(Normative) Moral Theory and Nursing Practice

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Introduction.

It's quite a task to write succinctly on moral theory and nursing practice not least because of the problem of almost infinite regress. The challenge is to say something of interest to and, importantly, of everyday use to nurses in their practice, whilst avoiding both trite oversimplification and disappearing down the rabbit hole of abstract and detailed philosophizing. John Rawls' definition of moral theory is a case in point:

> Moral theory is the study of substantive moral conceptions, that is, the study of how the basic notions of the right, the good, and moral worth may be arranged to form different moral structures. Moral theory tries to identify the chief similarities and differences between these structures and to characterise the way in which they are related to our moral sensibilities and natural attitudes, and to determine the conditions they must satisfy if they are to play their expected role in human life (Rawls 1974, p. 5).

If this isn't necessarily a definition I would recommend to an undergraduate class of nurses, it nevertheless captures the point that to understand the nature and function of moral theory (as academic study as well as intended action guide) also requires some understanding of prior moral concepts. Later in the same paper Rawls refers to 'a correct theory of right and wrong, that is, a systematic account of what we regard as *objective* moral truths' (1974, p.7, emphasis added), introducing a metaethical question that many nurses will regard as unnecessary as they navigate their moral environment. Moral theory can be understood to have two functions. A theoretical (metaethical) purpose concerned with the features of moral properties and words, what makes things good or bad, right or wrong (Timmons 2021), and a practical (normative) purpose, to articulate a decision procedure which anyone can use to justify right action in a given situation. This chapter considers normative moral theories.[1]

Must nurses know about moral theories? Should they?

A starting point in considering the place of moral theory in nursing practice might be the questions of how much moral theory should (all) nurses know – and how much they must know. The answer to this lies, at least for the latter question and for UK nurses, in the Nursing and Midwifery Council[2] document '*Future nurse: Standards of Proficiency for Registered Nurses'*, the nearest there is to a national curriculum for nursing. The document '…provides clarity to the public and the professions about the core knowledge and skills that they can expect every registered nurse to demonstrate' (NMC 2018a, p.6). This document doesn't mention the word 'moral' but uses the word 'ethics'[3] twice. Once in relation to research ethics and once to require that at the point of registration the registered nurse will be able to 'understand and apply relevant legal, regulatory and governance requirements, policies, and ethical frameworks (NMC 2018a, p.8). That's all there is – there's no more

[1] Possibly unwisely. Prior to any discussion of morally right action, we should ask ourselves what is the purpose of nursing? What is it for? How can you recognise a good nurse, or assess your own nursing care? What outcomes are we trying to maximise? Health, objectively measured, or patients' individual preferences? (Snelling 2018). Our answers to these questions underpin any normative enquiry.

[2] The Nursing and Midwifery Council (NMC) is the statutory regulator of nurses and midwives in the UK. It sets educational standards and maintains a register.

[3] In this context I regard these words as virtually synonymous – that is, a moral theory is an ethical theory.

detail about what this entails or includes, or whether a moral theory can be regarded as a framework. The details are for individual universities to decide within curricula, provided they meet the standards.

By contrast, the Institute for Medical Ethics (IME)[4] collaborates with the General Medical Council, the UK medical regulator, to produce a core curriculum for undergraduate medical ethics and law, detailing that students should be able to 'Recognise different approaches to ethical theory, values, and reasoning that inform decisions in medical practice, policy and law' (Institute of Medical Ethics 2019, p.6).[5] There's clearly a difference here which may have an impact on discussions and ethical decision making within multidisciplinary teams. It is argued (Gallagher 1995, 2018) that nursing ethics can be regarded as distinct from medical and other healthcare ethics, but the application of moral theory to which all parties in a discussion can refer to provides a common moral framework upon which to approach moral dilemmas. This is only possible if contributors, or at least those in professional roles, can all draw upon a working knowledge.

But this is not to suggest that ethical dilemmas can be resolved solely by reference to moral issues. In the environment of professional health care, these decisions are influenced by many other factors, most importantly the law. Some decisions, for example whether to accede to a request for Medical Aid in Dying (MAiD) are governed by statute, varying between jurisdictions. A nurse or doctor who argues that MAiD in a specific circumstance is morally allowable or obligatory, risks a very great deal by *acting* upon their moral conviction where it is prohibited by law, even where it is well argued, supported by this or that moral theory. In addition, regulated healthcare professionals follow a code of ethics[6] which guides and directs practice, and if many of these documents are more akin to legal than ethical prescriptions (Snelling 2016), transgressions, even if they are not unlawful, can be career ending. These consequences for individuals can be built into calculations in some moral theories, but moral theories and moral thinking more generally are better understood in the context of professional healthcare as judgment-informing rather than action-guiding.

