

Failure to report as a breach of moral and professional expectation

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Abstract

Cases of poor care have been documented across the world. Contrary to professional requirements, evidence indicates that these sometimes go unaddressed. For patients the outcomes of this inaction are invariably negative. Previous work has either focused on why poor care occurs and what might be done to prevent it, or on the reasons why those who are witness to it find it difficult to raise their concerns. Here we build on this work but specifically foreground the responsibilities of registrants and students who witness poor care. Acknowledging the challenges associated with raising concerns, we make the case that failure to address poor care is a breach of moral expectation, professional requirement and sometimes, legal frameworks. We argue that reporting will be more likely to take place if those who wish to enter the profession have a realistic view of the challenges they may encounter. When nurses are provided with robust and applied education on ethics, when ‘real-world’ cases and exemplars are used in practice and when steps are taken to develop and encourage individual moral courage, we may begin to see positive change. Ultimately however, significant change is only likely to take place where practice cultures invite and welcome feedback, promote critical reflection, and where strong, clear leadership support is shown by those in positions of influence across organisations.

Introduction

The issue of poor care has received considerable attention over the past few years. Much of this interest has focused on exploration of why it occurs and what might be done to prevent it. Stenhouse et al. (2016) provide an overview of these discussions, with Paley (2014), Randall and McKeown (2014), Roberts and Ion, (2014) and Bagnasco et al. (2017) among the many who have contributed more detailed accounts. An additional strand of work has examined the responses of those who witness poor care, with evidence suggesting that many choose not to

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take action – reviews by Jackson et al. (2014) and Ion, Smith, and Dickens (2017) summarise much of this literature. In this paper we consider a related, but comparatively neglected issue – specifically the legal, moral and ethical position of those who witness poor care. In doing this we acknowledge and draw on the work of Skarlicki and Kulik (2004) whose detailed model provides a valuable framework for understanding the responses of those who witness unjust behaviour in the workplace. Taking account of a range of factors, including the characteristics of transgressors and witnesses, interpersonal relationships, as well as the perceived severity of the transgression and the likely response of organisations, they outline the interplay of factors which inform decisions about whether or not to take action when faced with perceived unfair, unjust, morally or ethically unacceptable behaviour. Here we deal with one element of this, namely the need to ensure that witnesses understand both their role and their responsibilities in relation to injustice. Without a clear understanding of this, it is unreasonable to expect that individuals will act in ways which may often have a negative impact upon them. We make the case that nurses are obligated to act to protect patients and clients and that failure to do so compromises patient safety. In doing this we acknowledge the challenges associated with speaking out and intervening, especially in toxic, hierarchical cultures (Darbyshire & Thompson 2018), but argue that failure to do so privileges the needs of the nurse over those of the patient. Finally we suggest approaches which may be used to encourage action and promote responses that foreground the needs of patients and prioritise their safety and dignity.

Defining the problem of poor care

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Professional and ethical guidance from across the world makes it clear that nurses are expected to prioritise patients' welfare and ensure their safety (American Nurses Association, 2015, ICN, 2012, Nursing and Midwifery Council 2015, Nursing Council of New Zealand). There is now a well-documented evidence base indicating that these priorities are often ignored, forgotten or overridden (Reader & Gillespie, 2013). This may be a consequence of committed and competent staff trying to manage competing priorities under very difficult circumstances. It may also be an outcome of errors, omissions or mistakes. This does not however, account for all instances of care failure. The focus of this paper is poor care - a term we use to describe actions or omissions by health care staff that involve deliberate neglect, abuse, or incompetence, systemic and personnel failures or toxic/confounding combinations of the aforementioned. It may or may not lead to serious or even fatal consequences for patients. Where errors, mistakes and episodes of missed care may lead to the same serious outcomes, we distinguish them from poor care in that the former are unintentional actions which are a result of human or organizational factors (Ion, Jones, & Craven, 2016). To further clarify, our interest here is in what might be called failures of health care humanity where, for example, patients are ignored, left unkempt or uncared for, neglected or otherwise treated as unimportant. What we have termed 'poor care, others have more bluntly described as 'shitty nursing' (Richards & Borglin, 2018).

