ALTHOUGH THE TERMS ‘ethics’ and ‘morals’ tend to be used interchangeably, they have different roots in the ancient worlds of Greece and Rome. Ethics originally referred to the accepted standards of conduct in a particular setting, while morals were held to be absolute standards of right and wrong (Vardy and Grosch 1999). Both words have relevance for the nurse prescriber. Our society lays down the standards to which it expects prescribers to adhere through the codes of practice of a range of organisations from the Nursing and Midwifery Council (NMC) to the Association of the British Pharmaceutical Industry (ABPI). Prescribing can sometimes involve important moral judgements. In this article, the term ‘ethics’ will be used to include both these dimensions.

While it would be much simpler if there was one agreed framework in our society for ethical decision making, the reality is that there are several. We may all agree that murder is wrong, but diametrically opposed opinions are held about the ethical status of, for example, abortion or physician-assisted suicide. So it is necessary for the nurse prescriber to have an awareness of the range of perspectives that can be used to illuminate ethical issues, and those expecting an understanding of ethics to provide clear-cut answers to clinical dilemmas are likely to be disappointed.

Ethics should be regarded as an aid to the process of reflection on clinical practice rather than a formula for guaranteeing the ‘right’ answer (Rumbold 1999). Many books and articles on nurse prescribing combine coverage of ethics and law, but these aspects represent overlapping elements of a spectrum rather than synonyms for identical approaches (Lovatt 2010). Sometimes an issue comes before the courts before it has received much attention from ethicists and a decision has to be made, for example, about how surrogacy should be conducted. For other topics, ethicists have taken the lead by exploring the conflicting principles that underpin them, as with decision making at the end of life (Adams 2010).

Key concepts in ethics

One of the pioneers of ethical thought was the Prussian philosopher Immanuel Kant (1724-1804), who wished to develop an ethical framework based on reason rather than religious belief (Gregor 1998, Kuehn 2001). Two concepts developed by Kant have continued to exert a major influence on the field of ethics. The first of these is the idea that ethical actions arise from our ‘duty’ to fellow human beings (Wood 1999). This approach is sometimes called deontological ethics, from the Greek word ‘deontos’ meaning ‘duty’ (Blackburn 2003). Kant wrote that, as rational beings, everyone could experience the ethical imperative of a duty to others (Norman 1983). Nursing has often proclaimed a ‘duty to care’ and so deontological ethics accords well with a traditional strand of the nursing profession’s view of itself (Gastmans 2006).
The second influential concept derived from the work of Kant is that of human equality. In an age of autocratic governments, Kant argued that justice or fairness was fundamental to an ethical society and that human beings have equal value and so must not be used as a means to an end—however worthy that end might appear to be (Wood 1999). For example, if the experimental trial of a new pharmaceutical product is known to be hazardous, the potential benefit to humanity as a whole should not be held to outweigh the need to consider the health of the individual research subjects.

While Kant’s argument that human beings must not be regarded as a means to an end informs modern ideas of universal human rights, the inflexibility of deontological ethics has proved to be more controversial. Nurse prescribers may feel a duty to provide the drugs that the patient needs, but they are likely to have their practice constrained by numerous policy restrictions, including finite drug budgets.

So critics conclude that deontological ethics present an impractical and outdated approach to ethical decision making (Singer 1993).

In an attempt to develop a more practical ethical framework, two English philosophers, Jeremy Bentham (1748-1832) and John Stuart Mill (1806-1873), promoted ideas which came to be known as ‘utilitarianism’ (Lindsay 1957). Their advocacy of an approach which aimed to achieve ‘the greatest happiness for the greatest number’ requires that the consequences of an action, rather than the action itself, must be examined from an ethical standpoint.

Utilitarianism is therefore sometimes referred to as a ‘consequentialist’ approach to ethics (Blackburn 2003).

One of the clearest examples of the application of utilitarian ethics to the clinical situation is the role of the triage nurse in the emergency department. Patients are seen not in the order in which they arrive, but in accordance with the severity of their injuries, so that the limited resources of the department can be deployed to preserve life and hence to maximise ‘happiness’ (Chung 2005).

The consequentialist needs to adopt ‘evidence-based care’, because evidence is required to select the treatment option which offers the prospect of the greatest benefit for patients. In Scotland, guidance and advice on clinical effectiveness is provided by NHS Quality Improvement Scotland. For Northern Ireland, similar resources, including policy guidance for nurse prescribers, are provided by the Department of Health, Social Services and Public Safety. In England and Wales, the National Institute for Health and Clinical Excellence (NICE) is required to assess interventions on the basis of relative costs and benefits, but it also strives to distribute health resources in a fair manner to society as a whole (NICE 2008).

The Hippocratic tradition

For more than 2,000 years, healthcare workers have been required to abide by an evolving series of ethical codes that have sought to regulate their behaviour towards patients and fellow professionals. The Hippocratic Oath, dating from ancient Greece, contains many precepts which have stood the test of time, such as the need to maintain patient confidentiality (Downie and Calman 1994).

