Covenantal relationships: Grounding for the nursing ethic

This article is in reaction to recent articles in *Advances In Nursing Science* by Yarling and McElmurry and Bishop and Scudder, which interpret the nursing ethic as grounded in the social reform of the institution or in the role of the nurse on the health care team. It is argued here that covenantal relationships between the nurse and the patient provide a more substantial foundation for the nursing ethic. Arising from the moral principle of fidelity, this model furnishes guidance for the nurse, a link for the nursing ethic with traditional moral theory, and, most important, a grounding in the unique experience of the nurse-patient relationship.

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RECENT ARTICLES BY Yarling and McElmurry[1] and Bishop and Scudder[2] offered new interpretations of the foundations of nursing ethics. Yarling and McElmurry's timely article, "The Moral Foundation of Nursing," called attention to the constraints, frustrations, indignities, and immoral conditions that frequently characterize the hospital setting in which nurses practice. Claiming that these conditions have become impediments to the free moral agency of the nurse, they called for a nursing ethic that is "first and foremost a social ethic,"[1(p71)] directed toward reform of the social institution of the hospital and the traditions that foster an environment in which nursing's moral agency amounts to little more than a theoretical ideal. Insisting on a nursing ethic characterized as "a special ethic interested in social reform,"[1(p71)] they concluded, "Unless nursing, through the reform of the institution in which the majority of its members practice, acquires a balance of controlling power in that institution or creates new

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structures for the organization of practice, it cannot effectively implement standards of care for its own practice."[1(p73)]

Taking issue with Yarling and McElmurry, Bishop and Scudder's article, "Nursing ethics in an age of controversy," suggested that Yarling and McElmurry's proposal for institutional reform to ensure greater nursing autonomy failed to address the primary concern of the nurse, which "ought to be the well-being of the patient and not the practitioner's autonomy."[2(p40)] Furthermore, they argued that nursing ethics should begin with the "moral sense of nursing,"[2(p42)] which is "embedded in nursing practice."[2(43)] Rather than seeking greater autonomy in practice, the nurse is challenged to capitalize on the "in-between situation"[2(p41)] of nursing, which is understood as being "caught between the traditional authority of the physician, the emerging rights of the patient, and the growing power of hospital bureaucrats."[2(p41)] From this vantage point, the nurse may promote a team approach to moral decision making wherein no one acts autonomously, "because all of their deliberations are needed for the decisions and actions fostering the well-being of the patient."[2(p40)]

Both articles, one calling for a nursing ethic that is "first and foremost a social ethic"[1(p71)] and the other advocating an ethic that arises from the "moral sense of nursing,"[2(p42)] proposed new foundations for nursing ethics. They failed, however, to provide a convincing account of the nature of the nurse-patient relationship, and they overlooked a fundamental experience of moral agency by the nurse *within* this relationship.

This article demonstrates the limitations of a nursing ethic grounded in the social context of health care or in the role of the nurse on the health care team, by arguing that the covenantal relationship between nurse and patient provides a more substantial foundation for the nursing ethic. This is true, in part, because interaction within this relationship is ultimately dependent, not on the degree of constraint within the institution or the cooperative spirit of the health care team, but on the willingness of the nurse and patient to become so engaged. Inherent in this relationship, which is ideally characterized by mutuality, reciprocity, and caring, is the concept of fidelity.[3,4]

The distinction being made is not simply theoretical. It rests chiefly on a focus on the primacy of the nurse-patient relationship in nursing. On a practical level this view is distinguished from the Yarling and McElmurry and Bishop and Scudder paradigms by the nature of the nursing role within that relationship. What has been overlooked in their views is the capacity for moral agency, unimpeded by institutional restraints or demands of the health care team, within the nurse-patient relationship.

Virtually no one disagrees that the moral agency of the nurse and the patient's health care needs are variables that frequently place the nurse in a position of potential conflict with both the institution and other health care team members. This reality provides a substantive basis for arguing that institutional reform and health care team interactions are long overdue and are components of concern for a nursing ethic. They do not, however, constitute an adequate foundation for the nursing ethic. To ground the nursing ethic in a foundation

restricted by social factors or health care team cooperation would leave nursing ethics vulnerable to the whims of either the institution or the health care team. However, to ground the nursing ethic in the nature of the nurse-patient relationship would provide a framework that is not only defined by nursing but is also solidly grounded in the nursing experience.