Bystanders to poor care

As well as formal legal sanctions, national nursing organisations have mechanisms for judging and sanctioning those who are found to have directly participated in neglect, abuse or incompetent care. In the UK for example, the primary role of the Nursing and Midwifery

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Council (NMC) is the protection of the public, with its Fitness to Practice panel holding the ultimate sanction of removal of a registrant's right to practice. While there may be few contentious issues concerning the disciplinary consequences for those who are judged to have directly contributed to poor care, the position and culpability of those who are witness to these cases is sometimes less clear. Our focus here is on these witnesses or bystanders. We consider the explanations proffered for why some who directly observe poor care decide to raise their concerns, while also exploring accounts explaining why others choose to ignore them. We examine legal, professional and ethical guidance for health workers and the implications of not reporting, both for the patient and the nurse. Finally, we reflect upon the steps that might be taken to address the problem of those professionals, at whatever organisational level, who remain passive when faced with neglect, abuse or incompetence. Our overarching thesis is that both from the perspective of deontological ethical theory (the ethics of duty and obligation) and from consequential and virtue ethics perspectives, registrants who witness poor care ought to take action when they encounter it. To do otherwise is a breach of professional and ethical guidance that in some cases may also contravene national legislation. It is also, quite simply, morally wrong.

Is poor care a significant problem?

There is good evidence to suggest that this is a significant problem. It is a global issue and appears to be becoming more commonplace, if not 'the new normal' as some suggest (Richards & Borglin 2018, p.2). Nursing care is particularly implicated in many of these notorious cases. It is now ten years since the explosive depictions of the appalling 'care' and neglect

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experienced by predominant elderly people in the NHS detailed in the Patients' Association report: 'Patients not numbers: People not statistics' (The Patients' Association, 2009). It is six years since the scale of care failure at Mid Staffordshire NHS Trust in the UK became apparent with the publication of the Francis Report (Francis, 2013). This was quickly followed by revelations of failure at the Vale of Leven (MacLean, 2014), at Winterbourne View (Phelvin, 2014), Morecambe Bay (Walsh, 2013) and in Wales (Andrews & Butler, 2014). Health care and the state of professional caring in the UK is under significant scrutiny, with nursing care particularly implicated (Traynor & Buus, 2016). In 2018 a possible new nadir was reached with publication of the 'Gosport Report' in the UK detailing the possible 'shortening of the lives' of some 600 or more older people in a hospital (Darbyshire & Ion 2018, Darbyshire & Ion 2019)

Poor care is not however a purely British phenomenon. Malmedal, Hammervold, and Saveman (2014) have shown that abuse, neglect and inadequate care are realities for patients in many countries - a claim borne out by Hindle, et al. (2006) in their analysis of eight inquiries across six countries. In a more recent review of patient neglect in health care settings, Reader and Gillespie (2013) noted widespread public concern around the issue in both Europe and North America, reporting on evidence of its occurrence across these continents, as well as in Asia and Africa. It may be tempting to argue that this is a recent phenomenon and evidence of a modern malaise in the health care professions. This would be to ignore the historical record which clearly indicates that abuse and neglect of patients has always been with us (Ion & Beer, 2003, Ryden-Grange, 2015). It would be similarly incorrect to think that the poor care problem has been resolved in the wake of the fallout from previous scandals. In an interview in February 2017, Sir Robert Francis made it clear that he felt another failure on the scale of Mid-Staffordshire was now inevitable in the UK health system (Ford & Lintern, 2017). Similarly in

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Australia another scandal has recently unfolded at Oakden ‘care facility’ for older people with dementia and other mental health issues, where the official report subtitled, ‘A Shameful Chapter in South Australia’s History’ describes the situation, somewhat predictably, as one which should never have happened and must never happen again in the future (Lander, 2018).

Reporting poor care: how do witnesses respond?

In the wake of the events at Mid Staffordshire (Francis, 2013), there was critical debate in the literature about the extent to which bystanders were fully aware of the degree to which standards were compromised. Two related lines of argument were put forward. First, that contextual factors, including the pressure of the work environment, may have meant that some staff simply did not notice what should otherwise been apparent (Paley, 2014) and second, that continued exposure to poor care might have inured some to the reality of the situation (Timmins & De Vries, 2014). It may be hard to comprehend, but, if nurses are unaware of poor care or are unable to identify it, then we cannot expect them to respond. Although work may need to be done to address the circumstances which affect the ability to recognise transgressions, our focus here is on those who are aware that abuse, neglect or incompetence have compromised patient safety.