Case studies and dilemmas

Though there is a moral dimension to everything that moral agents do, or choose not to do, in teaching, research, and discussion of moral matters it is common to focus on dilemmas, which can be thought of as instances where moral reasoning identifies two or more defensible courses of action which are mutually exclusive. Nurses do not need a code of ethics or a moral theory to tell them not to steal from their patients, but ask any class of students to discuss anything from their practice that has troubled them morally and there will likely be a

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[4] The Institute of Medical Ethics is 'Dedicated to improving education and debate in medical ethics. As a charitable organisation we promote and support the impartial study and understanding of medical ethics and its integration into clinical practice through education, research, and publication.' (IME, nd)

[5] To be fair this is not an exact comparison. There is no mention of moral theories in the General Medical Councils 'Generic Professional Capabilities Framework' (GMC 2017), but the point is that there are detailed curricula guidance produced for doctors but not for nurses certainly in the UK. Reviews of ethical competence and detailed suggestion of what should be taught are available but these haven't made their way into a process that informs and guides curricula in the same way as the IME (Lechasseur *et al.* 2018, Gallagher, 2006).

[6] Codes come in varying titles, forms, and function, including Codes of Ethics, Codes of Conduct, Codes of Practice and various combinations (Snelling 2016). In this chapter I lump them together as Codes of Ethics.

range of experiences offered. This is from my experience as a ward manager many years ago: A patient with sickle cell crisis was experiencing severe pain. At that time the analgesic of choice was Pethidine, an opiate drug supplied in vials of 100mg/2ml. The prescription was for 150mg, taken to the patient as an injection of 3ml of clear fluid in a syringe. There were some concerns about dependency, and it was also considered that the patient was exaggerating their pain[7] and so the prescription was reduced to 100mg. However, fearing a difficult discussion and likely confrontation with the patient during the night shift, nurses added 1 ml of saline to the (now) 2ml of Pethidine in the reduced dose so that when they went to the patient with the Pethidine, the syringe still contained 3ml fluid. Looking at the syringe, the patient asked 'is that my Pethidine?' Stephanie, the registered nurse replied that it was.[8]

What moral theories are we talking about?

There are many moral theories, all with many varieties. Books on moral theories commonly include sections on egoism, hedonism, existentialism, contractarianism, and rights theories (For example, Graham 2004; LaFollette and Persson, 2013; Timmons 2021). Books on nursing ethics also come in many varieties. Many, perhaps the majority, (for example, Wheeler 2012; Avery 2013; Tingle and Cribb 2014; Buka 2020) cover both law and ethics and as we have seen this combination is probably more useful for practicing nurses as action-guide. These books tend to cover three main ethical theories briefly: First, consequentialist moral theories commonly referred to for simplicity as utilitarianism and associated with Mill and Bentham. Second, non-consequentialist theories with various versions of Kantian deontology most commonly referred to and finally, agent centred moral theories, commonly virtue ethics associated with Aristotle. Some texts (for example Wheeler 2012) include versions of feminist and care ethics as similar in some respects to virtue ethics though focussing on relationships with others rather than solely the character of the moral agent.[9]

Each of these three theories had been proposed, rejected, discussed, amended and generally picked over at great length and in great detail for centuries, millennia in the case of the virtues, and explanations of a few paragraphs leave the merest and transient scratch upon the surface. They can be regarded more as developing projects rather than quasi-religious texts fixed in the time and cultural context of initial writing. Aristotle owned slaves and believed that women were naturally inferior to men. Kant also believed in the subordination of wives to their husbands and was unambiguous in his racism. Mill, though for his time a champion of women's rights,[10] also accepted and defended the racism and colonialism of his age

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[7] See Lipscomb (2022) and responses on this point.

