ResearchGate

See discussions, stats, and author profiles for this publication at: https://www.researchgate.net/publication/303404571

Deceit and dishonesty as practice: The comfort of lying

Article *in* Nursing Philosophy · May 2016

DOI: 10.1111/nup.12129

CITATIONS
4

READS
1,356

1 author:

Melody Carter
University of Worcester
32 PUBLICATIONS **126** CITATIONS

SEE PROFILE

Some of the authors of this publication are also working on these related projects:

Understanding the Experiences of Nursing and Midwifery Academics during the COVID- 19 Pandemic View project

Materiality of Mourning View project

All content following this page was uploaded by Melody Carter on 17 January 2018.

The user has requested enhancement of the downloaded file.

doi: 10.1111/nup.12129

Original article

Deceit and dishonesty as practice: the comfort of lying

Melody Carter PhD, RGN

Associate Professor, The School of Nursing and Midwifery, The College of Science, Health and Engineering, La Trobe University,, Kingsbury Drive, Bundoora, Melbourne, Australia

Abstract

Lying and deceit are instruments of power, used by social actors in the pursuit of their practices as they seek to maintain social order. All social actors, nurses included, have deceit and dishonesty within their repertoire of practice. Much of this is benign, well intentioned and a function of being sociable and necessary in the pursuit of social order in the healthcare environment. Lying and deceit from a sociological point of view, is a reflection of the different modes of domination that exist within a social space. French philosopher Pierre Bourdieu theorized about the way that symbolic power works within social space. The social structures and the agency of individual actors moving within it are interrelated and interdependent. Bourdieu's ideas will be used to theorize about real clinical experiences where acts of deceit can be identified and a case example will be presented. Nurses are actors in the social space of clinical care, and their world is complex, challenging, and often fraught with the contradictory demands and choices that reflect and influence their behaviours. An exploration of lying and deceit in nursing as an instrument in the modes of domination that persist enables us to challenge some of the assumptions that are made about the motives that cause or tempt nurses to lie as well as to understand the way on which they are sometimes lied to, according to the acts of domination that exist in the field. Lying or acting dishonestly is a powerful act that is intent on retaining stability and social order and could be seen to be a justification of lying and deceit. However, we need to pause and consider, in whose interests are we striving to create social order? Is it in the end about the comfort of patients or for the comfort of professionals?

Keywords: Pierre Bourdieu, deceit, dishonesty, reflexive sociology, lying, nursing practice.

Correspondence: Dr Melody Carter, Associate Professor, School of Nursing and Midwifery, La Trobe University, Kingsbury DriveBundoora, Melbourne, Vic. 3086, Australia. Tel.: +61 3 94795987; fax: +61 3 94791161; e-mail: m.carter@latrobe.edu.au

Introduction

Nurses play a pivotal role in health care. They act in relation to patients, carers, other disciplines, and in the leadership and management of organizations. They are often the external and objectified public

© 2016 John Wiley & Sons Ltd

face of health and health care. Deceit and dishonesty, just as truthfulness and honesty in nursing, are instruments of power, and these acts are used by both those who are powerful and by those who are powerless. The ideas presented by the authors of *Lying to Ourselves* (Wong & Gerras, 2015) are relevant to nursing and to other health professions. The military monograph explores the phenomena of lying and deceit in a hierarchical and rigidly structured military institution. For the most part, modern healthcare systems have evolved from a model that has inherited similar cultural traditions and practices. We have seen on repeated occasions that healthcare organizations face constraints in their capacity to uniformly meet the expected standards for systems of care. Be it the power of the military or of our health system, we rightly have high expectations of the ethics and practice of the professions in whom we trust.