Numerous researchers and commentators have examined this topic. Jackson et al. (2014) reviewed the empirical work which explores the responses of registered nurses to poor practice, with Milligan et al. (2017) Ion, Smith and Dickens (2017), Bickhoff, Levett-Jones, and Sinclair, (2016) and Fagan, Parker, and Jackson, (2016) undertaking similar work in relation to nursing students. They reach the same general conclusions. First, those who witness poor

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care and report it tend to do so because of their personal moral position and / or a commitment to professional standards. Here the act of addressing poor practice is often framed as personally and professionally challenging and may require what Bickhoff et al.(2016) describe as moral courage. Second and crucially for this paper, it is clear that many of those registrants and students who witness poor care do not report it. In the main this is because they fear a range of negative personal and professional consequences that may befall them if they ‘whistleblow’. Examples might include: bullying, ostracism by co-workers and negative impact on future career prospects . Some also choose to ignore the problem because they believe that their intervention is unlikely to make any tangible positive difference to the situation. There is a well-developed social psychological literature on the subject of excuse-making and exoneration, which is broadly reflective of these findings (Antaki, 1994). This argues that decisions to privilege self over others is frequently justified through the development of arguments or excuses which position the individual facing an ethical dilemma as having little or no choice in terms of how to respond. It is suggested that the potential negative consequences of action are so great that inaction, or in this case non - reporting of poor care, is the only reasonable course open to the witness and moreover, this is the same inaction that most reasonable people would take under the same conditions. According to Ion et al. (2016) accounts of this type serve to protect the individual both from cognitive dissonance and from the potentially negative evaluations of others, which might be expected to occur by placing self before patient.

The outcome of much of this work has been a general acceptance of the very real difficulties associated with whistleblowing and an acknowledgment that the decision to keep quiet in the face of poor practice may be ‘understandable’, or at least the only reasonable option open in many cases. Duffy et al. (2012) for example, asked if we may be expecting too much of nursing

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students by expecting them to raise their concerns, while Glasper (2015) has talked of the support that must be provided if challenging poor practice is to be a reasonable option. The motives or moral integrity of such authors is not in question, but it is possible that repeated insistence on the difficulty of reporting may inadvertently perpetuate a culture of avoidance. It could be argued that this position is further sustained in some of the official reports and professional commentaries that have been written on the topic and that highlight the challenges of raising concerns. Francis' (2015) grim account of whistleblowing in the UK health service may be an example, as is the recent report from the UK House of Commons Public Administration and Constitutional Affairs Committee (2017), which details the UK Health Services' poor record on investigating and handling complaints, exasperatingly entitled: "Will the NHS Never learn?"

While this 'it's difficult' stance seems to be the dominant position, it has been questioned by some commentators. In their discourse analysis of student nurses' accounts of actions and omissions in relation to reporting poor care, Ion et al. (2016) suggested that credence be given to the idea that perhaps nurses who witness poor care and do not report it are opting to privilege self, in preference to protecting the patient by directly tackling instances of poor care. Arguing for the continued relevance of moral character and individual accountability Darbyshire, Ralph, and Caudle, (2015) have also been critical of those who have tried to remove all responsibility from the individual in order to place it within a depersonalised system or situation. Roberts, (2016, 2017) has also explored the issue of personal responsibility and poor care. Drawing on Sartre's concept of 'bad faith' and his position on individual freedom, he argues that, while reporting poor care may be an uncomfortable or even very unpleasant experience, it is disingenuous for individuals to claim that they were unable to do so. In preference to the deterministic position taken by those who maintain that whistleblowing is often too dangerous

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to consider, following Sartre, Roberts, takes the view that we are fundamentally free to choose what we do, or do not do. By extension, if we opt to turn a blind eye to the occurrence of bad practice, we do so freely and not because we had no other option. In summary then, although it has become commonplace to argue that a failure to report poor care is understandable and as such excusable, there is a developing literature which questions this view and which foregrounds the position that nurses are professionally, morally and legally bound to challenge care which is harmful, regardless of their personal concerns about doing so.