THE NURSE-PATIENT RELATIONSHIP

Throughout the history of nursing, the image of the nurse-patient relationship has served as the substantive basis from which to begin understanding the nature of nursing. Without the central characters of the patient and the nurse, there can be no nursing. Nursing literature testifies to long-standing and fundamental interest in the nurse-patient relationship.[5-8]

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As nursing practice has become increasingly complex, the role of the nurse in relationship to the patient has been described in a variety of ways. Recent portrayals of this relationship include the nurse as priest, contracted clinician, colleague,[9] patient advocate,[6] healer, health educator, parent or physician surrogate,[10] existential advocate,[11] covenantor,[4] or a composite of the above.

While the centrality of this relationship to nursing is without question, the different meanings of the relationship's nature remain a subject that, by virtue of its intimate relevance to the very essence of nursing, demands continued and careful inspection by thoughtful nurses. Using the work of May,[3] Veatch,[12] and Gadow,[7] this article examines the nurse-patient interaction as a covenantal relationship. It is the writer's belief that such a relationship, grounded in the moral principle of fidelity and characterized by mutuality, reciprocity, and responsiveness on the part of both the patient and the nurse,[3] provides the foundation for the nursing ethic and creates an arena for endless possiblities of enrichment and healing for the nurse and the patient.[3,4]

The most exhaustive account of covenantal relationships between health caregiver and patient is found in May's book, *The Physician's Covenant*.[3] While this work focuses on the physician and the patient, its delineation of the character of covenantal relationships applies to those relationships between patients and any caregiver. Theologian Paul Ramsey has suggested that "[T]he moral requirements governing the relations of physician to patients and researcher to subjects are only a special case of the moral requirements governing any relation between man and man."[13(ppx1-x11)] Moral requirements that support a commitment to care are not restricted to physicians. Indeed, nurse writer Marjorie Stenberg asserts that May's notion of covenantal relationships "emerges as an inclusive and satisfying model for nursing ethics."[4(p21)] Not only does such a model delineate a prima facie ethical principle to guide nursing response to the patient, but also it goes beyond

ordinary relations between people by delineating those special obligations that characterize the nurse's commitment to care for another person.

MAY'S COVENANTAL RELATIONSHIPS CONCEPT

May describes five images of the healer, suggesting that the image that undergirds all others is that of covenantor. Grounded in an understanding of the Old Testament covenant between God and His chosen people, May's convenant arises from a Judeo-Christian ethic and contains three elements:

1. a gift that precedes the covenant;
2. a promise that is based on the original gift, which, when experienced by the covenanted people, alters their being; and
3. a set of obligations developed out of this changed being, by which the people then live.

Essential to May's concept of the covenant is the notion that covenantal relationships originate within the context of indebtedness, ie, the nurse responds to a gift received from the patient. Such responsiveness acknowledges the caregiver's debt to the community for educational advantages and to the patient for the opportunity to practice. May writes:

> Despite all flattering impressions to the contrary, professionals undertake their responsibilities not as godly benefactors but as those who, first and foremost, benefit. The human activites of healing, teaching, parenting, and the like, do not create—that is God's work—but, from beginning to end, respond. Only within a fundamental responsiveness do professionals undertake their secondary little initiatives on behalf of others.[3(p116)]

It is important to note that the initiative in the caregiver-patient relationship originates with the patient. The caregiver's initial activity within the relationship is one of responsiveness to the patient's initiating presence. However, this does not mean that the indebtedness of the caregiver to the patient is dependent on a competent or responsive patient. Rather, the patient's gift to the caregiver is the mere presence of the patient.

The promissory nature of the covenant is contained in the willingness of individuals to enter a covenantal relationship. This is demonstrated by the entry of the patient into the health care system and the acknowledgment of this entry by the caregiver's response to the patient. When entering the relationship, the nurse either implicitly or explicitly makes certain promises, including a commitment to the mastery of technical skills and an agreement to safeguard the patient, provide unqualified care, and free the patient from the fear of abandonment and unnecessary pain.[4]

It is within this promissory context that special obligations arise. The work of the philosopher W.D. Ross[14] is helpful in understanding the nature of these special obligations. Ross suggests that special obligations, as opposed to general obligations, arise in one of two ways. First, special obligations arise from acts that were not meant to create such obligations but create them nevertheless: for instance, the acceptance by the nurse of the benefit of practice that is incidental to the patient's presence. May writes, "A covenantal ethic positions human givers in the context of a primordial act of receiving a gift not wholly deserved, which they can only assume gratefully."[3(p108)] The duty of grati-

tude to the patient, which has already been addressed, is the appropriate obligatory response by the beneficiary.