Lying and deceit: a comfortable and long-term habit

When we speak of deceit and deception, we might consider whether we believe that there ever was a 'golden age' when there was less of this about. There is, in western cultures at least, a perception that values are in decline and that there once was a time when those who chose nursing were trustworthy, honest, and not likely to give into any motive to deceive or to be dishonest in their professional practice. We have a significant inheritance; both classical and religious literatures imagine a time when people were predisposed to truth and honesty and the present time when in decline we seemed to have become motivated to act and speak in our own interests (Van Houdt 2002). Dishonesty and deception of ourselves and of others leads us potentially towards an ever increasing degenerative state. So in these times we may say that we can only therefore rely on truth and honesty where there is a vocational or altruistic motive. This acts as a 'signal' to us that individualistic and selfish motives have been set aside and helpfulness and goodwill will follow. Either way trust has long been a desired attribute expected in professional work of all kinds.

Wong & Gerras (2015) speak of an 'alternative reality' where there exists, in the military leadership, a somewhat romantic perception of a history of ethically based behaviour that 'shadows' the real world of dishonesty and deceit. I would propose that both realities can exist. We are not either truthful or deceitful or moral or immoral (I am not taking a relativist position here); rather I am suggesting that we can be either or both according to our habits, or what Bourdieu (1989) would term the 'habitus'. This means that honest/dishonest practices will vary in each of us according to the occasion, circumstance, and the power differentials. Moreover, they will be dependent on what is at stake, for ourselves, for an individual patient, a group of patients and for the institution or profession. Habitus in this sense not only refers to the way that we classify ourselves but also the way we perceive the world.

> Their habitus, that is, the mental structures through which they apprehend the social world, are essentially the product of the internalization of the structures of that world. (Bourdieu, 1989 page 18)

Another person, in the same situation, may perceive a clinical experience quite differently which is why, in the spirit of reflexive sociology (Bourdieu & Wacquant (1992), it is shared here in an attempt to illustrate the agent's repertoire or product of such internalized structures.

It would be hard to contest that the pressures placed on nurses in contemporary clinical practice are significant. In addition to leading and managing nursing care, they hold a pivotal position in the interprofessional teams of most healthcare systems. This interface puts them in unique relationship with a range of professional perspectives and in relation to the patient. Nurses often have a privileged understanding the patient's experience. This can include their hopes and expectations of their treatment as well as insights into individual beliefs about care or treatment (Carter, 2015). The prevailing culture of health service institutions was a significant 'finding' of the Francis Inquiry Report into the care at the Mid Staffordshire Hospital NHS Trust (Francis, 2013). Likewise, in the Winterbourne View Hospital case (Flynn 2012), the quality of communication, values and relationships were identified as contributing factors to the way in which

© 2016 John Wiley & Sons Ltd

professionals (clinical practitioners and service managers) responded to (concealed and colluded with) poor practice and poor care.

There are, of course, different ways of looking at dishonest or honest behaviours; the approach of virtue ethics is a popular one in nursing, but this can lead to an essentialist approach. The world of health care is much more complex than there is room to describe here, but it is likely that particular situations under particular circumstances may have or could in time, lead all of us to act dishonestly. It is a mistake, therefore, to rely on individual character traits whilst ignoring the social and cultural dynamics that over time and under certain conditions, lead people to be more or less dishonest.

The experience and incidence of poor care and its concealment is one deception; the reaction or antidote to this has brought about another challenge as organizations seek to regulate and limit corporate liability. It has become the custom that organizations seek to regulate caring practices and behaviour through the use of reporting instruments and tools to document compliance with a quality and standard framework are rightly criticized for a misuse of authority to 'police' practitioners on occasion. Snelling (2013) points out that interventions such as these are not evidence based and the circumstances under which they have been implemented could be argued as being unethical. Practitioners are right to argue that these instruments can be a distraction from safe, high-quality 'hands on care' rather than an enabler of this and as such could be seen to be fundamentally dishonest. We are also aware that whistle-blowing, although intended to enable practitioners to cut across structural divides and vested interests, are often ineffective and whistle-blowers are left isolated when attempting to draw attention (through covert means) to even the most grotesque failures of professional care (Nursing Times, 2009; Flynn, 2012). In a culture like this, poor practice is likely to perpetuate, as nurses, privately critical of the practices they observe, are more likely to move on to another position than to stay and try to change or challenge the practices that distress them (Carter, 2010, 2014). However, this offers no opportunity to challenge the conditions in which people must practice.