Like all such codes of professional ethics, the Hippocratic Oath contains elements relating to contemporary etiquette which have no continuing relevance. One example is the prohibition on carrying out surgical operations, which was inserted because ancient physicians looked down on practitioners who combined running a barber shop with practising surgery. It has no relevance to modern health care but it is reflected in the tradition of British surgeons styling themselves ‘Mr’ or ‘Ms’, rather than ‘Dr’. This anomaly illustrates the fact that all ethical codes contain a combination of timeless precepts and those which have only contemporary relevance. Codes therefore require frequent updating to meet changing circumstances.

By the second half of the twentieth century, the academic community in the United States (US) felt the need to bring together doctors, other healthcare professionals, philosophers and theologians to adapt the Hippocratic tradition of ethics to the needs of the contemporary medical practice (Jonsen 1999). The Principles of Biomedical Ethics, first published in 1977 and now in its sixth edition (Beauchamp and Childress 2009), is the most influential product of this intense period of research, scholarship and debate.

The impact of Beauchamp and Childress’s ideas is apparent in codes of professional healthcare ethics around the world, including the NMC code (NMC 2008). NICE is also committed to the principles-based approach advocated by Beauchamp and Childress (NICE 2008).

While retaining timeless elements of the Hippocratic tradition, such as non-maleficence (‘do no harm’) and beneficence (‘do good’), Beauchamp and Childress added five new ethical dimensions to the Hippocratic tradition.

The first of these was respect for autonomy, which encapsulates informed consent. The prominence of this principle reflects a fundamental change in society that has occurred since the second world war. Patients generally reject paternalistic attitudes on the part of prescribers and now expect to be fully informed...
about their medication choices. Critics of the prominence that Beauchamp and Childress have given to potentially selfish individual autonomy have suggested that it reflects a characteristically American perspective on ethical values, which conflicts with more communitarian European cultural assumptions (Holm 2001). However, most prescribers would probably agree that the UK is moving ever closer to the US in this regard (Walley and Williams 2010).

Beauchamp and Childress’s (2009) identification of ‘justice’ as their fourth major principle reflects the influence of Kant (Box 1), but was a brave step for US ethicists in a healthcare system not noted for fairness. For those with the means to pay, expensive treatments and drugs were available, while millions of Americans lacked even basic health insurance cover.

In the UK justice or fairness was one of the founding principles of the NHS, with treatment based on clinical need rather than ability to pay and free at the point of access. However, even in the UK, issues of potential unfairness in medication prescribing cannot be ignored. The increasing fragmentation of the NHS into geographically based units has created a situation in which a costly drug may be available in one area but not in another: the so-called ‘postcode lottery’ (Hughes and Ferner 2010).

Of the four ‘rules’ which Beauchamp and Childress (2009) identified, confidentiality appears in the Hippocratic oath, but the other three (veracity, privacy and fidelity) are new (Box 1). Veracity or truthfulness should underpin respect for autonomy, as informed consent demands the provision of truthful information. While no nurse prescriber is likely to disagree with that rule, the issue of how much information to give remains unresolved. How many patients read and understand the information leaflet included with every box of tablets?

Privacy reminds nurses that patients should determine the boundaries of what is recorded about them in clinical notes, while fidelity underlines the responsibility to provide continuity of care to challenging service users. In addition, Beauchamp and Childress (2009) suggested that healthcare professionals should exhibit five ‘focal virtues’ in the care they deliver: compassion, discernment, trustworthiness, integrity and conscientiousness. These five virtues would seem to encapsulate the qualities that a patient should expect a nurse prescriber to have.

Consumerism and choice

One of the most profound social changes of recent years has been the trend towards greater power for the consumer. People now expect to compare products and services, from supermarket shopping to holiday bookings, from a range of outlets including the internet, and to make their choice based on feedback from previous consumers. The NHS has struggled to adapt to this new environment. It was founded in an era of medical paternalism in which decisions about treatment options were made largely by healthcare professionals. Successive governments of all political persuasions have been keen to overthrow what they have regarded as the inappropriate paternalism of the NHS. The website NHS Choices (2011) encourages patients in England to comment on their positive and negative experiences, but anecdotal nurses’ awareness of such openly available comments remains low.

In England, the recent white paper Equity and Excellence: Liberating the NHS announced that the government aimed to ‘put patients at the heart of the NHS through an information revolution and greater choice and control’ (Department of Health 2010). While this will be viewed as a laudable aim, it could potentially create ethical dilemmas for nurse prescribers. For example, what if a patient chooses a course of treatment that the purchasing consortium will not fund? Such a dilemma sets the principle of respect for autonomy (‘I want that drug’) against the principles of justice and/or fairness (‘the budget is limited and other patients have pressing needs’).