Second, special obligations arise directly "from acts the very intention of which, when they were done, was to put us under such an obligation."[14(p27)] Intentional acts may create special obligations by conveying implicit promises, described by Ross as "modes of behavior in which without explicit verbal promise we intentionally create an expectation that we can be counted on to behave in a certain way in the interest of another person."[14(p27)] For the nurse, these obligations are grounded in the assumption of the nursing role and the response of the nurse to the patient, whose presence implies a trust that needs will be addressed. The prima facie duty of fidelity within the relationship supports these special obligations. May suggests that the promise contained within a covenantal relationship is best characterized by "a pervasive fidelity that informs the performance of all duties."[3(p140)]

The special obligations of the nurse, therefore, grounded in postures of gratitude and fidelity, originate in the twofold act of accepting the benefits of the nurse-patient relationship and initiating care by the nurse in response to the patient's needs.

Critical to understanding the obligations within the context of a covenantal relationship is an awareness of the reciprocity of need: Covenantal relationships are mutually beneficial. Patients' needs, which include physical as well as spiritual and emotional needs, are determined as they arise rather than being prescribed when the relationship is established, as in a legal contract. Less obvious and more limited than patient needs, nurses' needs are acknowledged as basic human needs that are grounded in the original indebtedness to the patient and a recognition of the shared human condition. This acknowledgment of the reciprocity of need dictates mutual obligation. May writes, "[A] reciprocity of giving and receiving nourishes the professional relationship. The professional does not function as benefactor alone but also as beneficiary."[3(p115)]

VEATCH'S TRIPLE CONTRACT THEORY

Medical ethicist Robert Veatch[12] has developed the concept of the triple contract as a new foundation for medical ethical decision making. Like May's, Veatch's work is concerned with the relationship between the physician and the patient, but is relevant to the nursing experience for several reasons. First, his primary intent appears to be to provide a framework for ethical decision making for the health caregiver and patient, and he thereby offers a reasoned method for making explicit the moral foundations of ethical decision making within the context of covenantal relationships. Second, Veatch's theory, while broader than May's, is understood to include a covenant between the professional and patient that supports the notions of mutuality and reciprocity characterizing May's notion of covenantal relationships. This aspect of Veatch's contract provides support for the long tradition in nursing that advocates patient decision making at a personal level and assumes equal patient input in the decision-making process. This is in contrast to impersonal

decison making that excludes the patient and is primarily distinguished by professional, bureaucratic, or social concerns.

Believing that unless caregiver and patient share the same moral framework it is difficult to satisfactorily resolve moral questions within the relationship, Veatch developed the notion of the triple contract. Its purpose was to provide a context for the explicit acknowledgment of the moral foundations of ethical decision making by patient and professional, thus enabling the patient to choose a morally compatible caregiver and substantially reducing conflicts in moral decision making. Addressing three levels of contract—social, professional, and personal—Veatch uses Rawls' theory of justice and Firth's theory of ideal observer as the paradigms for reasoned and just ethical decision making.

The first level of the contract is the basic social contract that articulates the fundamental moral principles of a society. These basic social principles share a moral point of view (the view that the other's welfare is considered equally with one's own), as well as an acknowledgment of humans' finite capacity to understand what is moral.

At the second level, a contract between society and a profession is developed. This secondary professional contract, based on the principles of the first-level basic social contract, provides a moral framework for the special role-specific duties of both laypersons and professionals. The importance of this level is twofold: First, individual members of society have input into the specification of these role-specific duties and second, the nature of the duties of both the layperson and the professional are made explicit. It should be noted that Veatch's theory at this juncture assumes equality and mutuality between professional and layperson.

Within the first and second levels of the contract some moral choices for individuals will remain, since both professionals and laypersons need the right to make choices based on personal beliefs and values. Veatch argues that the primary social contract and the secondary professional contract "can never, however, specify in any detail what the trusting, harmonious relationship will be at the individual level."[12(136)] It is in the third-level contract or covenant that these individual choices are made and decisions are negotiated. Veatch writes,

> This contract or covenant between the professional and the lay person would fill in the gaps—it would stipulate the belief system, the residuum of moral values, the specific understanding of how basic ethical principles apply to specific problems and lifestyle preferences that will constitute the basis of the specific relationship.[12(p136)]

Individual decisions are made within the context of the personal, third-level contract, while the first two levels establish broad patient rights and professional responses. On the third level, participants "are bound together by bonds of mutual loyalty and trust. There is a fundamental equality and reciprocity in the relationship, something missing in the philanthropic condescension of professional code ethics."[12(p125)]

While May posits fidelity as the moral principle that undergirds covenantal relationships, Veatch proposes the concept of promise keeping as central to his theory.