[8] Was Stephanie lying? A lie is told when an agent says something that she knows to be false with the intention that others accept that it as true. Stephanie could say that she didn't lie, but hers is certainly an act of deception (Carson 2015). To those who say I should have picked a clearer example of lying, I reply that moral life is complex and nuanced. However much law and morality turns on wafer-thin distinctions, discussion about whether something is a lie or not can miss the point about the morality of the particular act. This could be the subject of a chapter in itself.

[9] The question of whether care ethics can be considered as a completely different theory, or set of theories, than virtue ethics will be of great interest to many and of no interest to others. Space in both curricula and texts is always limited. Choices are made.

[10] According to Reeves (2007, p.414) no less a scholar than Martha Nussbaum referred to Mill as 'the first great radical feminist in the western philosophical tradition.'

(Sterba 2005). None could have anticipated anything of modern nursing practice, but the principles which have guided discussion and development of their theories remain of great importance.

Consequentialism

Consequentialism is a group of moral theories of which the utilitarianism of Mill (1806-1873) is the best known, which holds that the morally correct action is the one that produces the best, or least bad outcomes. This seems plausible; much of what we do is done with the future in mind. When Stephanie deceived her patient into believing that the dose of Pethidine had not been reduced, she was likely thinking of everyone in the ward. The patient would have a more peaceful night without the confrontation and the arguments, she herself would be able to spend more time with other patients who would be able to sleep better in a quieter environment. The consequences for everyone would be better if she just added a little saline to the syringe. Who amongst us hasn't told a lie to prevent a greater harm?

Though intuitively attractive, in its more abstract formulations, utilitarianism poses some very difficult questions. What is the thing that we must maximise? How can we make the calculations? Do we have to make the calculations for every moral action? This latter question produced two distinct versions. In act utilitarianism, a calculation is made (for all acts) which compares likely outcomes of available options. The moral choice is the option which produces the best outcomes, as far as we are able to predict. Apart from the matters of what to maximise and how, act consequentialism requires very many calculations as well as, on occasion, requiring some acts which seem counterintuitive to moral life, exemplified in several famous thought experiments.[11]

In rule consequentialism, rules that tend to maximise outcomes are developed. Generally speaking, the world goes better if people tell the truth, and so to prevent people from having to stop to calculate consequences before every act, it would be better simply for everyone to follow a rule of not lying. Again, an appealing development but it wouldn't take too long to encounter an issue where it would be significantly better to tell the lie, if it prevented a death, or two, or ten, or a hundred. At some point it would be (much) better to tell the lie, and so the question is asked: when can the rules be discarded? One way to address this is not to discard the rule but to amend it. In this way rules are reformulated and repeatedly specified, and rule consequentialism collapses back into act consequentialism. Two-level theory theories have been proposed as one way to recognise the value of following rules and on occasion, casting them aside (See for example, the english utilitarian R.M Hare [1981]).

Reconciling rules and acts in this way may seem rather complex but healthcare professionals do this as part of their everyday practice. For example, in the matter of disclosure of information, a rule explicit in codes of ethics is that confidential information should not be disclosed. Sound consequentialist reasoning requires this; if healthcare professionals gossiped

[11] For example, Philippa Foot's trolly problem (Foot 1967) which has been much enlarged and adapted (for example by Edmonds, 2014). A trolley hurtles down a track heading for five men. But there is a side spur where a single man is standing. Can we deflect the train so that only one man is killed? Or can we push a man in front of the train to stop it but killing him in the process in order to spare the five? Both the deflection and the push save five lives at the cost of one. Are they morally equivalent? Thought experiments like this are very useful to test intuitive objections to moral theories.

about their patients, this would likely result in a reduction of trust and fewer people seeking medical help, causing poorer health. However, there are some instances where keeping a confidence could lead to very poor consequences, if serious communicable disease or an intention to harm others was disclosed. In deciding right action healthcare professionals must consider consequences for the individual act of disclosure but also consider the risk of undermining the general rule of confidentiality. The below quotation is from guidance applying to all health professionals released by the UK government.[12]

> . . . Exceptional circumstances that justify overruling the right of an individual to confidentiality in order to serve a broader societal interest. Decisions about the public interest are complex and must take account of both the potential harm that disclosure may cause and the interest of society in the continued provision of confidential health services (Department of Health 2010).