This issue goes to the core of the prescriber-patient relationship. The elitist power exercised by the prescriber is usually justified using arguments drawn from utilitarianism. For example, greater happiness results from nurse prescribers employing their specialist knowledge to achieve healing, minimise harm and use limited resources fairly,

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**Box 1**

The principles-based approach

**Principles**
- Respect for autonomy.
- Non-maleficence.
- Beneficence.
- Justice.

**Rules**
- Veracity.
- Privacy.
- Confidentiality.
- Fidelity.

(Beauchamp and Childress 2009)
compared with a situation where patients are allowed a free choice of any medicine they wish to select. Radical voices argue, however, that as much more information is now available to patients via the internet, the role of the Medicines and Healthcare products Regulatory Agency is now redundant (Appleby et al 2003). Certainly, the pharmaceutical industry continues to call for a relaxation of the regulations on direct-to-consumer advertising, using the argument that if patients have more information about drugs they will be in a stronger position to contribute to the prescribing consultation (Bonaccorso and Sturchio 2002).

A further element in the debate about increasing patient choice concerns the role of evidence-based health care. It could be argued that ever greater adherence to the findings of research derived from randomised controlled trials may actually reduce the number of options available to patients (Ashcroft et al 2001). Critics of NICE have argued that the necessarily broad scope of its decisions does not give sufficient weight to the views and needs of individuals (Speight and Reaney 2009).

**Pharmaceutical industry regulation**

The ABPI, the industry body for companies that produce prescription medicines for human use (ABPI 2011), publishes a code of practice for the pharmaceutical industry which regulates the promotion of prescription medicines. Complaints about alleged infringements of the code are adjudicated by an independent body, the Prescription Medicines Code of Practice Authority (2007). Many complaints adjudicated by this authority are brought by one pharmaceutical company against another and concern alleged infringements of the clauses of the code, which cover marketing activities.

It is essential that all nurse prescribers are aware of the ABPI code and in particular its guidance on promotional aids and hospitality offered by pharmaceutical companies (ABPI 2011). The section of the code covering promotional aids, which comes into force from May 2011, forbids pharmaceutical companies from offering staff previously permitted gifts, such as coffee mugs, diaries and surgical gloves (ABPI 2011). The ABPI code now states: ‘Notebooks, pens and pencils are the only items that can be provided to health professionals and administrative staff for them to keep and then only at bona fide meetings. They cannot be provided, for example, by representatives when calling upon health professionals. The total cost to the donor company of all such items provided to an individual person attending a meeting must not exceed £6, excluding VAT. The perceived value to the recipient must be similar’ (ABPI 2011).

Pharmaceutical companies have also been generous sponsors of meetings, lectures and conferences. The ABPI (2011) code states that sponsorship may be provided for scientific meetings, but that the hospitality ‘must be strictly limited to the main purpose of the event’ and ‘must not exceed that level which the recipients would normally adopt when paying for themselves’. Companies have been censured for offering perks to prescribing nurses that fall outside the provisions of the ABPI code (Kmietowicz 2005).

Such marketing activities by pharmaceutical companies can raise genuine ethical concerns. On one hand, nurses often find it hard to access relevant sources of information to keep their clinical practice up to date and without sponsorship many worthwhile events would not take place. On the other hand, international drug companies are engaged in an aggressive commercial environment with huge sums of money invested in new products, and experience constant demands from shareholders for attractive financial returns (Ferner 2005).

There is some evidence that, while prescribers have few concerns about the effects that pharmaceutical marketing has on their judgement, patients and service users are much more likely to believe that improper influence may be brought to bear on the prescribing process (Gibbons et al 1998, Crigger et al 2009a, 2009b). The time has come to consider more formally the impact of how patients view the appropriateness of these actions (Crigger et al 2009b). Some NHS trusts claim to have policies in place to prevent inappropriate contact between prescribers and pharmaceutical company representatives, but anecdotal evidence suggests that their effect may be limited.

**Concept of trust in prescribing**

Recent years have witnessed a series of scandals in medicine and nursing which may have damaged the public’s trust in the probity of healthcare practitioners. Examples include the Beverley Allitt and Harold Shipman cases. While politicians seem to devise ever more restrictive mechanisms to control health professionals, O’Neill (2002) has argued that society gains most from trusting the majority who act ethically. She believes that healthcare professionals should always act in ways that foster public trust. The ability to prescribe inevitably places an individual nurse under public scrutiny. Therefore, each nurse prescriber needs to continually reflect on how his or her actions will be interpreted by patients and carers to ensure that trust in the integrity of the prescribing process is maintained at all times.
Conclusion

It is tempting to turn to the study of ethics for precise and authoritative answers to the ever-changing clinical dilemmas encountered by nurse prescribers. However, this is an unrealistic expectation. The power to prescribe involves the application of evolving scientific knowledge to an almost infinite number of complex organisational and human scenarios. No ethical code can provide definitive guidance for every such encounter. Professional and industry codes can be formulated only in terms of broad principles rather than detailed prohibitions. So the value of an understanding of ethical frameworks lies in their ability to illuminate and deepen the reflective approach which all prescribers should be adopting in their role.

References