Failure to act and its potential consequences

For staff who witness poor care, there are undoubtedly 'benefits' to be gained from deciding those who spoke up had been ostracised and become unwell as a consequence, as well as cases where the impact of their actions had spilled over into family life. Francis (2015) was equally clear that the negative consequences for the individual of doing the right thing could to ignore it. These are predominantly the avoidance of potentially negative consequences. In their review of the whistleblowing literature, Jackson et al. (2014) identified situations where be very significant. An awareness of these potentially adverse consequences is also clear in some of the empirical work on student encounters with poor care which was reviewed by Ion, Smith and Dickens (2017). Sadly such fears are well-founded as the literature on the negative effects of whistleblowing on the whistleblower shows (Wilkes et al. 2011).

The evidence that negative outcomes always arise and that when they do they are invariably significant for those who raise concerns is less clear. This is particularly in cases where poor care is challenged less formally (Jones & Kelly, 2014) or when the culture in which reporting takes place is supportive (Levett-Jones & Lathlean, 2009). In situations of this type, the

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consequences for reporters may even be positive. Moreover, work with student nurses has indicated that some of those who report do so out of a sense of moral or professional commitment. Presumably in these instances, there is the possibility that reporting has positive psychological outcomes insofar as action taken is complementary to the individual's own ethical compass (Ion et al. 2016).

For patients, the failure on the part of health workers to take action has no known positive outcomes, only a wide range of negative ones. Given the evidence that that much poor care goes unreported, it is difficult to quantify the full scale of human misery associated with professional inaction. We do, however, know what the consequences of poor care are and can therefore conclude that failure to report it is likely to perpetuate suffering. Although profound, the reporting of mortality statistics alone does not necessarily capture the full nature of patient suffering caused by poor care. A clearer view of this is provided by Reader and Gillespie (2013) in their review of patient neglect in healthcare. They identified examples of rudeness and failure to meet patient hygiene and pain relief needs in two South African obstetric units (Jewkes, Abrahams, & Mvo, 1998), failure to assist bedridden patients in German homes (Goergen, 2004), the ignoring of patients and allowing unnecessary delays in attending to their needs in Norwegian nursing homes (Malmedal, Ingebrigtsen, & Saveman, 2009) and failure to provide adequate nutrition and hydration in American nursing homes (Zhang et al., 2011) Further examples can be found in Masala-Chockwe and Ramukumba, (2015) and Chokwe and Wright (2011) whose work with student midwives in South Africa revealed examples of registrants ignoring patients cultural preferences, 'screaming' at a patient in the operating theatre, sleeping while on duty and failing to provide emotional support to a women whose baby had died before birth. A similarly stark picture of the impact of poor care is provided in the UK Parliamentary

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and Health Service Ombudsman's report (Health Service Ombudsman, 2011) that detailed ten cases of care failure across the English NHS, quoting one relative as saying:

Our dad was not treated as a capable man in ill health, but as someone whom staff could not have cared less whether he lived or died (p.1).

That the life of a loved one could appear to be of so little value to those charged with their care is profoundly troubling. Perhaps most disturbing of all is the evidence that has emerged over recent years regarding the involvement of American medical and nursing personnel in the torture and degradation of enemy combatants in Iraq, Afghanistan and at Guantanamo. Mohr's (2009) chilling summary makes very discomfoting reading:

... 60 years after the Nuremberg trials, America's healthcare professions are faced with the knowledge that their members have been complicit with abetting torture and concealing evidence or remaining silent about brutalization of human beings in their care (p. 289).

Put simply, while the failure to raise concerns may be understandable regarding any disruption of the status quo of the health professional's life, the potential consequences for patients may be catastrophic. There is a clear tension here between the needs of the health care worker as a person and the needs of the vulnerable people for whom they provide care. There is a similar dissonance between the health worker as a person and their professional position.

Ethical practice and the expectation that nurse will protect the vulnerable

Health care workers are subject to a range of legal, ethical and moral frameworks which dictate, guide and suggest how they should respond when faced with difficult decisions or

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circumstances. Here we consider these in light of the problem of what to do when faced with evidence of incompetent care, abuse or neglect of patients.