Utilitarian reasoning is frequently seen in issues of population health, for example in rationing decisions, where the process of allocating resources using the Quality Adjusted Life Year (QALY) is an attempt to calculate benefit between conditions so that outcomes within financial constraints can be maximised (Spencer *et al.* 2022). During the Covid-19 pandemic, calculations of maximising benefit was seen in population health measures like lockdowns and the possibility of allocation of ventilators (Savulescu, Persson and Wilkinson 2020). Rule utilitarianism would require Stephanie to tell the truth, and this could be overruled by an act calculation if the consequences were severe.

Deontology

Deontological moral theories focus on duty. Deon is the Greek word for duty. In a sense the word ‘duty’ is commonplace in professional language, without implying a Kantian approach. The NMC Code mentions a duty of confidentiality (NMC 2018b p.8) and the professional duty of candour. Deontological theories, largely associated with the work of the german philosopher Immanuel Kant (1724-1804) require that we do our duties for their own sake – only then has any act moral worth (Walker 2023). But there is no list of duties. Instead, Kant provided a maxim or guiding principle which requires that moral agents act according to a maxim which can at the same time be valid as a universal law’[13] (Kant 1994, p.24). This means that you should act only in a way that everybody should act, that universality is the essence of morality, arrived at through reason rather than any subjective consideration favouring either the moral agent or anyone else. There is no emotion, no special account of relationships. Your duty must be undertaken just because it is your duty. Kant has a reputation for promoting rigid exceptionless manifestations of the principle which cannot be set aside by appeal to unfavourable consequences. He is unambiguous with respect to lying in an essay entitled ‘On a Supposed right to lie because of Philanthropic Concerns’ published towards the end of his life in 1798: ‘To be truthful (honest) in all declarations is, therefore, a sacred and unconditional commanding law of reason that admits of no expediency whatever (Kant 1994, p.164).’

[12] Guidance on these matters is much more developed for the medical profession than others, and for nurses is largely non-existent though the same considerations apply (Snelling and Quick 2022).
[13] The precise wording depends on translation.

Some of the reasoning in his short paper will be familiar to critics of various forms of utilitarianism, that it is impossible to know what consequences are. Walker (2023) amongst others, considers that Kant is not very good at setting out his case, and refers to 'that unfortunate paper' (Walker 2023, p.122). It is simple to think of examples where it would be extremely challenging to accept that lying is wrong. What if truth-telling resulted in the death, or two, or ten, or a hundred? If a terrorist asked you if you knew where a battery needed to complete an explosive device was located? In the matter of lying, Kant was clear but without this awkward pronouncement – or in other moral circumstances where he was less prescriptive – the rule of universality could be specified in a similar fashion to the move from rules back to acts in utilitarianism. Even with the clarity provided in the case of lying, 'most deontologists reveal themselves to be of the threshold variety' (Alexander 2008 p.86). The moral law is followed to a certain point after which consequentialist considerations overrule what the deontologists regard (below the threshold) as something *intrinsically* right. Even if the location of the threshold is impossible to identify, threshold deontology does at least ameliorate intuitive misgivings about rules followed to the extreme. This should not bother Stephanie were she to take a deontological approach. She should not lie.

Virtue Ethics (and Care Ethics)

Virtue ethics has its roots in ancient times, most famously in the writings of the greek philosopher Aristotle (384BCE-322BCE). Virtue Ethics focusses not on deciding right action, but instead on considering the features of a good life and how to be a good person; on character rather than action, with the assumption and expectation that good people do good things. To do this, moral agents cultivate virtues, which can be described as traits of character resulting in a disposition to think feel and act in certain ways. These dispositions are not innate but can be cultivated through habituation. Acquiring the virtues involves some circularity as Aristotle demonstrated with regard to the virtue of temperance: 'It is by refraining from pleasures that we become temperate, and it is when we become temperate that we are most able to abstain from pleasures' (Aristotle 1953 p 34-35).

