kinds of medical achievements raise the question of how much of an individual's body can be replaced with artificial components while they can still be regarded as being a human being. Movies such as *Blade Runner* and *Ex Machina* play around with these ideas.

There is no *single* attribute common to all persons by which any individual can be said to be, or not to be, a person. Ideas about what constitutes personhood have varied from age to age and from culture to culture, and no doubt will be different in the future. The way philosophers express this situation is to say that personhood is 'discursive' – that is, 'personhood' is a loose concept comprising a set of attributes that hang together more or less coherently, and that are broadly agreed upon by a community. It is a flexible concept, the boundaries of which are determined differently at different times and in response to different issues. One dreadful example of this occurred in Germany and European countries under Nazi occupation during World War II. Under this regime, people of the Jewish faith, homosexuals and people with certain disabilities were excluded from the category of persons, and were imprisoned and executed on the basis of a racist ideology of Aryan supremacy (Tatz 2003). Clearly, where a society draws the line between persons and non-persons matters because, overall, the suffering of non-persons is valued less than the suffering of persons.

In Australia, the legal system and mainstream social institutions and practices presuppose three basic features of persons: first, that only members of the species *Homo sapiens* are persons; second, that persons are embodied beings; and third, that persons are socially situated.[1] These three features can be seen, for example, in the legal regulations concerning human births and deaths, and the practice of abortion. When a birth is registered, the child's name is recorded, as is the name of the mother (and father if possible) and the date and place of birth, then a birth certificate is issued. This legal process is extremely important because it marks the child's entry into the community and entitles the child to all the legal rights and protections of the laws of the community. The birth certificate is one of the first formal, legal ways in which a child is given social *recognition* as a person.[2]

REFLECTIVE QUESTION 1.1

What kind of features characterise persons?

In Australia, we do not require dogs or cats or horses to have birth certificates because those animals are not recognised as members of the community of persons. We still value and care about our animals, and they do have some legal protections, but the role and legal entitlements of animals are nothing like those of persons. Only those beings who are recognised as persons can have all the

rights and responsibilities of citizenship. These rights include the right to hold a passport, own and sell property, vote and consent to medical treatment and so on. However, the birth certificate is not the only way in which legal recognition of one's membership of the human community can be bestowed. Indigenous people living in remote areas, immigrants and refugees may be unable to trace their birth records because of different cultural practices, war or social upheaval. In these cases, other means can be used to establish the person's legal status, such as sworn testimony of someone from the person's place of origin. Such testimony is simply another form of social recognition of personhood.

PERSONHOOD IS A RELATION BETWEEN THE BIOLOGICAL, INTERPERSONAL AND SOCIAL ASPECTS OF A HUMAN BEING

The practical approach to personhood on which this book is based takes as its starting point some biological and social facts about human life. In exploring these ideas, we must keep in mind that some human beings may temporarily or even permanently lose some of the capacities and attributes of persons. While the loss of all capacity does not mean that such human beings automatically lose our moral consideration or their legal standing, it can affect how they are regarded by other people. Some of these human beings will be among the most vulnerable people that you will encounter as a nurse. How you respond will be a measure of your own humanity and morality.

To begin, let's review some biological facts. We come into the world through a process of sexual reproduction that involves the bodies (or tissues, at least) of a woman and a man. As foetuses, we develop inside a person's body, and we are born physically immature and require considerable care to survive. It is now widely agreed that children's bodily experiences (sensations and perceptions) in infancy and early childhood are fundamental to their physical, psychological and moral development (or lack of development) (Anda et al. 2006; Calhoun 2008). These earliest experiences can play a crucial role in the development of emotional dispositions, intellectual capacity, the ability to understand and interact with other people, and the ability to value oneself and one's life. The reasons for this are complex and fascinating, and part of the explanation lies in the fact that human biology plays a fundamental (but not exclusive) role in the kind of *mind* that each individual develops (Gallagher & Meltzoff 1996; Hambrick et al. 2021).

Sometimes we can fail to appreciate the physical aspects of the mind. This is partly because we experience thinking differently from other bodily experiences, such as stretching, indigestion or giving birth. Thinking seems to be unconstrained by the physical limitations of time and space. For example, you can represent in your mind objects that are much bigger than your head, such as the Himalayan mountain range, and you can recall in a short period of time a series of events that took much longer in real time, such as a holiday. But other aspects of thinking can indirectly be shown to have a bodily basis. An obvious example is the effect of mind-altering chemicals, such as alcohol, narcotics and anaesthetics. Even more obvious is the effect of pain. Experiencing pain changes the way a person perceives and thinks about the world around them (Gligorov 2017).

