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Covid-19, Ethical Nursing Management and Codes of Conduct: an analysis

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Abstract:	The conduct of nurse managers, and health service managers more widely, has been subject to critique because of high profile organisational failures in health care. This raises concerns about the practice of nursing management and the use of codes of professional and managerial conduct. Some responses to such failures seem to assume that codes of conduct, will ensure or at least increase the likelihood that ethical management will be practised. Codes of conduct are general principles and rules of normative standards, including ethical standards, and guides for action of agents in particular roles. Nurse managers stride two roles. Contra some accounts of the roles of a professional (nurse) and that of a manager it is claimed there is no intrinsic incompatibility of the roles though there is always the possibility that it could become so and likewise for codes of conduct. Codes of conduct can be used to support nurse managers in making practical decisions via an 'outside in' approach with an emphasis on the use of principles and an 'inside out' approach with an emphasis on the agent's character. It is claimed that both approaches are necessary, especially as guides to ethical action. However, neither is sufficient for action because judgement and choice will always be required (principles always underdetermine action) as will a conducive environment that positively influences good judgement by being supportive of the basic principles and values of healthcare institutions. The response to the Covid-19 pandemic has created a unique set of circumstances in which the practical judgement, including ethical judgement, of nurse managers at all levels is being tested. However, the pandemic could be a turning point because staff and institutions (temporarily) freed from managerialism have demonstrated excellent practice supportive of ethical and other practical decisions. Organisations need to learn from this post pandemic.

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The conduct of nurse managers, and health service managers more widely, has been subject to scrutiny and critique because of high profile organisational failures in health care. This raises concerns about the practice of nursing management and the use of codes of professional and managerial conduct. Some responses to such failures seem to assume that codes of conduct, will ensure or at least increase the likelihood that ethical management will be practised. Codes of conduct are general principles and rules of normative standards, including ethical standards, and guides for action of agents *in particular roles.* Nurse managers seem to stride two roles. Contra some accounts of the roles of a professional (nurse) and that of a manager it is claimed that there is no intrinsic incompatibility of the roles though there is always the possibility that it could become so and likewise for codes of conduct. Codes of conduct can be used to support nurse managers in making practical decisions *via* an 'outside in' approach with an emphasis on the use of principles and an 'inside out' approach with an emphasis on the agent's character. It is claimed that both approaches are necessary, especially as guides to ethical action. However, neither is sufficient for action because judgement and choice will always be required (principles always underdetermine action) as will a conducive environment that positively influences good judgement by being supportive of the basic principles and values of healthcare institutions. The response to the Covid-19 pandemic has created a unique set of circumstances in which the practical judgement, including ethical judgement, of nurse managers at all levels is being tested. However, the pandemic could be a turning point because staff and institutions (temporarily) freed from managerialism have demonstrated excellent practice supportive of ethical and other practical decision. Organisations need to learn from this post pandemic.

Hybrid nurse managers, codes of conduct, codes of ethics, healthcare management, ethical management

Introduction

Nursing management is central to the effective organisation and delivery of care in the UK and internationally. [1 2] However, the conduct of nurse managers and health service managers more generally, has been subject to scrutiny because of a number of high profile organisational failures in health care. For example a large scale hospital failure in England was caused in part by the existence of a culture where staff were scared to speak out about poor standards of care because of the attitude and behaviour of managers.[3] Similarly Lakeman and Molloy [4] have questioned the quality of leadership of mental health nursing in Australia and the harm that can result from 'toxic nursing leadership' has been identified in the United States.[5] This issue has assumed even greater significance as nurse leaders face the challenge of managing the service response to the COVID-19 pandemic.[6] The practice of registered nurses is governed by a code of professional conduct to ensure the interests of patients are paramount and standards of professional practice are 'not negotiable or discretionary'[7]. In view of this it is important to consider the role of codes of conduct in nursing management in order to examine how failures in the past have occurred and whether such codes are helpful to nurse managers in their approach to the COVID-19 pandemic.

Background

Managers and their conduct have been implicated in serious failings in health care over many years. For example, Walshe [8] examined a selection of ten major inquiries conducted into organisational failures in the publicly funded UK National Health Service (NHS) over the period 1969 to 2001. A common theme was inadequate leadership by managers and clinicians including weak or bullying management styles, and reluctance to tackle problems even in the face of extensive evidence.