He writes, "Contract keeping is a special case of promise keeping so any ethic that is grounded in a contract theory has to have a special place for the principle of promise keeping."[12(p179)] He continues, "If an ethic for medical decision making will, in part, be determined by a contract between the profession and the society, it would appear that those people engaged in that discussion would want to have some account taken of the fact that contracts and other promises ought to be kept."[12(p184)]

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GADOW'S CARING RELATIONSHIP CONCEPT

Nurse—philosopher Sally Gadow's understanding of caring within the nurse-patient relationship embodies covenantal concepts of mutuality, reciprocity, fidelity, and moral decision making. Capturing the essence of the respect inherent in a covenantal relationship, Gadow asserts that caring in a nurse-patient relationship is not an "interpersonal technique" but rather "entails a commitment to a particular end. That end, I am proposing, is the protection and enhancement of human dignity."[11(p32)] For Gadow, there are two primary ways in which the nurse embodies caring in relation to the patient, which not only affirm the integrity of the patient but also provide an opportunity to experience Veatch's moral decision making, as well as May's notions of human enrichment. The first way involves truth telling and the second way involves touch.

With regard to truth telling, Gadow assumes mutuality and reciprocity between the caregiver and patient. She confronts the grandiose claims by professionals that the big questions for the caregiver are whether to tell the truth and how to tell the truth, since both questions assume that the truth for a particular patient exists apart from the other persons involved and, "like an experimental drug, is accessible only to the professional, who may offer it to the patient, who in turn can accept or refuse it."[11(p38)] Rather, within the context of the caring nurse-patient relationship, the truth includes "subjective as well as objective realities, idiosyncratic as well as statistical tendencies, emotional as well as intellectual responses,"[11(p38)] and is constituted anew by patient and professional together in each situation. In other words, the patient creates his or her own truth within the occurrence of illness, making his or her own decisions affecting care, based on the unique meaning of the experience of illness. This process is facilitated by the nurse who helps the patient reexamine and clarify values in the face of the current illness. This approach, unlike a paternalistic posture by the caregiver, embodies behaviors and attitudes reflecting the nurse's belief that the patient's experience of illness

should define and direct the patient's needs.[11]

Touch, the second way Gadow suggests that the nurse participates in a caring relationship with the patient, is an essential feature of the physical care and assessment of the patient. It is grounded in the nurse's ability to address the "objectness" of the patient without objectifying the patient.

However, like truth telling, touch can be understood by the caregiver as a philanthropic act, a nonreciprocal experience, a gift from one who is whole to one who is not whole. Such touching, which is both distancing and demeaning to the patient, occurs when the caregiver fails to acknowledge his or her own vulnerability, neediness, and dependence as a human being, ie, the mutuality of the human condition. In contrast, Gadow argues that the very nature of touch, which "is a more compelling form of contact than sight or hearing, because it is the symbol of vulnerability"[11(p40)] provides a unique occasion for overcoming the "objectness" to which patients are often reduced in the health care setting. Gadow writes, "In the modern clinical context, in which objectness so easily undermines dignity, empathic touch becomes a means of continually re-establishing the *mutuality* in which patients then are affirmed as persons, rather than objects."[11(43;emphasis added)]

Touch is seen by Gadow as a means of overcoming the objectivity of both the patient and the professional by the temporary dissolution of distancing boundaries. Touch makes possible communication between the nurse and the patient that "reaches past the objectivity of treatment ... allowing the patient, in turn to reach out of the solitude of suffering."[11(41)] Essential to and implicit in this experience is a responsiveness on the part of nurse and patient to one another, which promotes the humanity and dignity of the participants.

COMPARISON OF THE THREE MODELS

The most striking commonality between the three writers is their insistence on mutuality and reciprocity within the caregiver-patient relationship. May suggests that "a reciprocity of giving and receiving nourishes the professional relationship."[3(p115)] Veatch writes, "There is a fundamental equality and reciprocity in the relationship...,"[12(p125)] while Gadow claims, "[M]utuality becomes the moral foundation of nursing commitment to the dignity that distinguishes persons from objects."[7(43)] May and Gadow emphasize the mutual benefits of such an enterprise in terms of human enrichment, while Veatch underscores the enhancement of moral decision making by equality and mutuality.