The second important consideration in telling the truth, and this is born out in numerous healthcare scandals, is the personal cost of truth telling. There is a heavy emphasis on the individual to 'speak out' or to whistle-blow in some way and less emphasis on the accountability of healthcare organizations to their patients and to their employees to meet the required standards of care. The accounts we have of those who have spoken out has been deeply sobering in that the person is usually left isolated, vulnerable, can lose their job and even face being 'struck off' the professional register. The power of superiors, but also subordinates and peers, cannot be understated in an organizational context which depends on sustaining the appearance of order. Most have found that telling the truth does eventually result in some change but always at great personal cost to them. Most people who have spoken out in this way will also see their lives in two parts namely, before they spoke the truth and afterwards, as almost two different existences. Blowing the whistle on the behaviours of some employees working at the English Winterbourne View Hospital (Flynn, 2012) is a case in point. In this, we have the example of another whistle-blowing failure. In order to expose the reality of the experience of the adults living in that institution, a journalist had to do something deeply dishonest in order to expose the truth through a covert operation in a BBC Panorama programme *Undercover Care: the Abuse Exposed* (Casey, 2011). So in this case, we see another nurse who, having been ignored by those who should pay attention, having to go outside of her profession/organization to protect the patients in her care. This cannot have been achieved without considerable personal and emotional cost bearing out the old saying that every good deed brings its own punishment.

Bourdieu (1984) situates social practice within the relations of social structures and the habitus (our dispositions or predispositions). There is a strong argument that those who join a particular social organization are in some way predisposed to support and maintain social order. Judgements about acts of deceit, dishonesty or truth, and honesty are made on the basis of the achievement or maintenance of that social order through the operation of cultural capital

© 2016 John Wiley & Sons Ltd

within the 'Field of Power' (Swartz, 1998). Nurses practise in a field (a given social and cultural world) where power is played out in a range of social formations. When we choose to be truthful or to lie we are (usually) making that choice because of the way that we recognize the dominant forces in that field and according to what is at stake. We are most likely to act in a way that reflects our access to resources, past experiences, and how we anticipate that things will probably unfold according to actions we choose to make. We are in this way accomplices in the power relations and consequences that shape the future as well as the present (Bourdieu, 1990). There is, in essence, a logic to our practice; we tend to have an intense sense of 'our place' Bourdieu (1984) page 471, cited by Swartz (1997). The implication of this is that our habitus does not begin in the practice here and now, but is embedded in earlier life experiences and even the influence of intergenerational reproduction of cultures or practices. Decisions to lie or be dishonest may appear, at times, impulsive but they tend to be more complex than that.

How then, do nurses live and work within a social world, a field of practice? We can consider how our lives and practices are situated within social structures and the way that we act according to the habits of practice. Bourdieu's ideas of the habitus is a way to understand how people act, according to their dispositions and predispositions within a field of play with rules of the game to be learned and then observed and then drawn upon for practice. Bourdieu (1984) explains social domination as being based upon the individual's feel for the game or practical logic. Some situations accord rules and regulations for practice but often as not there is a vacuum where guidance or agreement about the rules should be. The nurse's understanding of how to operate within this field will include those habits (character traits/virtues) but will also be subject to the way that other activities and events are interpreted and operate within the field. Honesty and truth telling are operating activities, therefore, which are not, therefore, tactical or overtly strategic (nurses do not usually set out to lie or to be dishonest to patients), but rather they act on what feels right or appropriate in a given and often extremely complex situation.

An experience of deception

When an issue or event arises where moral judgment is required, we may or may not take into consideration the prevailing power relations or other complex dynamics; we tend rather to think only of the patient and ourselves. This is demonstrated in a scenario from a practice experience that happened to me more than 30 years ago. This is a personal account that illustrates an experience of knowingly participating in a deceit and choosing to act dishonestly in withholding information about the hope of recovery from a patient in intensive care.