Subsequently there have been many other major systemic failings within the NHS and internationally. [9 10 3 4] There have also been failings in public life more broadly contributing to the creation of an environment in which *trust* in public institutions has been undermined. [11]

The response to such failings has included the introduction of codes of conduct for public officials, [12] managers, [13 14] revisions to professional codes for nurses [15] (and doctors [16]), to include a duty of candour[17] for example, fundamental standards, and virtue terminology such as compassion. Also, in the UK an expert group was convened to conduct a review of standards in public life.[18] The group set out seven principles for public life which were: selflessness, integrity, objectivity, accountability, openness, honesty, and leadership and they have been incorporated in the Ministerial Code, [19] . The need to review standards in public life is also an issue of global concern, reflected in the creation of international codes and principles for public officials.[20] This has resulted in the development of a number of specific codes for managers in healthcare organisations such as the NHS[21] which were modelled on the Institute of Health Care Management Code[22] designed to apply to independent providers, healthcare consultants, and the armed forces as well as the NHS. In contrast to the comparatively recent introduction of managerial codes of conduct, healthcare professionals have been bound by professional codes of conduct for many years as a means of codifying the duty of care and setting standards of professional practice.

The development of codes of conduct in response to concerns about failures in health care and public conduct more generally seems to derive from an assumption that they will ensure or at least increase the likelihood that ethical management will be practised. Codes of conduct normally include ethical principles and rules. The regaining of trust by public healthcare organisations and the trustworthiness of practitioners, including nurse managers, involves adherence to these ethical principles and rules. The changes to existing professional codes and the introduction of new codes of conduct for managers can perhaps be seen as evidence of a recognition of this, arising from an

assumption they will have a positive effect on actions and demonstrate a commitment to patient care. [23] The current COVID-19 pandemic has thrown many nursing leadership and management issues into sharp relief. Opportunities to process decisions and access to a reflective space are important for nurse managers, in order that they can process the difficult decisions need to make when faced with challenges COVID-19 presents.[24] Codes of conduct may help them do this in two ways: an 'outside in' approach or an 'inside out' approach. [25 26] Both approaches are necessary though not sufficient.

Because codes of conduct provide standards and action guides for a defined group of people (a profession for example), and nurse managers can be members of two groups-nursing and management, the next section will briefly explore the role of the nurse manager in order to demonstrate there need be no intrinsic incompatibility between the two groups, though there is always the possibility it could become so, before examining the role of codes of conduct for ethical nurse management.

The role of the nurse manager

The role of the nurse manager can be defined in different ways. [27] If the variety of routes into, and forms of nurse management are considered arriving at a definition that encompasses all types of nurse managers is difficult.[28] This itself may be problematic for deciding what it is that nurse managers should do as well as how they should be. For this discussion, a nurse manager is defined as a person who is a nurse and also a manager. It is a 'hybrid' role [27] 'combining' managerial and professional responsibilities, values, and dispositions in order to organise and deliver care. It involves co-ordination of autonomous skilled workers with authority based on trust and a service ethic as core professional values and responsibility for quality balanced with the need to achieve organisational targets, such as reductions in waiting times, and accountability for measurable results, such as reduction in hospital based infections.[29] (p.190) The responsibilities and values are

set out in a code of conduct and part of the professional disposition is to work by the code,[30] so there will also be a hybridisation of dispositions. There seem to be two broad positions or ideal types[29] that could make the *ethos* of management and professional *roles* different, perhaps even intrinsically different, a managerial approach and an essentialist approach to the professions.[31 32 33] It is recognised that as a strict dichotomy this is inaccurate, however it is one that appears as a recurrent theme in the literature.[29 31 32 33 34 35]

There has been much critical commentary about the suitability of a managerial approach in health care (whether privately or publicly organised) and indeed public services more generally. For example, Ranson and Stewart[36] argued that because the public sector has *fundamentally* different purposes, values, and conditions from those of the private sector, models founded on commercial principles of the private sector were unsuitable. Public managers have to balance client needs, with the policy driven nature of the service rendering it unique. As a consequence, private sector prescriptions for improving public management were inherently flawed. Dopson and Stewart[37] found that public sector managers saw commercially based practices as inimical to public services because they undermined their core values and sense of professional identity. The fact that public service *managers* felt that their core values were undermined by managerial approaches is an important point showing that the term manager and management (at least in public services) need not be equated with managerialism.[29 37]