These three authors also agree that the covenantal relationship differs from a contract or a professional code. Professional activity grounded in a professional code easily becomes couched in philanthropic and altruistic terms that assume that the professional's duty to the patient is gratuitous. May suggests that the notion of contract fails in that it denies the element of the gift from the patient to the professional. Furthermore, contracts promote self-interest, provide recourse for legal enforcement, and regulate needs to those specified within the contract, thereby

reducing the professional obligation to "self-interested minimalism."[3] Veatch criticizes the "philanthropic condescension of professional code ethics,"[12(p125)] while Gadow contrasts caring as a moral ideal with the technology of interaction that is characterisic of an explicit set of behaviors. The writers appear to agree that the "spirit of a covenantal relationship differs from that of relationships defined by code or contract. May writes, "[C]ovenants cut deeper into personal identity."[3(p119)]

Finally, May and Veatch explicitly identify fidelity[3] and promise keeping[12] as central ethical principles undergirding covenantal relationships. While Gadow does not specifically identify fidelity as a moral principle supporting the caring relationship, she implicitly assumes a posture of fidelity on the part of the nurse who is challenged to "be there" for the patient, to participate in the nurse-patient relationship with the "*entire* self, using every dimension of the person as resource in the professional relation."[7(p90)]

THE NATURE OF FIDELITY

Before examining the implications of covenantal relationships for nursing ethics, a closer look at the nature of fidelity is indicated. The experience of covenantal relationships cannot be understood apart from the nurse's willingness to incorporate the moral principle of fidelity into the understanding of himself or herself as a nurse. Likewise, the nature of fidelity or promise keeping that undergirds covenantal relationships instructs the nurse with regard to the special obligations to the patient.

Promise keeping, or fidelity, is widely recognized as an obligation within the context of all relationships. Veatch and Fry write, "If people did not generally have an obligation to keep promises, then the very act of making a promise would be meaningless."[15(p138)] Promise keeping is more than a morally neutral act; it is a duty that claims independent moral status.

Fried[16] argues that the obligation to keep promises is grounded in the principle of respect for individual autonomy and in trust. Beauchamp and Childress[17] propose that fidelity is a moral rule derived from the independent and basic moral principle of autonomy, but Veatch and Fry submit that fidelity is stronger than a rule. They write, "Fidelity is another principle of many ethical systems. It, like autonomy and truth-telling, may be a right-making characteristic of ethical action, binding on a person independent of the consequences."[15(P144)] Ramsey agrees, claiming that fidelity is a fundamental ethical principle.[13]

May understands the principle of fidelity as comprehensive, stating, "The duty to protect the weak and the vulnerable eventually expands into a comprehensive fidelity that exceeds specification."[3(p107)] Similarly he writes of "a pervasive fidelity that informs the performance of all duties."[3(p141)] Like Gadow, he uses the example of truth telling to demonstrate the virtue of covenantal fidelity by suggesting that "[t]ruth becomes a question not only of telling the truth but of being true."[3(p142)] For May, fidelity is understood as more than a moral principle; it is a way of being. It is morally fundamental within a covenantal relationship.

Veatch's discussion of promise keeping focuses on the role rather than the nature of promise keeping. Like fidelity, "promise keeping, or contract keeping, is a right-making characteristic independent of the consequences"[12(p183)] and constitutes a principle of the social contract. He suggests that if contractual relationships between physicans and patients do indeed provide the basis for ethical decision making, then promise keeping is essential to the ongoing character of the relationship.

Fried sets down strict requirements of promise keeping. He maintains, "An individual is morally bound to keep his promises because he has intentionally invoked a convention whose function it is to give grounds—moral grounds—for another to expect the promised performance. To renege is to abuse a confidence he was free to invite or not, and which he intentionally did invite."[16(p16)]

Like Fried, Ross argues promise keeping or fidelity is a duty which rests on previous acts. Specifically he says that some duties rest on previous acts of one's own. These duties include those resting on a promise or what may fairly be called an implicit promise and may be called the duties of fidelity.[14] Ross contends that to make a promise "is to put oneself in a new relation to one person in particular, a relation which creates a specifically new prima facie duty to him. . . ."[14(p38)]

IMPLICATIONS FOR NURSING

In light of these strong claims for the primacy of the principle of fidelity, what does it mean for the nursing ethic to be grounded in covenantal relationships? Specifically, how would it affect the role of the nurse?