Practitioners are subject to the laws of the country in which they work. At the extreme end of the spectrum, poor care may overlap with criminal activity, for example in cases of patient abuse. It is possible therefore that a member of staff who witnesses, or is aware of, financial, physical, psychological or sexual abuse of a patient may breach the laws of that country if they choose to ignore the action. In doing this they invite legal sanction. From a professional perspective, guidance provided by regulatory bodies invariably makes it clear that staff have a duty to respond to and raise their concerns if they are concerned about patient welfare. For example, section four of the Code of Ethics of the International Council of Nurses (ICN, 2012) states that the nurse must take:

....appropriate action to safeguard individuals, families and communities when their health is endangered by a co-worker or any other person.

There is no ambiguity here and it is clear that a nurse who fails to act is in breach of this guidance. An expectation that the registrant will take action is also made clear in the Nursing and Midwifery Board for Australia's (2018) Code of Conduct for Nurses in which Principle 2 makes it clear that nurses must act upon concerns about patient safety. In the UK, a similar position is made explicit in the Code (NMC 2015), which states that registered nurses must

... work within the limits of your competence, exercising your professional 'duty of candour' and raising concerns immediately whenever you come across situations that put patients or public safety at risk.

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This guidance makes it clear that patient safety is paramount and that there is an expectation that concerns about poor care will be addressed proactively. To conclude that behaving otherwise might be either negotiable or discretionary is wrong. Failure to address poor care is a direct breach of standards which puts the witness of such abuse, neglect or incompetence at odds with the expectations of regulators and may incur professional sanction.

Health care has sought guidance from a range of ethical and moral frameworks to help consider the way to best respond to difficult situations and dilemmas which arise in work with vulnerable people (Edwards, 2009). These invariably draw on Anglo-European traditions such as deontological, utilitarian/consequential, virtue or principle-based approaches. With the exception of utilitarian/consequence based systems where it might be possible to construct an argument that a greater good could be served by privileging the needs of the many over the individual, these principles offer little room for doubt when applied to the problem of how to respond to poor care. Applying Kant's categorical imperative, often interpreted as 'do unto others as you would have them do unto you' (Edwards, 2009, p. 838), it is hard to see a case which allows for inaction in the face of abusive, negligent or incompetent care. Similarly in virtue ethics, where for nurses virtue is commonly taken to mean behaviour which is aligned with kindness, care, sensitivity and courage, it seems very unlikely that nurses could legitimately argue that allowing the continuation of preventable distress through the failure to intervene is a legitimate course of action. The same conclusions are reached when an answer to the problem of poor care is sought through application of Beauchamp and Childress (2013) principles of beneficence, non-maleficence, justice and autonomy. Commonly interpreted as do good, do no harm, act fairly and respect the rights of the person, the health worker who is witness too, but ignores poor care, is clearly at risk of breaching one or more of these (Gamble & Ion, 2017).

Responding to the challenge

Poor care is an unpleasant reality that results in significant suffering. Legal, professional and ethical guidance is unequivocal in relation to expectations about the behaviour of registrants who witness it. We now explore what might be done to address the phenomenon of the passive bystander who witnesses abuse, neglect or incompetence but chooses to ignore it. Our focus here is on moral courage - the idea that individuals will act in the face of possible risk to self if they believe that there is a 'right' course of action that must be followed to achieve a greater good. Before doing this we wish to emphasise that moral courage is only one element in the reporting of poor care. Of equal and perhaps greater significance are the cultural norms and values which prevail in health systems. We include not only organizational culture and leadership style but also the relationships between employers, employees and professional bodies and trades unions. Where these are open, transparent, insistent on hearing 'bad news' as well as 'good news', where they expect and value feedback, reward professional engagement and value partnership over adversarial approaches, then individuals must step up and speak out. There is no acceptable excuse for not doing so. However, if the environment is toxic, honest dialogue becomes impossible and thus only the very courageous will speak out. As Hindle et al. (2006) noted, reliance on 'personal heroism' alone is woefully insufficient and indicative of a system or organisation that is morally bankrupt. Such a system seems to tacitly accept that poor care is an inevitable part of the 'norm' as are the malevolent power plays that would readily silence all but the most 'heroic' of whistleblowers. It is almost impossible to see any aspect of such a system that is acceptable today. Put bluntly, if your staff must be 'personally heroic' in the face of systemic toxicity as they report poor care, there are not merely some 'bad apples' but a rotten and poisonous orchard (Darbyshire & Thomson 2018, p.142). Our discussion here is focused on what can be done by ordinary nurses in environments where