We also know that physical factors (such as exposure to sunlight, massage, exercise and sexual activity) also have an effect upon the way a person feels, and therefore on how the person thinks and behaves. In addition, certain mental and intellectual changes are well known to accompany hormonal changes during adolescence and menopause, and large-scale changes in a person's personality are not uncommon after brain trauma following a motor vehicle accident or stroke. All this provides us with very good reasons to take seriously the idea that the human mind has a physical basis and is profoundly influenced by a range of core physical factors: sexual reproduction, experiences during infancy, developmental brain processes, developmental changes related to adolescence and ageing, and the effects of the physical environment throughout life (Keenan et al. 2016; Michel et al. 2018).

Now consider some social facts. Human life is intrinsically social because human survival requires social cooperation to ensure the provision of food, shelter, protection, companionship and sexual mates, and to pass on those skills to succeeding generations. As a result of close and prolonged interaction with carers during infancy, each individual acquires a set of skills that aid survival. These are skills in setting and achieving goals, delaying satisfaction, self-regulating emotions, communicating and forming relationships to secure personal and shared goods. It is thus clear that our basic social relations are tied directly to our biological needs. In this sense, persons are socially constructed: we acquire personhood only in a social context (Gallagher 2005, 2017). All this is a function of the simple fact that human beings have bodies – or, more specifically, are *embodied*. When you provide nursing care, you are not merely doing something to the person's body, as if it is simply a special kind of object. You are interacting with the person's *life*.

LAW AND ETHICS IN PRACTICE

In his book *The Man Who Mistook His Wife for a Hat*, Oliver Sacks describes a clinical encounter with a patient suffering from a brain injury, Mr Thompson, who had previously owned a delicatessen:

> 'What'll it be today?' he says, rubbing his hands. 'Half a pound of Virginia, a nice piece of Nova?'
>
> 'Oh Mr Thompson,' I exclaim, 'and who do you think I am?'
>
> 'Good heavens, the light's bad – I took you for a customer. As if it isn't my old friend Tom Pitkins … Me and Tom (he whispers in an aside to the nurse) was always going to the races together.'
>
> 'Mr Thompson, you are mistaken again.'
>
> 'So I am,' he rejoins, not put out for a moment. 'Why would you be wearing a white coat if you were Tom? You're Hymie, the kosher butcher next door.'
>
> This banter goes on for some time, with Mr Thompson coming up with other identities for Dr Sacks, based on various visual cues, such as the stethoscope around the doctor's neck. Finally, Mr Thompson says:
>
> 'You're not my usual chest-thumping doctor. And by God, you've a beard. You look like Sigmund Freud – have I gone bonkers, round the bend?'
>
> 'No, Mr Thompson. Not round the bend, just a little trouble with your memory – difficulties remembering and recognising people.'
>
> 'My memory has been playing me some tricks,' he admitted. 'Sometimes I make mistakes – I take somebody for somebody else … What'll it be now, Nova or Virginia?'
>
> (Sacks 1985: 103–4)

Think about how important friendships and relationships are to one's own sense of who one is. What might be the impact of being unsure if the person you are interacting with is the same person as you had interacted with previously?

PERSONHOOD AND REFLECTIVE SELF-AWARENESS

Next, briefly consider the idea that a person's sense of being someone with a life of their own – reflective self-awareness, in other words – arises from the fact that human beings are embodied (Merleau-Ponty 1961).

One of the key features that philosophers have attributed to persons is the capacity for reflective self-awareness (barring serious brain injury). This means that persons not only have awareness of their surroundings (as, say, an insect might), but they can *know* that they have this awareness. When you reflect upon your own awareness of your surroundings, you become self-aware – that is, you realise that you exist in those surroundings. For example, when you are consciously aware of hearing a piece of music, you know that it is *you* who hears the music: you are simultaneously aware of the music and of yourself. Furthermore, you may become

aware that the music makes you feel a certain way, and then you may wonder why it makes you feel that way. Those further reflections may evoke a memory associated with the music, and so on.

It may sound unnecessary to say that when you know that you are aware of something, you simultaneously know that it is you who is aware, but it has important implications. If you were only ever aware of your surroundings and not of yourself, you could not, for example, intervene and change your behaviour or your personality traits. Reflective self-awareness makes it possible for us to take our own selves as objects of experience. So, just as we pass judgement on objects in the world, we can pass judgement on ourselves. For example, I may not only be aware of the colour of my hair and the size of my feet, but might also judge my haircut to be fabulous or my feet to be unshapely. In the same way, I can judge my attitudes, values and actions to be good or bad, better or worse. This awareness provides me with the opportunity to change who I am and what I do. It gives me *choice*. Being able to make considered decisions and being able to direct one's life accordingly means having autonomy. (We will consider autonomy again in Chapter 3.)

