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Introduction

To reflect on the nature of the ethical capacity of nurses, it seemed appropriate to look into the history of the profession that could animate people to give care to others. This is obviously not the purpose of this study to conduct a comprehensive study of care concepts that contributed to the current professional identity of nurses, but of trying to reconcile the ethical concerns of the profession and its evolution (Storch, 2009). A development that journeys towards autonomy which is not unrelated to a double emancipation always being acquired: morality in relation to Christianity and professional compared to the medical profession.

Although one can say that the care exists since man exists, this is a mark on an organizing early care, in our Western society at least. The second mark on the genesis of the nursing profession is in the middle of the nineteenth century with the creation of the first modern school of nursing by Florence Nightingale in London.

Care is based on compassion but also the experience, observation and statistical data. The patient is considered a person with a potential capacity to change the situation. The curative purposes regarded not as an end in itself but as part of the nursing period, the inclusion of the person in a holistic (bio, psycho, social, cultural) are the unifying elements of care concepts that contribute the identity of the profession (Tschudin, 2003). The development of these concepts was carried out parallel to the secularization of become a professional nurse.

The nurse activity is now part of a threefold responsibility: the delegate role (implementation of the requirement) in collaboration role, and own role. These roles intermingle

and therefore call for a professional question that can be ethical. The ethos of nurses formed around common values of benevolence and universalism. In concrete terms, we can say that this moral base where individual and professional values are found expressed in the concept of "caring" (Tschudin, 2003).

In nurse ethics, it is not absurd to think that the nurse made practical presence, discussion, consideration of otherness, of unconditional respect of the other, empathy, sympathy, responsibility. This is somehow the place of practice of nursing wisdom, caring ethic. The nursing is part of universality.The reality of a nurse own thought is irrefutable thinking that led to exercise some autonomy. If there is not a "clean" ethics of the profession, we must admit that the patient does not expect the same thing from a nurse or doctor. Of "taking care" that is part of a demand for comfort, aid in the gestures of everyday life and listening ethical reflection can emerge whose origin is different from the doctor after the diagnosis. The nurse ethics could not just intuition, namely the experience to reveal behind appearances that the patient does not say, does not know or cannot express.

In the course of this discussion, the ethical and professional obligations of Katie's case has been discussed according to the 'Four principles approach' given by Beauchamp & Childress. Thus, in order to analyse the given case, it seems appropriate to first discuss Beauchamp & Childress Four principles approach'.

Beauchamp & Childress' 'Four principles approach'

Researchers, professionals and users of health systems want to act morally, but they face ethical dilemmas more and more for which traditional norms (moral rules, religious or ethical), though still valid, are not very enlightening (Häyry et al, 2010). Everyone knows that it is forbidden to kill an innocent person, but this standard gives us little or no information about the

morality of a refusal or cessation treatment that prolongs life, such resuscitation , dialysis, parenteral feeding. The place for discussion of these issues is currently in court. However, the nature and complexity of the ethical issues raised, require further and more comprehensive approach, considering all aspects of the issues involved. Thus, bioethics approach as multidisciplinary or trans-disciplinary, includes knowledge from different health disciplines, including medicine and nursing, but also sociological, legal and ethical knowledge (Emanuel et al, 2003). The bioethical approach is not to juxtapose that knowledge, but rather to bring together the development of guides for responsible human action.

Bioethics revives the philosophical debate, i.e. the relationship between (what is) and Ought (what should be), since it aims to establish guides to action ethically and morally good, both in the case of individuals solution (micro-ethics), as in the development of guidelines for care policies (macro-ethics). These guidelines cannot be made without proper knowledge of the facts and scientific, ethical and legal standards that govern them; otherwise they would not be applicable (Häyry et al, 2010).

It is important before going further to situate bioethics in all disciplines or specialties that deal with ethics or morality. Several authors use ethical and moral terms as synonyms. They are based on Greek etymologies (tà ethica) and Latin (moralis) which both refer:

1. Customs, attitudes and behaviours;
2. Rules governing them;
3. Justifications and foundations of rules (Häyry et al, 2010)

Because of its regulatory target, bioethics is in the sphere of general and applied normative ethics. The general normative ethics studying ethical theories in order to answer the

question: what are the best guides for action morally and ethically right and why they are the best guides? The applied normative ethics is unique to a particular field of activities. It is concerned to provide adequate solutions to a given problem in a given sector.