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speaking out may at times be uncomfortable or even difficult, it is not concerned with situations where only a hero would take a risk. We consider three questions. First we ask if we can be confident that those who enter the profession fully understand the responsibilities they have committed to when doing so? It would be unreasonable to expect individuals to act against self-interest if they have no sense that this might be a requirement of the role at the earliest point possible. Second we consider whether or not we can be confident that all nurses fully understand the ethical frameworks upon which the profession is built. Without this we are expecting individuals to make difficult choices and decisions based upon experiences and knowledge gained outside the discipline and we cannot be certain that this alone will suffice. Finally we consider the issue of action and what might be done to develop and activate individual moral courage.

According to Cabaniss (2011), popular conceptions of the profession are often outdated and frequently depict an image that harks back to a non-existent halcyon past in which selfless young women assisted heroic male physicians. A recent review of twenty-one studies by Girvin, Jackson, and Hutchinson (2016) found similar misconceptions about the work of nurses, which were also echoed by Tuckett, Kim, and Huh (2017) and Glerean et al. (2017). If as seems likely, applicants draw on this pool of cultural information when considering entry to the profession, it is hardly surprising that they may feel overwhelmed when faced with the reality of clinical work. If the profession expects those who enter to fully understand the nature of the work and the personal commitment it requires, then it needs to take steps to ensure this. There are some simple messages which can be conveyed in both recruitment campaigns and more generally when presenting the work of nurses. While it can be tremendously rewarding and provides many opportunities, nursing is hard, nursing is difficult and it requires skill alongside personal qualities such as kindness, trustworthiness, fierce intelligence and at times,

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moral courage. In addition nurses need intelligence, a sense of curiosity, an eye for detail and a commitment to what is often denigrated as 'basic care', but which would be better framed, as it is through the eyes of patients, as essential or fundamental care. It is rarely if ever glamorous - how could it be otherwise when it involves supporting the troubled, the sick, the dying and the bereaved? It is challenging and assuredly places a burden on the individual. Part of this burden is the heavy responsibility that cannot be sloughed off, for the care of others, which comes with professional registration. Those who understand and accept this may be better equipped to deal with the fallout that can sometimes result when taking action to protect the vulnerable.

Having a realistic understanding of the work may help to some extent, but is not on its own sufficient to equip practitioners with the knowledge and skills they need to respond to concerns about care provision. Although individual moral frameworks are developed in a variety of ways across a lifetime, there is a clear need for educators and employers to provide robust ethics and indeed 'political' (small 'p') education which adequately prepares nurses to deal with ethical dilemmas, such as the reporting of poor care within the complex systems in which many will work. The extent to which this happens is unclear (Ion, De Souza & Kerin, 2018). While professional bodies are invariably explicit that education providers must address ethical issues in their programmes, the manner in which this is done is left to the institution. This in turn may be dependent on the interests and inclinations of individual faculty. This suggests that there may be room to strengthen the ethics component of many undergraduate and continuing professional development programmes, not least by more tangibly integrating the "real worlds" of clinical practice with ethical theory and philosophy. Woods, (2005) for example, argued over ten years ago that ethics education for nurses may not be fit for purpose and in doing so called for nurse academics to review their teaching approaches. Work by Grady et al. (2008) also found that exposure to ethics education amongst American nurses and social workers was

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variable. Of equal importance they found who those had received it were both more confident and more likely to take moral action. Robinson et al. (2014) similarly reported that enhanced applied approaches to ethics teaching can have a positive impact on behaviour in the practice setting – specifically, that participants felt more able to respond to ethical challenges, including unethical practice by others. More recently Chao et al. (2017) demonstrated that ethical decision making competence amongst student nurses could be improved using a web-based teaching package. In summary there is evidence to indicate that ethics education should be strengthened and that when this occurs, carefully designed interventions can have a positive impact on both knowledge and action in the field. Educators need to review their approaches to ensure that students are fully prepared for the challenges presented by clinical practice. Unless we can be certain that this is the case, it is simply wishful thinking to trust that they will always respond appropriately when they encounter difficulties.