Reflective self-awareness is sometimes regarded as the function of a purely intellectual power or faculty, but it is in fact a bodily function (Atkins 2008; Gallagher 2005). Reflective self-awareness is a product of the body's ability to feel itself and to connect its feelings to bodily functions and actions through the sensorimotor system, which is coordinated in the brain. This begins in infancy. The sensorimotor system allows the infant to feel, move and coordinate its body parts in such a way that gives rise to purposeful actions without the child having to form any conscious representation or thought of what it is doing. This can be seen in various infant reflexes that precede the development of permanent fine and gross motor skills – for example, the rooting reflex, whereby if the child's cheek is stroked the baby turns their head, opens their mouth and begins sucking; and the stepping reflex, whereby when the child is held above a surface and lowered so that when their feet touch the surface, the child moves them as if to walk (Keenan et al. 2016). In these examples, the infant's body is unconsciously tracking and coordinating the movements of its body parts in relation to one another, without having to be consciously or reflectively aware of what it is doing. This ability is known as proprioception (Gallagher 2005).[3]

Proprioception is the first (and a necessary) stage in the development of a sense of self. It gives the human body the innate ability to sense itself as an integrated whole, and to regulate its movements by coordinating itself as a whole. This gives rise to a sense of unity and allows the formation of an individual perspective. Proprioception commences *in utero* and is fully developed in early childhood

(Holst-Wolf et al. 2016). It underpins both conscious and unconscious bodily movements. To illustrate proprioception in action, consider what happens during sleep. Have you ever wondered why you do not fall out of bed when you are asleep? Proprioception keeps you safely in your bed because while you are sleeping – while your usual self-awareness is inactive – your body nevertheless continues to sense where your limbs are and where the edge of your bed is, and confines your movements to the safety of the bed.

In addition to being able to sense itself (through proprioception), the child's developing body also senses the bodies of other people, notably those of its carers. This adds an interesting aspect to the development of self-awareness. In infancy, when children are bathed, they not only feel the warmth and the wetness of the water on their skin, but they also feel the size, texture and shape of the hands of the person bathing them. So the sensations that infants feel *in* their body are not simply their own inner sensations, but a mixture of perceptions of their own body and of the hands of the person bathing them. For example, an infant being bathed feels a sensation in their back as a result of the pressure from the bather's hands. The infant's body seems to treat that sensation as belonging to it, even though the hands themselves belong to someone else's body. This mixing of sensations arising from the child's own body and the body of the child's carer explains why styles of parental care, with their different rhythms of speech, types and intensity of touch, modes of play and emotional force, powerfully influence the child's developing sense of self, and make each child's self-experience complex and unique (Negayama et al. 2015). The experiences arising from the infant–carer interaction actually stimulate the growth of neural pathways in the child's developing brain that structure how the child reacts to the world around them and to other people (Gallagher & Hutto 2007; Vincini et al. 2017). This gives the child's developing sense of self an interpersonal dimension. In other words, it orients the child's brain (and behaviour) to the existence of other people – specifically, the people with whom the child has some relationship of dependency. This interpersonal orientation will later assist the child to develop their sense of being a person *in general*. Regarding oneself as a person among many other, similar persons demonstrates that selfhood has a social dimension.

Along with the development of cognitive and behavioural abilities, the infant–carer relationship is the ground for the development of moral qualities, such as self-esteem, self-trust, resilience, integrity, empathy and the ability to act from reasons of one's own. In general, children who are treated gently, have their needs met and are applauded for their endeavours will develop a positive sense of self – a strong sense of optimism, resilience and integrity, all of which are necessary for strong moral

capacities. This is demonstrated by research into the effects of adverse childhood events (ACEs), including interpersonal trauma, which indicates that children who are treated roughly and are neglected have more difficulty developing a positive sense of self and empathy for both self and others (Oral et al. 2016; Perry 2013). In severe cases, they may not expect very much from life and may have reduced capacity for moral reasoning and autonomous action. Such children may instead rely heavily on strong and stable social structures (such as schooling) to provide the guidance and support necessary for healthy self-esteem and self-trust, successful relationships and social integration (Cox et al. 2020).

It is important to note that we are frequently quite unaware of our background emotional dispositions. This is because our emotional dispositions are more than mere representations in our minds upon which we can easily reflect, such as the memory of a good meal or a sad film. Rather, they function as a kind of unnoticed background against which our conscious ideas, attitudes and beliefs stand out. This is why the concept of emotional intelligence has been a focus of recent research. Emotional intelligence refers to the awareness and understanding of one's emotional dispositions and tendencies, and the ability to reason about one's emotions in order to have constructive interpersonal and professional relationships (Mestre & Barchard 2017). In fact, much of our waking life is driven by non-conscious habits and dispositions. This is why philosophers have emphasised the importance of self-reflection and self-understanding to autonomy. To genuinely understand ourselves and other people, we need to look beyond our express beliefs and attitudes to include an understanding of our background assumptions and the conditions under which those beliefs and attitudes were formed. Importantly, this includes the personal, historical and cultural context within which we each acquired our personalities and values. As a nurse, you should be aware of your own background assumptions about other people, cultures and belief systems, since they will influence how you interact with your patients and how therapeutic your relationships will be.