Aristotle (1953) discusses a number of virtues in *Nicomachean Ethics* each of which is to be cultivated in the mean between excess and deficiency. For example in the sphere of self-expression, the mean of truthfulness lies between the excess of boastfulness and the deficiency of understatement. The list of Aristotelian virtues is not fixed and can be amended or enlarged. Begly (2005) for example gives a list including compassion, honesty, kindness tolerance and courage; some of these virtues will be familiar to UK nurses as they form part of the nursing strategy '*Compassion in Practice'* (Department of Health 2012).[14]

Virtue ethics, has been subject to a number of criticisms (Ferkany and Newham, 2019), but perhaps the most significant for Stephanie is that it fails to deliver action-guidance and is therefore of little practical use. Begly's (2005) refutation of this charge, borrowing from Hursthouse (1999), relies in large part on comparisons with competing theories; it's not so

[14] This strategy was introduced in the wake of the Francis Report into a scandal of very poor care in the NHS, and articulated 6 values for nursing: Care, Compassion, Competence, Communication. Courage, and Commitment. At least one evaluation – O'Driscoll *et al.* (2018) - showed professional resistance and anger amongst nurses that the strategy is a top-down initiative which fails to recognise structural constraints.

much that the virtues fail to give action guidance, more that the other competing theories are poor in this regard as well. The virtues can be regarded as implying rules (Hodkinson 2008); the virtue of truthfulness reformulated as a rule to tell the truth. If this lacks application, so do utilitarian and deontological rules, which is why they need detailed specification. Aristotle acknowledges that only general rules can be given, that questions of conduct and expedience are not fixed and that general rules are not precise:

> […] but the agents are compelled to think out for themselves what the circumstances demand, just as happens in the arts of medicine and navigation (Aristotle 1953, p.33).

It's not clear that this helps Stephanie very much either. Thinking about the best course of action may help Stephanie to become a virtuous practitioner, guided by professional phronesis (wisdom), but until complete, the journey to phronesis itself provides scant guidance. Virtue theory can't tell Stephanie what to do, but there is clear presumption on telling the truth (Hodkinson 2008).

Nursing has provided fertile ground for agent centred moral theories,[15] likely due to the account within utilitarianism and deontology of an ethic which is both impersonal and, in different ways, calculating - requiring the moral agent to step away from a situation and have a good think about what is the best thing to do. This is not to say that agent centred theories don't require careful consideration, but they also allow or require some connectedness with the situation and with other people. Though rarely attained, abstract moral thinking involving universalizable principles was characterised as the highest level of moral development in Lawrence Kohlberg's work on moral development (McLeod-Sordjan 2014). However, as his erstwhile research assistant pointed out, Kohlberg's research sample consisted only of boys. In her seminal work *In a Different Voice* Carol Gilligan (1982) argued that women's values centred on caring relationships rather than impersonal justice. The book is widely considered a starting point for feminist ethics of care developed by others including Nel Noddings (1984), Joan Tronto (1994), and specifically related to nurses, Helga Kuhse (1997), finding a natural home within nursing's purpose rooted in care[16] and an overwhelmingly female workforce.

As a normative moral theory, care ethics possibly has little to offer Stephanie other than she should care for her patients. Appealing though it may be to those who see the nurse-patient relationship as based on emotional attachment, care ethics has been criticised for being vague. Perhaps a more serious charge is that the empirical findings which provided the initial impetus (that is: women don't think like men) are unreliable (Paley 2006).

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[15] A CINAHL search (1999-2023) for the keywords Nurs* and Ethic* combined with Deontolog* scored 89 hits, combined with Utilitarian* OR Consequentialis* scored 63 hits, and combined with virtue* scored 205 hits. A search in the journal *Nursing Ethics* 1994-2022 using the words utilitarian*, deontology and virtue* scored 228, 136 and 632 hits respectively. There are book length applications of virtue ethics in nursing (Armstrong 2005, Sellman 2011) but none that I am aware of for utilitarianism or deontology. Hardly a bibliographic analysis but perhaps indicative of the field.

[16] And, as a reminder, Care is the first of the 6C's

Moral theories in Use – Frameworks and Empirical research.

Perhaps the most commonly used framework in bioethics generally is the four principles approach by Tom Beauchamp and James Childress first published in 1977 and now in its eighth edition (Beauchamp and Childress, 2019).[17] This book changed the field of bioethics when it first appeared in 1977, only 5 years after the end of the infamous Tuskegee experiment (Washington 2008) at a time when medicine was finally addressing the malaise of deeply paternalistic practice which disempowered patients and marginalised other professionals. This text, sometimes referred to as a theory it its own right proposed that the eponymous principles (respect for autonomy, non-maleficence, beneficence, justice) could be derived from all the moral theories. In decision making processes then, detailed referral and discussion to Mill, Kant or Aristotle was unnecessary. Once accepted, the principles are explanation enough of what should guide action. Later editions emphasised the importance of common morality rather than moral theory, that is constructing the principles from below rather than deriving them from above (Baker 2022). This change in emphasis is perhaps of greater interest to philosophers than to practitioners, but there is at least one common theme: Practitioners don't need to know a great deal of moral theory to make moral decisions. There is some evidence however, that they do find moral theories useful (Monteverde 2014).