But the need for a different identity and distinct set of core values for healthcare professionals such as nurses has been expressed in *moral* terms whereby some have posited a clear demarcation, as intrinsic incompatibility, because of an 'internal morality' based on an essentialist nature of the profession concerned.[32 33 34] The role of manager has been characterised as having external norms that do not always coincide with the good of the patient and may even be harmful, because it is focussed on 'business' concerns such that the commitment to certain values, in this case a public

service *ethos* of providing a service of necessary goods or values such as justice, education and healthcare, or more specifically commitment to patient care and to improving patient care[23], is lost, corrupted or overlooked.[32 33 34]

However, an 'essentialist' account of the nature of nursing or any other profession, is difficult to justify[38] and is not an accurate reflection of contemporary practice[39] (although strictly speaking the latter point could be seen as irrelevant from an essentialist position which could simply state that contemporary nursing practice was morally wrong[32] or morally corrupted[34]). And in relation to nursing and management *roles* nursing at all levels has always included elements of management.[39] So, it is not plausible to make a distinction between nursing and healthcare management on moral grounds alone. It is more accurate to suggest that a nurse manager is an ethical role but with different foci and scope. The type of good or value that nurse managers can provide for the patient will vary on a continuum from immediate physical and psychological outcomes achieved as a result of frontline nurse managers organising and leading safe high quality clinical care, to the more indirect, though no less important goods or values, of fair distribution of resources and quality services reflecting the contribution of nurse managers undertaking middle management and executive level roles.[40] Their involvement in managing the wider institution has the moral goal of ensuring the wellbeing of patients. At all levels it is reasonable to suggest that nurses in such roles draw on elements of nursing and management and are thus hybrid in nature. Indeed, Causer and Exworthy [41] identified three broad roles that reflect points on this 'hybrid' continuum-practising professional; managing professional; and general managers. Thus, the artificial separation of the professional role from the manager role in health care is an inaccurate and unhelpful characterisation.

Codes of conduct

As the background section suggests, in the wake of healthcare failures there seems to be an assumption that following codes of conduct will help to ensure ethical conduct. There are differences between codes of ethics, codes of conduct and codes of (professional) practice, with the former regarded as 'aspirational' and the latter two as regulative rules. However the terms are often equated for example Spielthenner [42] argues codes of ethics are created by professionals for various reasons but then states "It is hardly surprising, therefore, that ethics learning and teaching often takes its starting point from professional codes of practice…"(p. 195). Usually, codes of conduct include moral principles and rules as well as non-moral, particularly legal, rules and are written in prescriptive and descriptive language.[43] In this section we use the term code of conduct because its focus is on their use and proceeds from the assumption that whether it be legal or moral principles or rules in the code its aim (be it in spirit or in letter) is to ensure *good*, understood as ethical conduct not just good enough conduct,[43] is the outcome. Here a distinction between ethical motivation and prudential motivation and ethical principles and prudential principles may be pertinent with good enough conduct being motivated by self-interest of avoiding legal sanctions but in many cases it is the outcome that ultimately matters.

Codes of conduct set standards and are guides to action and it has been argued they can do this in two ways; by means of an 'outside in' approach or an 'inside out' approach.[25 26] With an outside in approach the *emphasis* for action guidance is on the use or following of principles and rules; whereas with an inside out approach the emphasis is on the agent's character or ability for situational appreciation.[25 26] Some responses to the systemic failings in NHS care reflect both approaches. For example, it has been claimed that nurses lacked good character and the moral ability to 'see' what was happening around them such as patients being left in soiled bed clothes for lengthy periods of time and water left out of reach.[3] The response was to promote virtue terms[44 45] and emphasise them in the principles and rules of revised codes of conduct.[7 15 16] This may be a

form of (re) 'ethicisation' of professional codes of conduct,[44] through refocussing on the moral objective of the code, the need for education, the importance of moral disposition, and sensibility, [44] and the requirement for particular character attributes such as honesty and integrity.