> I am assigned to care for a patient (I will call him 'Tony'). He is the recipient of a ground breaking, novel piece of medical technology. This has been inserted to support the functioning of his heart following a massive heart attack. He is relatively young, just 45 and feels pretty well using the device. However the scale of the 'pump' and its novelty, means that he is confined to his room; as yet a portable version has not been developed. His condition is 'critical' by most measures but he is sitting up in bed, talking, eating and drinking, watching television (an unusual situation for this kind of unit) creating an air of normality. He and his family are under the impression (they tell me this and talk about it to each other and to Tony's visitors) that he will be eligible for a transplant as soon as an organ becomes available. They believe that he is in a temporary state rather than a permanent one. The talk in the clinical meeting makes it clear that this is not the case. I feel ignorant and overwhelmed by the whole situation but I do ask the question about whether this outlook has been/will be discussed with the family? I receive a vague and apparently evasive answer.
>
> I do not know the patient or the family well enough to decide what their real take on the situation is other than to guess at their fear for the immediate and long term future. But I recognise that they remain hopeful and outwardly calm. When I am assigned to care for Tony, I find myself distancing myself from him. I find that I am restricting conversation because I am afraid I will say something unhelpful or tactless. They probably think me detached and perhaps cold. I show that I am focussed on Tony's physical care needs and monitoring the functioning of his life support. He and his wife have no time alone I'm always there. I'm not actually lying but I do feel part of a benign deception.
>
> His death comes a week later, it is abrupt, devastating and I have never forgotten it.

Reflecting on experience

Revisiting this now, I conclude that I was, as I thought at the time, colluding with a general act of

© 2016 John Wiley & Sons Ltd

deceit, contributing to the desire for maintenance of a social order of some sorts. Experience teaches me that there was nothing really orderly about the patient's predicament and yet we did not want to make things emotionally or psychologically uncomfortable, perhaps for him but also for his family, and for us, the professional team. Stability (social order) is the goal of intensive care, both physiological and psychological; it is essential for patient safety and to achieve the optimal or life-saving outcome. Truth telling about the prognosis and almost certain outcome of this medical intervention could result in extreme psychological distress, existential questions that have no answers and present challenges that those with a part to play cannot possibly resolve. I am not entirely powerless in this, I have weighed up the cost of being candid, and I for the reasons I have described, decided against it. None of those caring for this patient (if memory serves) were ever asked by him or the family, to explain. In my opinion, we all colluded in the maintenance of a social order brought about by our ignorance of the 'elephant' sitting in the corner of the patient's room. In that context and so many others, we can argue that maintaining hope, by not discussing or sharing professional knowledge justifies a 'benign' deceit or sharing evasive and mysterious possibilities. But I question the justification of this in terms of the patient's own agency in the life-threatening situation. Others have commented on the role of nurses in patients' states of hope and hopelessness (Miller, 1989; Lipscomb, 2007). Hope as a concept and a justification for lying is a common perception but we need to consider what the hope is for and whether we, in our individual role can really do more than the patient would do given the choice to work things out for themselves?

Should we even try to imagine a world where truth and honesty were easy options? A better aim perhaps would be to consider the domains where truthfulness really matters and the ways in which we recognize where dishonesty and deceit causes, brings or perpetuates harm. Clearly atrocities in health care and nursing practices do occur, and there are some important considerations where culture and the forces of social domination (and fear) provide clues to why good people act badly. Those that worked on the Francis inquiry report into the events at the Mid Staffordshire NHS Trust, asserted that open, candid institutional cultures were crucial to ensuring that staff would not stand by and allow poor care to happen (Francis, 2013). However, even after the worst of events, where the institutional culture lies at the centre of the problem, life tends to go on pretty much as before.

Bourdieu (1984) wrote at length about the way in which cultures tend to reproduce themselves. We like to make things (systems and activities) in our own image. We get used to accepting the status quo and find comfort in familiar ways of doing things. To return to the military analogy, to '*speak truth to power*' (American Friends Service Committee, 1955) is nearly always personally and professionally threatening. How do we make truth, honesty, transparency, and openness our first choice position? Well we certainly need to include in our consideration the dimensions (including the personal cost) of saying what we are really thinking.

