OF CODES AND CONSCIENCE: REFLECTIONS ON NURSING ETHICS IN THE NETHERLANDS

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About a year ago (January 2015), I had the privilege to co-author and present the first national professional code of ethics for nurses and other care workers in The Netherlands to the Chief Nursing Officer, Marieke Schuurmans, PhD.[1] For our small country this occasion was of some historical significance, but perhaps there is something to be learned for other countries as well. What follows are a few comments to contextualize the discussions, and the resolution of several key issues.

Historical Aspects

To understand the significance of this national professional code, some background information is necessary. The way the Dutch organized their society in the twentieth century gave it a matrix-like structure. On the horizontal rows, so to speak, there were societal and cultural groups, organizations, and institutions—like unions, sports clubs, schools, political parties, healthcare facilities, media networks, and so on. In the vertical columns the Dutch very consciously located their ideological and religious traditions with fault lines between the organizations on the horizontal rows. The daily realities of family life, work and leisure were thus characterized by this *modus vivendi* for a religiously and ideologically pluralist society. To illustrate, children from a Reformed denomination would have typically attended a Reformed school and Reformed sports clubs (no matches on Sunday), and their parents would have typically read a Reformed journal and voted for a Reformed party in elections. An example of the fault lines can be seen in a comparison with Roman Catholic families whose sports leagues did play matches on Sunday. Typically, interaction between the ideological and religious groups (e.g., between Roman Catholics, liberal democrats, or Socialists) was very limited, in some cases even non-existent.

Accordingly, when nurses started to vie for professional and academic recognition (roughly after the Second World War), a plethora of nursing associations emerged. Not only did these emerge along the ideological and religious fault lines, but also according to sectors of health care. Thus there were Protestant, Catholic, (and other) associations for community nursing, operating theatre nurses, pediatric nurses, and so on.

This is a remarkable contrast to nearby countries such as Great Britain and the Scandinavian countries where a single national body existed to advocate the interests of nurses! Because of these national bodies, at least some nationwide impact was possible on education, quality of care, working conditions, and, significantly, the formulation of ethical codes. Also, these national bodies were in the center of things when the nursing profession began formulating their professional codes of ethics. Such codes were first formulated in the early 1950s with the International Council of Nurses (ICN, 1953), the global association for Roman Catholic nurses, CICIAMS (1953), and the American Nurses Association (1950) setting the example. After three decades or so, evolving from the ICN code, Scandinavian countries, Canada, and the United Kingdom followed suit. Interestingly, the contents of these codes have been influenced not only by the Hippocratic medical code, but also by the pledge or set of moral principles formulated by nursing pioneer Florence Nightingale (around 1875). In turn, she was inspired by her training from Lutheran pastor Theodor Fliedner's school for deaconesses in Kaiserswerth, Germany.

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Toward a Unified Code

At this point it should be clear why a national code of ethics for nurses in The Netherlands was something of a historic event. Some of the largest of these nursing associations had taken it upon themselves to formulate codes of ethics for their own membership. In the 1970s, five such codes were known for nurses alone! Moreover, a few smaller associations for Christian nurses jointly published a Christian code of professional ethics for nurses (1995), in part to take a stand against inflated patient autonomy. Needless to say, nothing close to a consensus on nursing codes existed in the Dutch nursing profession as a whole. (As an aside, the medical profession in The Netherlands has long been a 'glitch in the matrix,' so to speak: it has had a unified, royal society and a single ethics code since the mid-nineteenth century). And although the matrix-like structure of Dutch society has been eroding rapidly since the end of the twentieth century, it was not until 2006 that the main nursing associations sat at one table for their first—and failed—attempt at a unified ethics code for Dutch nurses.

For a society as diverse as The Netherlands is today, it is remarkable for organizations with such deep-running, traditional differences to cooperate, much less reach a consensus on something as fundamental and value-laden as an ethics code—especially without financial or other external motivators. These historical developments highlight just how significant it was that the main nursing bodies were able to cooperate, but furthermore that the associations for Christian nurses with their Hippocratic ethical convictions also decided to participate in the conversation. This meant they were willing to consider giving up their Christian code of ethics, provided the new code would reflect ethical positions they could accept as well. In my personal opinion it was nothing short of a blessing that this is exactly what happened: important principles from the Christian code of ethics became part of the consensus document. This is especially important when it comes to the position of nurses with conscientious objections to specific interventions or procedures, particularly any cooperation in abortion and euthanasia—a point to which I will return shortly.

Basic Principles

By and large, the new code is in line with the ICN code, with its sections on the nurse's relationship to practice, to the patient, to those she works with, and to society. Likewise, with respect to its basic principles it conforms to the international code, with a proviso or two for new developments such as self-employed nursing and responsibilities for quality care. Three of those basic principles are worth mentioning before we address conscientious objections, as they were very much on the agenda for Christian nurses.