Bioethics constitutes an original approach which does not call for a unified theory which could be derived from standards for action, as occurs in traditional ethical theory. The term therefore not applied here refers to the use of a deductive method, but rather concrete and corporate practice.The now classic method is the approach by bioethics principles, developed by Beauchamp & Childress (1994). The authors analyse the present ethical issues in medical practice based on four main principles:

1. Autonomy;
2. Beneficence;
3. Non- Maleficence;
4. Justice

These principles come from different sources. Thus, the principles of beneficence and non-maleficence are inspired by the medical tradition, as stated in the codes of ethics; respect for the autonomy of the person has been identified in the guidelines since the first experiments in Helsinki Declaration in 1964 and the principle of justice was put forward by the work of the US Presidential Commission for study of ethical issues in medicine and biomedical research. These four principles were needed to deal with problems of biomedical ethics. They correspond to general moral standards from common morality and traditions. As such, they give only very general indications as to the morality of decisions. So:

1. The principle of respect for autonomy requires respect for autonomous decision making of people;
2. The principle of beneficence imposes not only be beneficial posing positive actions, but weighing the benefits against the possible harm that may arise, so as to maximize benefits and minimize harm;
3. The principle of non-maleficence imperative not to inflict harm on others;
4. The principle of justice requires fairness in the distribution of profits and risks

These principles are common to all cultures and are found in most ethical theories. These are universal principles that are within the domain which Beauchamp (1996) called morality in the narrow sense of the term. He distinguishes in fact two types of morality, one that consists of general precepts are vague, abstract and universal and the other corresponding to the interpretation by different groups and cultures in terms of practices and specific rules. Bioethical principles belong to the first type of morality. As such, they provide only vague indications for action and are likely to be interpreted in multiple ways. To be applied to solving concrete problems, they must be defined more specifically.

Utilitarian and Kantian theories principles as conceived by Beauchamp & Childress (1994) impose a moral obligation to respect the autonomy of the individual, not wrong to do it, to act in order to procure a profit. The authors retain the idea that the principles generate moral obligations prima facie, meaning that each of them is binding, unless they conflict. In the pluralistic deontologistism, the examination of the facts then tells us which of the conflicting principles will be binding. Ethical analysis will seek to establish harmonisation between principles and demonstrate why the moral obligationgenerated by one of them will predominate.

The development of benchmarks for action is performed by a dialectical approach between facts, interpretation of facts and knowledge that we have in different disciplines on the one hand, and pins from ethical analysis and theories, ethical standards and common morality, on the other. In this process, common sense, not in its philosophical sense, that is to say, common sense plays an important role. Indeed, the ethical judgments from analysis that are incompatible with the judgments of common sense or common sense are rejected. This allows the development of solutions that are likely to consensus and which therefore, will apply.

Ethical Obligation towards Katie

In this particular case, Kate is scared of the psychiatrist and she does not want to see the on-call psychiatrist and that she will discharge herself from care if he arrives on the ward. This is the case of the autonomy of the patient which is given to the patient in Mental Capacity Act 2005.

According to Mental Capacity Act 2005, which was implemented in England and Wales in 2007, the patients are empowered and protected who will be unable to settle on a few choices for themselves. It additionally empowers individuals to arrange ahead in the event that they are not able to settle on essential choices for themselves later on. A large portion of the Act went live in October 2007, albeit a few sections of it got to be law in April 2007.

This Act applies to anybody who is 16 or more than 16 years of age in England and Wales. It ensures individuals with psychological well-being issues and in addition individuals with dementia, learning inabilities, or stroke or mind wounds. These individuals may think that it is hard to settle on choices sometimes. Anybody can utilize the Act to arrange ahead in the event that they are not able to settle on choices later on.

This Act also applies to circumstances where individuals may be not able to settle on a specific choice at a specific time. For somebody with an emotional wellness issue, this will rely on upon how they are feeling or the effect of their condition on them around then. Now and again, they may have the capacity to settle on the choice at a later date.

The Mental Capacity Act can apply to a wide range of choice, for example:

- Major choices, for example, choices about individual money, social consideration or restorative treatment;
- Everyday choices, for example, choices about what to wear or eat

The law chips away at the rule that everybody is accepted to have ability to settle on choices for themselves in the event that they are sufficiently given data, bolster and time. It secures the entitlement to settle on his or her own choices and to be included in any choices that influence him. Regardless of the possibility that the choice seems hasty or unpredictable, the Act makes clear that try not to be dealt with as lacking limit.

All therapeutic and social consideration experts and paid carers and individuals performing certain parts and capacities made by the Mental Capacity Act, must 'have respect to' the Code of Practice that goes with the Act when they are supporting somebody that needs limit. This includes paying consideration on the Code and having the capacity to show nature with its direction.

In this particular case the nurse, by clinical judgment developed from information gathered from the patient and / or her family, is in the position to understand that using the services of the psychiatrist is necessary for Kate. From a prescription, it is the exercise of the specific role that initialises the ability to lead a multidisciplinary reflection on the uniqueness of

a situation. However, the principles of bioethics and the Mental Capacity Act 2005 placed the autonomy of the patient at the centre where no decision can be taken without her consent.