Nursing is a profession with clear ideas of its identity and characteristic behaviours, its entire legitimacy and mandate depend upon it. Nurses, as individuals and as a professional group, derive a considerable degree of their professional power and influence where such values act as an essential mark of their distinctive professional brand. These are articulated in professional codes of conduct and ethics by regulatory authorities (NMBA, 2010, NMC, 2015) and in the values and codes of employment in the organizations that recruit, educate, and employ a caring workforce. The profession of nursing is a practice (a set of socially based activities) at its most simple. Nurses are employed by organizations and individuals to help other people in times when they have a particular health need. The opposite effect of helping is harming, and it is in this context that this paper approaches deceit and dishonesty.

Deceit as an instrument of power

I have approached the issues of dishonesty and deceit from the perspective of one who sees the practice of these and their opposite relations honesty and

© 2016 John Wiley & Sons Ltd

transparency on the basis of both individual and relational activities grounded in the social world of nursing. My argument is that deceit and dishonesty should be understood as a response to the exercise of personal or institutional power occurring in the context of a social practice (of one kind or another) and being subject to the dispositions and predispositions of the individual and also their society. Nurses as people are not just individual operators, they are both separate from and part of the social world in which they work.

Understanding motives in deceit are as interesting, if not as important, as guarding against its harmful effects. Recognizing the way that professionals use deceit helps us to understand who has power, who wants to use it and of course who feels powerless and, in the context of what nursing needs, whether this matters. When we consider the concept of power in relation to honesty and dishonesty, it becomes more complex than a question of a trait or a lack of virtue. When we have knowledge or insight (as described in the case example above) we are acting in an effort to control events or circumstances, it is an act of deception which is self-serving to a greater or lesser degree.

Steven Lukes (2004) describes three faces of power; this perspective is useful to us when considering deceit and honesty in professional practice. The first dimension relates to the way that the powerful want to be perceived by others; as influential and consultative when making decisions in the best interests of others. The second is the power that particular people have to set the agenda. For example, deciding what gets discussed and making sure that issues that might threaten the status quo get silenced or sidelined. The third and most insidious (according to Lukes) is the way in which people's thoughts and wishes can be manipulated to the point that people believe that those in power are working in their interests and that they want the same thing. Lukes asks us to consider the point; who decides what gets decided? This applies in the context of global/political issues but also in the everyday lives of vulnerable individuals. In the context of our social practices, we see that the use of power is necessary to the acquisition or retention of one form of capital or for successfully operating within the field of play. If – in caring for Tony – I had said what I was really thinking or asked the question out loud I would most likely have been in conflict with the professional team, my superiors and in difficulty with the patient and his loved ones. I certainly do not think that the patient had been helped to decide how and when his treatment might end. I do not think he was afforded (by me or anyone else) an 'equal dignity and an equal entitlement to shape (his own life, make his own) choices' (Lukes 2005, page 117). This is one of the problems with reflective practice, the more I reflect on the events the more I consider my role and the more uncomfortable I become, even now as I write this, 30 years on.

There is no context in which (assuming we have agency) we do not have the potential to exercise or be or to act as accomplice to power, according to the bounds of our scope, our skills, knowledge, and insight. Decisions to deceive others will therefore be governed by our dispositions or predispositions and according to the rules of the game and also our knowledge of the rules of the game. The example I have given about the withholding of knowledge or otherwise in the clinical context was not a deliberate malevolent abuse of power and perhaps reflects the practices of the time, but it did alter the power and control available to the patient and his family because of their lack of insight into the situation. Those who currently practice in this kind of context might be best placed to comment on whether much has changed. The reality of the predicament in which a patient may find themselves will determine behaviours and demands. This is both a disempowering act on one hand and a personal or professional survival tactic on the other and perhaps, to nurses and other health professionals would not be thought unusual. There are common experiences of healthcare professionals who will always have powerful knowledge to share or withhold. The real skill is knowing how and when to share the worst kind of news. It may seem an unbearable burden to pass on to the patient or their loved ones, and at the same time, bringing about challenging and even unmanageable consequences, disrupting the desired order of things.