Yet there are concerns about both outside in and inside out approaches to understanding codes of conduct as guides to action. These include criticism that , that principles within codes are too abstract to be useful and that codes prescribe rigid conformity of action that is inappropriate for the specific and complex situations of nursing practice.[46 26] Moreover abstraction, is conflated with idealisation which is unhelpful because, patients, and nurses are human beings, not idealised agents.[46] Although all practical reasoning involves abstraction to a greater or lesser degree,[46] the idea that adherence to rules requires *uniformity* in action is not necessarily accurate and may have arisen from a misunderstanding of rule following.[46] So (like everyone else), nurse managers need to be able to follow principles and rules intelligently (Kant and Mill both recognised this) and interpret both of their codes of conduct as well as discuss what their codes should be.[30]

The difficulty with an inside out approach is the inherent relativism and even loss of normativity involved.[46] For example as a code of conduct *for nurses*, the relativism is inherent.[30] Whereas the inside out approach may lead to a loss of *role* specific guidance because of the reliance on an *individual's* situational appreciation, which may not encompass the importance of the norms of the professional role or indeed norms for others.[23 46 47 48 49 50] The nurse manager may have contingent problems should her situational appreciation be divided between that of a nurse and that of a manager construing things with a different (not distinct) emphases.[49] Thus, contra some accounts of strongly particularistic views in morality particularly virtue ethics,[47] both outside in and inside out approaches to following principles and rules within codes of conduct are required. But even when adhered to by a virtuous nurse manager codes of conduct are not sufficient for ethical action because judgement and choice are always ultimately required.[46 25] Judgement involves deciding to

do once the many practical principles intended to guide action have been considered, and because they must remain at least somewhat indeterminate there will always be a gap between principles and act.[46] This is unlike the judgement made by a professional or regulatory body or an individual after the act when what has been done is known. Hence some pertinent critiques of codes of conduct about how clearly or otherwise they have been written and can be interpreted especially when used in a regulatory and disciplinary function.[43]

The regulatory function of some professional codes of conduct is unlike managerial codes. Professional codes of conduct are used by the respective regulatory bodies as a 'benchmark' for acceptable professional practice and a breach can be sanctioned by removal of the practitioner from the register which means they can no longer work a professional. In contrast if managers are dismissed they can be re-employed. For example, in 2015 it was reported that the average tenure of an NHS Chief Executive was 2 years and 4 months.[51] Nurse managers thus have an additional and important concern to consider in their actions that managers who are not nurses do not.

Codes *and* character can only do so much because in the environment of practice there are social pressures and economic forces that affect judgement and behaviour.[50 51 52] For example "Where existing realities force hard choices it may be impossible to meet all of the various requirements- ethical and legal, prudential and social, technical and professional- that agents take seriously"[46] (p. 208). The environment matters and the Covid-19 pandemic has highlighted both the need for ethical and other practical judgements to be made frequently by nurse managers in a complex, difficult and rapidly changing environment. Yet, it has somewhat paradoxically provided or emphasised means to do so.

The environment of practice and the covid-19 pandemic

Major ethical failings occur in healthcare organisations despite the existence of codes of conduct and other codifications of behaviour, such as the law and national guidelines. The results of enquiries

have consistently identified the organisational environment as the main cause.[53] It is important to recognise this if expectations of what codes of conduct or ethics can do for nurse managers and decision making are to be realistic. An extreme example of how the broader cultural and political environment can adversely affect healthcare is given by Manea[54] (p. 28) who found that "When working in other Western countries, Romanian doctors behaved as professionally as their colleagues, following the same high standards." Whereas in Romania where there is widespread corruption and bribery is common among people employed in the healthcare sector they were unable to practice to such standards.[54] Even assuming people who work in healthcare organisations are good people, are of good character and seek to adhere to their respective codes of conduct, a supportive working environment is also necessary. This suggests that rather than introducing new principles, new codes, new regulations and regulators, it would be more helpful to address ethical and other standards at an organisational level across the public sector, and indeed more widely.[55] The Covid-19 pandemic has created a situation in which health care has refocused on its core mission (particularly in the acute care setting) and the need to respond rapidly to the challenge of dealing with a new and largely unknown disease has created a situation in which there is 'freedom' to make changes. E.g. increased telemedicine; remote consultations; system innovation (COVID and Non covid areas) in order to cope with the crisis and keep 'normal' services going. [56] In a MacIntyrean sense the external goods of the institution and the internal goods of the practices of healthcare professions are both focused on the core good of healthcare[34 40] rather than the institution being *excessively* focused on external goods, some of which may be unacceptable to practice and the aims of public service.[40 44 46] What the pandemic may be demonstrating is that freed from the full brunt of managerialial[29] control ethical nurse management can be practiced because of, rather than despite, rapid change, and high levels of risk and uncertainty.