If the question of how much detail about moral theory that nurses need will be hotly debated not least because of competing priorities in an increasingly crowded curriculum,[18] there are other ways of assessing the use of moral theory in nursing practice. There are, for example, many examples of ethical decision making frameworks, some of which make explicit reference to theories. Park (2012) identified and integrated twenty models, producing a rather complex model which includes consideration of ethical rules, principles theories, professional ethics, legal aspects personal conscience and institute or society's values. The review of existing models suggested that most applied a version of 'ethical pluralism applying diverse ethical theories' (Park 2012, p.141). Consequentialism and deontology were predominantly used; care and virtue ethics were uncommon. Decision making frameworks can be helpful in directing thinking but it's not clear how they can be of use, except in retrospect and upon reflection, to Stephanie, whose moral decision was made in the moment.

Rules (which can be internalised) are helpful for these situations. In a study which used a version of Stephanie as a case study (Kristjansson *et al.* 2017), over 80% of participants responded that they would refuse to follow the practice of deception. Having indicated the decision, participants were then asked to identify, from a list, their reasons for their decision. The list gave six reasons, two of which represented virtue-based reasoning, two represented consequentialist reasoning and two represented duty-based reasoning. The headline message from a range of results specified by scenario and sub-sample is that the commonest justification was duty-based reasoning for all groups. This propensity for experienced nurses to rely on rules was described as 'a disconcerting picture' in a further publication from the study (Varghese and Kristjansson 2018, p.151).

A challenge for research like this is to make the reasons sufficiently specific so that the link between the reason and the moral theory is clear. One of the responses to the scenario

[17] A nursing 'version' of this classic text was produced by Edwards in 1996 and 2009.

[18] In my own university and in addition to a research-based literature review dissertation, there is space for a module on evidence based practice but not for one on ethics.

designated as a deontological reason is that 'You are professionally obligated not to deceive your patients' (Kristjansson et al. 2017, p.25). However, this reason could equally refer to professional rather than ethical reasons, following a rule in a code of ethics. Surveys are rather blunt instruments because it is difficult distinguish between reasons for rule following. A rule (or clause in the code) can be adhered to because it's your duty, or because it's derived from virtue or because it tends to maximise outcomes, or complied with (just) to avoid sanction (Spielthenner 2015). Qualitative research inquiring about how nurses understand their moral environment, tends to focus on experiences rather than detailed discussion whether or how this or that moral theory is utilised in shared decision making or dilemmas addressed (for example, see Karlsson *et al.* 2015).

Conclusion.

There has also not been enough space to consider other perhaps stronger influences on our individual moral outlook – culture, religion, and education, and the professional and legal context has been considered only in passing. That noted, would any of this chapter be of any assistance to Stephanie and her specific decision or any of the others that she would need to consider during her work? The moral theories I have introduced all argue in various ways and supported by survey evidence, that she was wrong, but I suggest that act-utilitarianism provides the most plausible defence. For my own part, though I admit to utilitarian tendencies, my objection was mainly deontological. Would Stephanie admit to being a utilitarian for all decisions? Kristjansson *et al.*'s (2017) study does not report data on whether participants were consistent in their approach across the six scenarios presented. Many, I suspect, will follow Gallagher (2018, p.105) in describing themselves as 'pragmatic pluralists' as far as normative moral theory is concerned even if this is not so much concerned with identifying right action as its justification and the way the decision is undertaken.

It seems to matter (though lack of space precludes analysis) whether care is delivered because of its consequences, or for the sake of duty, or because the nurse is genuinely caring, a trait which leads them to want to care, and/or has an emotional connection with the patient. As well as often arriving at the same normative conclusion, there can be common ground in the approaches such that a virtuous person can favour utilitarian arguments, for example. I would hope that Stephanie would benefit from understanding the broad approaches to normative moral theory, and I suggest that she would agree that there's no single *correct* moral theory for nursing practice.

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