© 2016 John Wiley & Sons Ltd

The idea of a nurse as representing virtuous values and behaviours is a social construct. People assume that to be helped means that honesty and truth underpin our decisions and practices, and that the person who comes towards us when we are sick and offering us care is working for our good and has our needs and wishes at the centre of their pratice. These precepts carry with them an inevitable problem of what is real and what is unreal about our motives and, depending on your point of view, what is true and what is false. These ideas are constantly tested and contested in terms of whether there is such a thing as an objective truth or real situation or whether the reality of things always contains a degree of subjectivity.

By applying the ideas of Lukes and Bourdieu, we can take a step towards the recognition of the ways in which deceit can be seen as an attempt to change the rules of the game. For nurses, we might attempt to alter the power dynamic in a professional situation and this can be as much about our desire to maintain the order of things as about wilfully attempting to subvert the wishes of others. Nurses are part of the wider institution and are at the forefront of maintaining the social order (smooth running systems for care) in health service institutions; it has, after all been found to be the best way to keep patients safe and comfortable. However, in order that institutions may demonstrate that the care they provide is what is needed, nurses are regularly required to complete reports on their caring activities. This practice is one of the ways in which 'leaders' choose to show that it maintains an institution's social order. The institution if required will give an account of what is written down rather than what actually occurred. Nurses have contested this return to ritualized practices as they weigh up the likelihood of disorder in its different ways. Most nurses would argue that the priority will always be the immediate care of the patients they are assigned to care for. In that hectic and fast paced environment perhaps at the end of a 12/13 hours shift the record keeping about care given on a shift (completed on behalf of the institution rather than the individual patient) may be easily fudged or dishonestly completed. It is difficult, and perhaps unnecessary, to divorce the idea of truth and deceit from a moral and political context. If we consider the range of contexts where nurses might lie or attempt to deceive others, there is without exception an 'explanation' that can be routed in the power dynamics of relationships, the system or something else.

There is a good deal of comfort (and physical safety) where there is social order; it is possible to say that being comfortable is dependent on the social order of a clinical world being maintained; the question is on whose terms and to what purpose? Nurses have, within the scope of their practice, the gift of comfort (both physical and emotional); however, something that can be gifted can also be withheld or withdrawn. Truth, in the form of useful information, has symbolic power according to whether it is given or withheld. We generally desire the comfort and well-being of others (this is usually why we pursue this work) as it contributes to the order of the social world we inhabit in our workplaces but also in the broader more general scope of things for our loved ones and ourselves. Lying or being deceitful is a personal and professional comforting practice; it can bring a form of temporary social order.

Attempting to tell the truth or just declaring that we will not intentionally deceive can have uncomfortable consequences. It can cause confrontations, distress, and misunderstanding and of course, eats away into our time and the time of others. It is the professionals that hold the power to decide whether to share or to withhold information. They have the choice to own up about shortcomings in knowledge, understanding or options for treatment and to be transparent or otherwise about the uncertainties that surround patient experience and our role in it. The conceptualization of dishonesty as an instrument of power is not particularly novel but is potentially a more critical way to engage with the power relations that exist in the social worlds that nurses inhabit. Professional practice is complex, contradictory, and challenging and is we know, undertaken by imperfect practitioners (Carter, 2013). We may make an ostensive demand for honesty, trustworthiness, integrity but principally we want perfect practice and unselfish motives in those who care for us when we are at our most vulnerable.

© 2016 John Wiley & Sons Ltd

Conclusion

To deceive or to lie is an issue for both the deceiver and the deceived. We may seek to alleviate suffering or support hope through our comfortable words or our silence. But it's worth remembering that being without hope of a long life does not rule out the hope for other good or helpful things to happen? The prospect of an untimely death does not necessarily equate with abjection either; we do not all see these things in the same way. We need to remember that these are assumptions we make about the feelings of others based on our own imagination or experiences.

The how and why of the use truth or deceit as an instrument of power is of concern to anyone who is interested in preventing the most harmful consequences of deceit or dishonest practice amongst vulnerable people. What is important is that we learn to recognize the instrumental nature of a lie or deceit and whether we consciously or unconsciously participate. Whether we talk of domination, concealment, subversion, misrepresentation in the hierarchy of the organization or amongst individuals we may agree intentional acts of deception are a threat to trust and to the dignity and rights of patients. Nurses, as well as others, have agency and the capacity to choose how to behave and this undesirable choice can include the continued domination of others in the roles we play.