Similarly, The GMC (2007) 0-18 years: guidance for all doctors, recommends: ◦ "…doctors must safeguard and protect the health and well-being of children and young people. Well-being includes treating children and young people as individuals and respecting their views, as well as considering their physical and emotional welfare. ◦ 'When treating children and young people, doctors must also consider parents and others close to them; but their patient must be the doctor's first concern"

However, a dichotomy may occur in this case as Kate wish to exercise her autonomy; and on the other hand, satisfied with the care she has been given, assuming a passive role. This is evidenced by contrasting a high level of overall satisfaction with the little patient participation in the answers concerning their autonomy.Moreover, it is shown that the cultural context shapes the doctorpatient interaction in the field of medical decision making (Ruhnke, 2000).

Thus, in this particular case, it seems obvious that although Kate does not give her consent for a psychiatrist, but she needs psychosis therapy for her treatment. The case study describes that when the nurse was completing her admission paperwork with Kate, the psychiatrist walks onto the ward. This shows that there is still some paternalistic attitude of the medical staff, which contradicts the desire, even tacit patient autonomy.

In this scenario, the role of nurse is very important. She first console Kate and convince her that instead of exercising her autonomy, it is more important for her to receive information regarding her general health condition directly involved in the process of making medical decisions.

The limitation of Kate in the exercise of their autonomy, is directly related with the level of education and degree of economic dependence, which is essential to further explanation in terms that can be understood by Kate. It is important that she must know her diagnosis. It is important that the doctor raised from the outset the various therapeutic options from an economic point of view, so that Kate is free to decide which option is the most suited to her situation, without compromising their autonomy.

Nursing Strategies to gain trust of Patients

To convince Kate that psychiatrist services is important for her treatment, the nurse has to gain her trust. To build relationships with patients which are based on trust and respect, the nurse must possess the qualities of listening, simplicity, availability, humility, authenticity, humour and compassion. It is this reciprocity built into a trusting relationship. Scope is an essential virtue guiding the nurse-patient relationships. It is said that interpersonal relationships and effective nurse-patient communication are decisive factors in the quality of nursing care (McGilton et al, 2006).

In this particular case, relationship, based on trust, with Kate is especially important because she has very different needs due to her limited capacity to adapt tohospital setting. One factor that influences the overall welfare of Kate depends on the affection,accompaniment and empathic therapeutic relationship that determine the emotional state of Kate and affect the understanding of the processes experienced. It is especially important in this case because Kate has no family at all and has no one to take care of her; that is why affection and accompaniment are the basis of a trusted relationship between her and her nurse (Mikkelsen & Frederiksen, 2011; Schimidt et al, 2007).

It is believed that, to improveknowledge on the aspects that to make up the nurse- patient interaction, it is required to assess the behaviours that have each of the actors involved in this process and deepen bothcontent and the structure itself that may haveinteraction at certain times and circumstances of care.Therefore, in order to know the factors thataffect or facilitate the relationship established between thenurses and hospitalized patients, it is important to identify the behaviours adopted by nurses which can influence the psychosocial well-being of the patients.

It can be said that behaviour of the patient in the relational dimension and behaviour of the nurse in the relational dimension. The trust of the patients can be gained by taking in consideration the perception, feeling and demands of patients from the relationship with nurses.

The communication in this relationship plays an important role and has several purposes. One purpose is to recreate and distract the patient during proceduresor medical examinations, and the other is to do with theintention to show empathy for the patient. The stimulus of laughter and joy is an important factor for healthy growth and development of children and encourages positive behaviours, in addition tolearning and social interaction. As Kate is in her adolescence she loves fun; it is suggested that the nurse should use jokes into her communication with Kate which helps to alleviate stress and anxiety. Clearly such interactions in communicationwith patients reported a therapeutic benefit. The humourand laughter is a resource that is used as a tool of empathy and effective distraction (Buxman, 2008). Patients usually valuethis stimulus positively and interpret it as amanifestation of encouragement for their soul.

It is also important for patients like Kate that the nurse show empathy towards her and she will start trusting the nurse because she has no one to trust and to share her problems. A key

point in the perception of Kate is the degree of harmony she feels in theinteraction. She will gradually start trusting the nurse due to the support and comfort provided.In addition, Nurse's demonstrations of affection for Kate are related to bodily expressions for therapeutic interventions, this helps them to create bond with ease.

Conclusion

The autonomy principle of bioethics compelled the nurse, in the mentioned case, to avoid using psychiatrist services without the consent of Kate. However, as it is important for Kate to use the services of psychiatrist, it is the duty of the nurse to convince Kate to give her consent to use psychiatrist services.

In order to get Kate's consent, it is important that Kate started to trust the duty nurse considers the nurse her friend. For this purpose, the nurse must adopt a strategy to build her relationship with Kate, based on trust and respect, with which the nurse can convince Kate that the services of psychiatrist is important for her and she should give her consent to use this services.

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