We now turn to the issue of moral courage, but before doing so we again wish to reiterate that we oppose simplistic exhortations to ‘be courageous’ in situations which invite personal catastrophe. Our interest here is in making a case for the value of courage in situations which may be difficult, but which are certainly not impossible. For Hamric, Arras, & Mohrmann (2015) three conditions need to be met before an action can be considered to be morally courageous. First it needs to involve some degree of risk to the person - action in the absence of risk may demonstrate any number of qualities, but does not require moral courage. Second, the action must be directed toward some desired social good. Without this it may be brave, but cannot be an example of moral courage. Third the actor must have thought through the potential consequences of their actions and determined that, despite the risk, intervention is required. This later point distinguishes courage from reaction in the heat of the moment. This final point is dependent upon the person being able to think through and consider a range of issues and

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evaluate the consequences of choosing a specific course. The ability to think critically is a key component of this process. In their recent systematic review of teaching methods used to develop critical thinking Yoe et al. (2017) argued for the importance of this skill, but noted that while discussion is not in short supply, there is relatively little empirical evidence to guide our teaching in terms of how best to develop this attribute. What we know minimally is that methods which directly engage learners in the evaluation of actions and the making of decisions seems to hold some promise. At the very least, educators need to review the emphasis they place on this skill and ensure that it is robustly addressed in preparatory programmes.

According to Gallagher (2011) moral courage is facilitated by practice. More specifically, courage is more likely to occur if we become habituated to using it. The issue here for educators and clinicians is to create opportunities for students and registered nurses to speak up, to challenge, debate, discuss and argue across curricula (DeSimone, 2019). This may be difficult in a profession which has traditionally valued conformity and deference over perceived expertise. This difficulty may be even more marked in a clinical world which seems to value the chimerical certainty of checklists and assessed competencies above all else. It may require a different approach to teaching and learning for many educational institutions - Goodman's (2013) comments on instrumentalism in nurse education are worth considering here - but if today's students cannot do this in the classroom, it is highly unlikely they will consider doing so in the practice setting.

Finally we turn to the issue of leadership and moral courage. Change may be glacially slow unless the profession's senior leaders in both practice and education grasp the problem and

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commit to making progress (Edmondson 2015). Writing about the unethical treatment of prisoners from the 'War on Terror', Wocial, (2009) stated that:

Nurse leaders must break their silence and speak out against the active or passive mistreatment of all members of the human family. (p. 294).

Mohr (2009) is equally clear in her assertion that nurse leaders must be unequivocal about their expectations of professionals. This must also be accompanied by an open debate which accepts the problem of poor care and nurses involvement in it, but which also makes a commitment to making the structural changes which have allowed it to flourish, such as the acceptance of a culture of silence. For example, MaCurtain et al. (2018), recently emphasised the importance of the leader in encouraging bystanders to intervene in situation where colleagues are being bullied. Leaders too are human beings who may be subject to the same degree of professional censure from their 'superiors' for speaking up, as are the most junior of student nurses. If they have been chosen wisely however, they should be fully aware of the expectations of their roles, one of which is to lead by example. There is nowhere for ANY health professional to hide in this crucible of poor care.

Conclusion

Poor care is a threat to patient safety and dignity and damages the integrity of our profession. Concern about poor care has been reported in health services across the world. Evidence indicates that it sometimes goes unreported and that suffering results as a consequence. Legal, professional and ethical guidance make it clear that nurses have a duty to take action when they encounter it. Work to date has focused on exploring why care failure occurs, with scant discussion about the obligations of those who witness it. We argue that the witness to poor care

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risks legal as well as professional sanctions if they remain passive and ‘look the other way’. Critically, failure to act in the face of abuse, neglect or incompetence leaves the witness in breach of all commonly accepted ethical guidance on how to respond when faced with moral dilemmas.

The likelihood of more proactive responses may be increased by ensuring that those who enter the profession understand the responsibilities of the registrant, by the provision of applied education which directly addresses the problems faced by those who encounter ethical dilemmas in the practice setting and by steps to develop and activate individual moral courage. Significant change in the poor care landscape is only likely to take place where practice cultures truly desire and welcome feedback and promote critical reflection around patient safety, dignity and care quality and where this cultural and professional bedrock actively and passionately supported by those in leadership positions. The price of failure here for nursing and healthcare is simply too terrible to contemplate.

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