Nurses need to be equipped to navigate and negotiate their way through the field, learning, and understanding the way in which power in its different dimensions operates and is operated. Being 'professional' requires that we own the context of our work as well as the practice of what we do. Perhaps this is one way in which we will make sense of our use of professional power and evaluate its consequences as being for or against the good of those we want to help.

Acknowledgements

My father, Tony Ford, 1937–2006 for lending his name for the scenario, died in an intensive care setting; both he and the nurses caring for him were in my thoughts a good deal as I wrote this.

References

American Friends Service Committee (1955) *Speak Truth to Power: A Quaker Search for an Alternative to Violence*. American Friends Service Committee, USA.

Bourdieu P (1984) *Distinction: A Social Critique of The Judgement Of Taste*. Routledge, Kegan and Paul, London, UK.

Bourdieu P (1989) Social space and symbolic power. *Sociological Theory*, **7**, 14–25.

Bourdieu P (1990) *The Logic of Practice*. Polity Press, Cambridge, MA.

Bourdieu P & Wacquant LJD (1992) *An Invitation to Reflexive Sociology*. Chicago Press, Chicago, IL.

Carter M (2010) Telling tales: 'atrocity stories' and the patient experience. *Nursing Management*, **16**, 28–31.

Carter M (2013) Nursing in the 21st century; perfect practice, imperfect practitioners. *Nursing Philosophy*, **15**, 57–59.

Carter M (2014) Vocation and altruism in nursing: the habits of practice. *Nursing Ethics*, **6**, 695–706.

Carter M (2016) Critical considerations in evidence-based interprofessional practice. In: *Evidence Based Practice: Issues and challenges for Nursing*. (ed. M. Lipscomb), Routledge, London, UK.

Casey J. (2011) *Panorama Undercover Care: the Abuse Exposed*, Panorama BBC 1 31/5/2011

Flynn M (2012) *Winterbourne View Hospital: A serious Case Review*. South Gloucestershire Safeguarding Adults Board, South Gloucestershire, UK.

Francis R (2013) *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*. The Stationary Office, London, UK.

Lipscomb M (2007) Maintaining patient hopefulness: a critique. *Nursing Inquiry*, **14**, 335–342.

Lukes S (2005) *Power: A Radical View*. Palgrave Macmillan, London, UK.

Miller JF (1989) Hope-inspiring strategies of the critically III. *Applied Nursing Research*, **2**, 23–29.

NMBA (2010) *Code of Professional Conduct for Nurses in Australia*. Nursing and Midwifery Board of Australia, Melbourne Australia.

NMC (2015) *The Code for Nurses and Midwives*. Nursing and Midwifery Council, London.

Nursingtimes (2009) *Whistleblowing nurse Margaret Haywood reinstated* [Online]. Available: http://www.nursingtimes.net/news/whistleblowing/whistleblowing-nurse-margaret-haywood-reinstated/5007290.fullarticle [Accessed 10/11 2016].

Panorama Undercover Care: the Abuse Exposed 2011. Directed by CASEY, J.: BBC 1.

Snelling PC (2013) Ethical and professional concerns in research utilisation: Intentional rounding in the United Kingdom. *Nursing Ethics*, **20**, 784–797.

© 2016 John Wiley & Sons Ltd

Swartz D (1997) *Culture and Power: The Sociology of Pierre Bourdieu*. The University of Chicago Press, Chicago, IL.

Van Houdt T (2002) *On the edge of truth and honesty: principles and strategies of fraud and deceit in the early modern period*. Leiden Boston: Brill.

Wong L & Gerras SJ (2015) *Lying To Ourselves: Dishonesty In The Army Profession*. Strategic Studies Institute, U.S. Army War College Commandant (AWCC-DSI/Publications), USA.

© 2016 John Wiley & Sons Ltd

View publication stats