TO SUMMARISE SO FAR

Persons are human beings with physical, intellectual, emotional, interpersonal and social dimensions to their personalities, which develop over time and are related in complex ways. Importantly, not all our beliefs, attitudes and dispositions are conscious or intentional. It is through the interrelation of physical and psychological attributes, interpersonal relationships, social participation and reflective self-awareness that we each develop the competencies and capacities of

personhood. Thus, who a person is must be understood by the story of that person's life. If we think persons can be understood simply as souls or brains or biological components, we will not be able to make sense of what people actually do, feel, think and need.

Recall Oliver Sacks' patient, Mr Thompson, who is losing his sense of self because he is losing his sense of his world and his place in it. He cannot adequately grasp his physical location (in hospital, not the delicatessen), his personal situation (being a patient with a brain disease) or the people around him (he continually misrecognises people). In a different way, a change of social context can befuddle our expectations and understandings of other people.

LAW AND ETHICS IN PRACTICE

Jenny spent a semester on a cultural exchange at a university in Greece. She was there alone over the Christmas period. One of the university lecturers who had helped her organise the exchange (a single, middle-aged man) invited her to spend Christmas Day at his home. Jenny found that she did not know how to interpret the invitation. Did he think this was expected of him as part of his role in the exchange? Was he just being polite and didn't really expect her to accept the invitation? Did he feel sorry for her? Was he making a sexual advance towards her? Or was it an innocent 'no strings attached' social invitation?

Jenny realised that her confusion arose because she couldn't construct a coherent narrative about her situation. She lacked knowledge about the Greek cultural norms around male–female interactions and student–lecturer interactions, so she lacked certainty about the kind of relationship she was in, what was expected of her, what she should expect of herself, and how she should behave.

» Do you think your own expectations of others' behaviour are influenced by your own culture?

VULNERABILITY

The word 'vulnerable' has several meanings, and often conjures up the image of someone who is weak or frail, or who is being taken advantage of. However, this is a very limited and inadequate way of understanding the term. This book uses the word 'vulnerable' in a specific, technical way. *This is important.* When the word 'vulnerable' is used, it is referring to a basic condition that applies to every human being, not just individuals who are disadvantaged in some way. Vulnerability can be both good and bad. However, in its basic meaning, vulnerability is *neither* good nor bad in itself; it is just a fact of life – a necessary condition for acquiring the skills and capacities of personhood. To say that we are vulnerable to something is

simply to say we can be affected by it. To say that persons are fundamentally shaped by their physical, emotional and intellectual relations to other similarly embodied individuals is to say that human beings are essentially *mutually vulnerable*. In other words, part of what it is to be a person is to be involved in a web of both voluntary and *involuntary* relationships with other persons. We fundamentally affect and influence each other, and no one is immune to being affected and influenced by others.

Some ways in which human beings affect each other are the same for every relationship. For example, all human beings can be affected physically by others by being slapped or pushed or prodded, regardless of age, gender or disability. Other ways of being affected vary from relationship to relationship, and from society to society, and vulnerabilities vary across the different stages of life and between personalities at the same stage of life. For example, teenagers tend to be more sensitive to peer pressure than middle-aged people, and some individuals are outgoing while others are more solitary. Individual relationships and characteristics are also expressed differently according to norms around friendships between men and women, public displays of emotion and styles of verbal interaction. Nevertheless, no matter how unique or solitary an individual may aspire to be, people who could *never* share the activities, ideas or emotions of other people would be incapable of really understanding either themselves or another person.

The things to which we are vulnerable are those things that can affect us physically, emotionally, psychologically, interpersonally and socially. For example, when we are affected physically, we may experience stimuli such as heat, noise, odours and textures. When we are affected emotionally, we may experience states such as joy, sadness, anxiety or relief. And when we are affected psychologically, we may experience states such as hoping, planning, remembering or imagining. We are also affected by our friendships, which may produce experiences of trust, loyalty or betrayal. Also, we may have social experiences, such as solidarity when playing in a sporting team, or national pride when visiting a historical monument. All these kinds of experiences overlap with each other: emotions are accompanied by psychological states (such as thoughts of the feared or hoped-for object); physical sensations are accompanied by emotional and psychological states; and our interpersonal and social experiences have physical, psychological and emotional aspects to them.

Vulnerability is a function of human embodiment, since it is our embodiment that determines the ways we can be affected and the kinds of experiences we can have. Our experiences may be positive or indifferent, or they may be negative. Vulnerability can give rise to negative experiences, such as contracting infections