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To begin with, as in the international codes, the very first clause of the code is a 'non self-serving clause': the good of nursing care is pursued in the interest of the patient (not in the interest of the team, the nurse, the family, or anyone else). This may seem obvious, but in a context

From left: Marieke Schuurmans, PhD, a nurse participant, and Bart Cusveller, PhD at a meeting to develop the first national professional code of ethics for nurses in the Netherlands.

where patients are often on the vulnerable end of the power balance, it is not superfluous to remind professionals of their commitment to ground their moral decision-making on the purpose of the nursing profession: to foster the patient's flourishing, not as a means to something else, but an intrinsically valuable end in itself. In Christian language, the nursing profession came into existence to serve the lives and health of those who cannot serve themselves—as Christ served us.[2]

Second is the 'non-discrimination clause,' which is also found in most nursing codes. Again, this is not an exclusive claim from the Christian code of nursing ethics, but it is, nonetheless, an important principle from a Christian perspective. If charity is worth anything, then it is not restricted to one's own clan or tribe, as in ancient societies,[3] but is extended to friend and foe alike. So even when nurses are confronted with a patient who lives a life they see as hopeless, unhealthy, or even sinful, it is not their place to judge and withhold care. Perhaps it is precisely such a patient (like the paralytic who had lived near the Bethesda baths for thirty-eight years) who most needs a nurse to really see him or her?

A third clause that became part of the new code for nurses in The Netherlands is the 'non-abandonment clause.' This, like the previous clauses, is not an exclusively Christian principle, but it stands out because it relates to the 'conscientious objections clause' to which we shall return shortly. It is significant because when a nurse has conscientious objections to a given intervention, her objections are limited only to those interventions and not to everything else that her care for that patient demands. Note that this requires a good deal of discernment and self-control, particularly when the objections create emotional turmoil. Thus, when a nurse is asked to participate in a procedure she thinks is wrong, say, preparing a patient for an abortion, she has both a right to refuse to participate in this preparation but also a duty to care for that patient in all other respects, such as hygiene and nutrition, and not abandon her.

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This, lastly, brings us to the clause on conscientious objection itself. It was here that something crucial was at stake for the Christian nurses associations. In the diversity of codes between the nursing associations, the right to refuse cooperation in objectionable procedures was not controversial as such. It is also included in health law and collective labor agreements in healthcare. How to couch the principle in an acceptable way to all parties, however, was an entirely different matter. A key difference existed between the Christian code of 1995 and some of the other codes. The Christian code stated that a nurse who refuses to participate in some procedure for conscientious reasons relinquishes her responsibilities to her superior (and provides her reasons for doing so). The superior can then consider how to proceed. This is in contrast to the code from nurses' unions AbvaKabo-FNV and CNV Publieke Zaak (1996, 2006), which states that a nurse with conscientious objections must relinquish her responsibilities to a colleague.[4] Their reason for this phrase ("relinquish . . . to a colleague") is the non-abandonment clause, which makes sense. But from the perspective of the objector this is unacceptable as it comes down to asking somebody else to do something the objector herself thinks is wrong. It comes down to saying, for instance, "I will not be involved in this euthanasia procedure, for I believe killing someone is wrong, but you go ahead." (In addition, in this formulation the nurse does not have to voice her objections to her superior, who could possibly intervene.[5])

For these reasons, therefore, it was important to get the final text for this issue right. In the end, we reached the consensus that the clause should read in the more principled way (relinquishing responsibility to her superior). The only exception is when there is no (acting) superior, in which case one would need to call upon a colleague or to resolve the conflict in some other way (while continuing to observe the non-abandonment clause). One could say that, even if the objection is based on a religious or other personal conviction, the code challenges the objector not to opt out by default but to present it as a professional objection and remain part of the discussion: "This is bad care. How can we improve it?" This, again, calls for discernment and other competencies to participate in 'ethics conversations.'[6] And such conversations about values are perhaps the way a professional code of ethics is supposed to work in the first place.

1 *Beroepscode van Verpleegkundigen en Verzorgenden*, Vereniging van Verpleegkundigen en Verzorgenden, 2015.

2 See also my "In Defence of Selflessness: A Philosophical Analysis of a Central Virtue in Professional Caring Practices," *Ethics & Medicine* 27, no. 3 (2011): 147–154.

3 While it was not a point of discussion in these meetings, it is well documented in the literature on the history of caring professions that in pre-Christian societies one usually did not care for the infirm outside of their own household. It was the Christian traditon in Europe that established hospitals with care for the stranger.

4 *Beroepscode Verpleging en Verzorging,* AbvaKabo-FNV & CNV Publieke Zaak, 1996 (revised, 2006).

5 I thank Dignitas editor Michael Cox for bringing this point to my attention.

6 See also my "Nurses Serving on Ethics Committees: A Qualitative Exploration of a Competency Profile," *Nursing Ethics* 19, no. 3 (2012): 431–442.