A responsiveness to the presence of the patient and his or her needs, an acknowledgment of the indebtedeness by the caregiver to the patient for the benefits of practice and engagement, and a recognition of the mutuality and reciprocity that distinguish the relationship indicate a willingness by the nurse to enter a covenantal relationship. This undertaking invites the patient to trust and consequently to become vulnerable. An implicit promise is made that includes the understanding that the nurse will safeguard the vulnerability of the patient. To break the promise is to abuse the trust and thereby to abuse the patient. To keep the promise is to practice the principle of fidelity within the relationship.

Grounded in the principle of fidelity, obligation within the covenantal relationship has a serious claim on the participants. The nurse's duty of fidelity to the patient is dictated by his or her previous choice to become a nurse and thereby to embrace the professional and moral responsibility inherent in such a choice. The nurse is obligated by the prima facie duty of fidelity to the patient, whether or not such a duty is made explicit. As Beauchamp and Childress put it, "[D]uties of fidelity may stem from the generation of expectations through words, gestures, or silence. Promises or contracts may be explicitly, implicitly, or tacitly made."[17(239)] Thus the nurse's duty of fidelity to the patient rests on previous acts by the nurse, ie, inviting the trust of the patient by engaging in a caring relationship. When entering into a relationship with the patient, an implicit promise

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of fidelity is made. Fidelity by the nurse is met with trust by the patient. Such reciprocity provides the environment for caring and healing.

Faithfulness in protecting the vulnerability of the patient dictates that the nurse be reliable in relation to the patient. In the face of the confusion and threat accompanying physical illness, such faithfulness, steadfastness, and reliability by the nurse provide a fundamental, experiential occasion for reaffirmation by the patient of a broader ontological experience of trust. The patient's experience of the nurse as trustworthy creates a climate of trust that not only reaffirms the patient's essential humanity but also supports the patient's willingness to trust further the faithfulness of the nurse. In this way, fidelity supports a caring context for healing. Patient Zaner, reflecting on his experience, reminds us that faithfulness to the "promise" of the relationship between patient and caregiver offers opportunity for the "*recovery of ourselves*, patients and caregivers, *as persons*."[18(p101)] Agreeing that fidelity is a critical component of healing, May writes, "The fidelity of others will not eliminate the disease, but it affects mightily the human context in which the disease runs its course."[3(p143)]

How then does the nurse enter a covenantal relationship with the patient? Just as Gadow understands the act of caring, participation in a covenantal relationship cannot be reduced to a particular technique. Rather, it entails a particular way of being, characterized by attitudes of gratitude, loyalty, and mutual respect. The outcome is determined in part by the potential for mutual participation by patient and nurse and is supported by the principles of fidelity and respect for persons along with "the natural sympathy human beings feel for each other."[19(p104)] Covenantal relationships are a way of being or a process, not a project to be mastered. May reminds us that a "covenantal people acts under covenant while eating, sleeping, working, praying, cheating, healing or blundering."[3(p119)]

Covenantal relationships are desirable for the nurse as well as the patient. Ramsey suggests that "covenant-fidelity is the inner meaning and purpose of our creation as human beings, while the whole of creation is the external basis and condition of the possibility of covenant."[13(pxii)] If Ramsey's claim is correct, participation in a covenantal relationship places the nurse in a position that promises unlimited potential for human enrichment, both for himself or herself and the patient. The nurse may regularly experience his or her own humanity by witnessing that of the patient. As a consequence, the commitment to consciously participate in the shared human condition with the patient is supported. The understanding developed by the nurse enhances every aspect of life, making possible a richness of experience heretofore unavailable.

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This article has proposed the model of covenantal relationships between the nurse and the patient as a foundation for the nursing ethic. Unlike the models of Yarling and McElmurry and Bishop and Scudder, this model not only promises enrichment and benefit for the patient and nurse alike, but also undergirds the strong moral component of the prima facie duty of fidelity that helps guide the nurse in decision making. Rather than focusing efforts on the enhancement of nursing autonomy in the work setting, the covenantal relationships model sets up the conditions for the individual autonomy of the nurse in relation to the patient. Rather than arising out of a "moral sense of nursing,"[2(p42)] it arises from the moral principle of fidelity, thereby providing more specific guidance for the nurse and a link for the nursing ethic with traditional moral theory.

Most important, by virtue of its grounding in the distinctive experience of the nurse-patient relationship, rather than in social or health care team concerns, the covenantal relationship furnishes a more appropriate foundation for the nursing ethic. In short, it offers a beginning point for explicating an ethic that is grounded in and thereby reflects the singular experience of nursing.

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