The organisation and delivery of care during the Pandemic has resulted in numerous examples of innovative practice that facilitates ethical nurse management by providing support to make decisions and appropriate space in which to make them. In a way it facilitates the *idea* behind 'slow ethics'[57], albeit in the midst of rapid change in a pandemic, with a focus on taking (some) time for contextualised listening, engagement, and support for moral *and other* practical concerns with the focus on patient care. For example, one US hospital created a "continuum of staff support within the organisation"[55] (p. 822) alongside effective leadership and management for resilience and information for empowerment claiming that if workers feel supported in a disaster they will be more resilient. This supports the idea that sole focus on individual (often nurse) resilience is likely to fail.[26] [55] The pandemic has shown how team support, often where teams are changing or include staff who are not usually part of the team, is crucial.[24] For example, adapted Schwartz rounds conducted more rapidly have been used during the pandemic involving nurse managers with direct patient facing roles.[30] The pandemic has demonstrated the need for relational-based forms of leadership development and for senior leaders to support middle managers/mid-level leaders[59] such as nurse managers. Virtue ethics and care ethics inspired accounts of management, sometimes called 'organisational ethics' [39 60 61] are examples of relational-based forms of management. During the pandemic there has been a greater emphasis on the importance of relationships both vertical, between leaders and their teams as well as horizontal, between colleagues for integration of support networks.[30 62] Experience of the pandemic has led some to advocate that:

> Rather than re-establishing the old health system that led us to an epidemic of burnout, we need to engage all team members in rebuilding new, higher-functioning systems that promote workforce well-being[60] (p. 2).

Part of the promotion of work force well-being should include cultural leadership strategies[60] which are crucial to the facilitation of practical decision making and perhaps especially ethical decision making within organistaions.[63] Some of these strategies have been identified above because enable

practical decision making in ethical situations where the epistemology and ontology are different from that required in empirical practical decisions.[62] Indeed, there is an opportunity here to '…draw energy and inspiration from the renewed support and admiration for nurses and the broader health workforce that we see through applause…around the world'[59] (p4) that has been evident in the pandemic to develop a wider sense of trust[64] to support nurses and nurse managers. The relational based forms of leadership and organisational ethics facilitate open communication, which in turn facilitates sharing of values and opinions which prevents the development of silo cultures[63] and the negative impact they can have on health care organisations. Relational leadership can also improve judgements by helping to acknowledge and reduce indeterminacy in order to foster agreement on what should be done.

> Agreement on principles and rules is not enough to resolve indeterminacy, which also needs discussion and communication, which can be enabled by cultures that support effective understanding of others views and proposals (p. 407).[63]

The pandemic has sharpened the focus on healthcare's core values and created a situation in which nurse managers feel able to enact them[62 63]. The pandemic could be a turning point where recourse to codes of conduct will be facilitated, not replaced, as the environment of care in this broad sense becomes a support to ethical nursing management.

7.Conclusion

The current pandemic is 'uncharted territory' for all nurses, including nurse managers. As COVID-19 continues healthcare professionals face a range of practical problems, many of which are ethical in nature. In such times of uncertainty and distress professional codes of conduct are essential and can provide some guidance to support nurse managers navigate the myriad challenges they face. They can serve as a point of reference in situations nurse managers are likely to have never experienced before serving as an 'ethical compass' for nurse managers in a time of uncertainty and challenge, but

the need for good judgement will always remain. This can be facilitated and encouraged if the current environment of trust can be continued post pandemic.

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